MENTAL HEALTH ACT REVIEW

Submitted by

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INTRODUCTION

The BC Coalition of People with Disabilities (BCCPD) was incorporated in 1977. We are a non-profit, cross-disability organization run by and for people with disabilities throughout BC. Our Coalition represents people with a wide range of disabilities working towards a common goal of increased control over our lives along with participation and integration in our communities. Our members include people with physical, visual, hearing, learning, psychiatric and mental disabilities.

Our ongoing commitments on behalf of people with disabilities include:

- -lobbying all levels of government on legislation, policies and attitudes which affect people with disabilities
- -promoting public awareness through conferences, workshops and the media
- -individual and group advocacy for people with disabilities
- -serving on government and community-based committees and panels.

The BCCPD is a member of the national Canadian Organization of Provincial Organizations of the Handicapped (COPOH). Together we are part of the emerging Disability Rights Movement in Canada. Persons with disabilities are coming together on a cross-disability basis to seek solutions to commonly experienced problems such as barriers to employment, inadequate education and training, poverty, and human rights concerns.

BCCPD PROJECTS

The BCCPD has initiated a number of special projects to address some areas of specific concern, for example:

Aids and Disability Action Project

The project produces specialized educational materials on AIDS for people with a range of disabilities, as well as raising awareness about AIDS as a disability. The two year program will culminate in an international conference in October 1991.

Transition Newsletter Society

The Coalition Newsletter is produced ten times a year and is distributed to over 400 groups and 1500 individuals. It is a vehicle for sharing information within the disabled community and with our able-bodied members.

Advocacy Access

This project is based on the model of persons with disabilities empowering other persons with disabilities to claim their rights and responsibilities following the self-help model. This office provides an information and referral service on the various programs, benefits and services available to disabled consumers in B. C. A one-to-one advocacy is available to persons experiencing difficulties. The greatest demand has been for information and advocacy regarding social assistance and pension programs. The advocates have developed skills in representing persons with disabilities through negotiation and appeal with several ministries including the Ministry of Health and the Ministry of Social Services and Housing.

The Mental Health Advocate Empowerment Project

Through the work of the Advocacy Access Office and community group networking, we recognized the need to expand our operation to the field of mental health. This need has become more apparent with the downsizing of Riverview and the emphasis on community living. Many persons with mental health disabilities are striving to make their way in a complex and often confusing bureaucratic social service structure. This specific disability community finds itself in the same position that other disability groups did in the past. Therefore the Mental Health Advocacy Project was formulated to facilitate the access of mental health consumers to key community services and government programs.

A training program was established to train two mental health consumers. The project targets those programs and services which are provided by the Ministry of Social Services and Housing (MSSH). Our priority has been to provide an avenue by which persons with chronic mental illness can apply and obtain "handicapped" status. This status is important because it provides recipients with a higher level of benefits and access to other programs such as subsidized housing. We anticipate that this project will provide important information on how GAIN legislation and policy may be amended to better meet the needs of the mental health community.

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THE DECADE OF THE DISABLED AND BEYOND

People will disabilities have made major advances in the past decade. In the past ten years we have seen the development and the refinement of important concepts such as independent living, peer advocacy, and consumer participation. The Declaration of the Decade of the Disabled articulates this new philosophy in eleven principles. As we approach the last year of this decade, an opportunity arises to consider where we stand and where we are going.

Next year, in 1992, a major international conference on disability issues will be held in Vancouver. Through Independence '92 British Columbians will be able to show the world the advances that have been made in such areas as accessible, mainstream public transit systems and in human rights issues as embodied in the Canadian Charter of Rights and Freedoms. The BCCPD is taking a leadership role in promoting these initiatives. Our organization is working to improve personal decision-making, enhance human rights and ensure dignity and community integration for the whole disabled community.

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DEINSTITUTIONALIZATION AND COMMUNITY LIVING

The BCCPD strongly supports the continued development and implementation of deinstitutionalization. However, we do not see this process a merely an adoption of principles. Governments should not empty institutions without providing the necessary community support. Any new legislation must emphasize that people with mental health disabilities have control over their lives through the provision of a broad range of community based services and supports. Programs should strive to recognize the inherent dignity and capability of the individual.

The principles of Mental health legislation must recognize the autonomy of the individual by providing a framework for community living. Community supports and services provide the environment in which the autonomy of the individual with a mental illness can be fostered and encouraged. Legislative principles should ensure that maximum community services and supports have been provided and exhausted before hospitalization is considered. Any involuntary hospitalization should be seen as a last resort.

HUMAN RIGHTS AND MENTAL HEALTH

Section 7 of the Canadian Charter of Rights and Freedoms provides that an individual cannot be deprived of life, liberty or security of person unless legislation is in accordance with the principles of fundamental justice. Section 9 guarantees the right not to be arbitrarily detained or imprisoned. Other legal rights include the right on arrest or detention to be informed of the reasons thereof, and to retain counsel without delay and be informed of that right. Canadians with mental health disabilities should not be exempted from these fundamental rights because of a special "mentally ill status". All Canadians should enjoy the same rights and protections that the Charter guarantees.

Rights Information and Advice

Historically many persons with disabilities have lacked important knowledge that could have had an impact upon their lives. The BCCPD's Advocacy access project provides information and advice regarding rights to a broad range of people. Rights information is crucial to any person facing a curtailment of their liberty. Rights advice must be provided at the time of detention. Information must be provided prior to an examination or assessment by a doctor. If a person is likely to have their freedom deprived, they should have the right to an independent review of that decision. Patients with a mental health disability have the right to be informed of proposed treatment, the likely side effects, and of available alternatives.

Right to Refuse Treatment

A competent patients right to accept or refuse treatment must be recognized. All patients must be advised of this right. The rules of informed consent apply to hospitalized psychiatric patients both voluntary and involuntary. This should not be reviewable. Consent must be obtained for each specific treatment intervention. A patient's refusal or agreement to provide consent must be recorded with accompanying reasons. The principles of fundamental justice require that a patient not be assumed to be incompetent. Should incapability be suspected, the patient should have the right to request a hearing on the issue of capability.

Confidentiality

During psychiatric examination and assessment, patients provide information about themselves, their history and their actions. This information may be important in formulating a treatment plan. A patient has the right to expect that such information and records should remain confidential. Mental health legislation should include a strict duty of confidentiality as improper release of information may have severe consequences. Notwithstanding, a patient should have access to his/her own medical records.

A FAIR LEGISLATIVE FRAMEWORK

The Least Restrictive Setting and Least Intrusive Alternative

Should intervention become necessary, it must conform to the standard of least restrictive setting and least intrusive alternative. A person with a mental health disability has the right to expect that this standard be maintained during periods of personal crisis. The burden of proof must be put on the psychiatric facility to justify the restriction of liberty and limitation of individual rights. Such intervention must be seen as temporary and the medical profession has a duty to restore individual liberty and the person's ability to participate in their recovery both in the hospital and in the community upon discharge. Also the patient has the right to be offered the least restrictive and least intrusive form of treatment. The state should not have the power to force treatment.

Objective Standards and Observable Criteria for Involuntary Admission and Detention

The power to detain and restrict a person's liberty is a profound power. Such decisions should be based on objective standard and observable behaviours. It requires specific identification of the observable behaviour which may lead to detention, such as acting in a manner which has caused or is causing another person to fear bodily harm from the person. In addition, the examining psychiatrist must be able to conclude that as a result of the mental disorder, it is likely that the person will cause serious bodily harm to self or others.

Pre-planning and Substitute Decision Makers

Preplanning is a desired component of health care for persons with mental health disabilities. Individuals must be allowed the means and opportunity to express and record their wishes regarding treatment and who will make treatment decisions in the event they are deemed incapable. These contracts should outline not only those treatment options the patient wants, but also those options that he/she do not want. If the person, when competent, has provided guidance as to future treatment, then the principle of informed consent cannot be overlooked at a time or crisis. There can be no restriction on a person's liberty or medical intervention unless it has been clearly determined through the appropriate "capability" criteria. Consent is a process based on acceptance and partnership and should not be seen as a hurdle to overcome.

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A person should be able to appoint their own substitute decision maker. The decision of the substitute decision maker should be reviewable only if the person had no say in choosing the substitute. In the event that the person is unwilling or incapable of appointing a substitute decision maker, legislation should give order of priority to categories of persons who can act as substitute decision-makers.

Independent Reviews

The legislation must provide for a fair review mechanism that will be available to patients to review their detention, decisions about competence or transfer to a more secure environment. This body would be in addition, not instead of the patient's right to go to court.

Where possible, the appeal mechanism should be community based and not overly bureaucratic, legalistic, or medically biased. Legislation should ensure that the person requesting the review have access to advocacy service to assist and advise them through any part of the appeal process.

In the view of the BCCPD, the appeal mechanism established under the GAIN legislation, is, for the most part, an accessible and independent review process. This provides a good model for other areas of legislation.

Out-patient Commitment

In no circumstances should legislation permit the forced treatment of a competent mentally ill person living in the community.

CONSUMER PARTICIPATION AND INVOLVEMENT

Health care systems are recognizing the value of involving persons with disabilities in policy-making processes which affect our lives. This participation serves to ensure that both health care professionals and policies and the decision-making bodies at all levels of government are sensitive to the needs and issues of persons with a disability on an ongoing basis.

The concept of consumer participation requires the formulation and promotion of mechanisms which will support and enhance the development of this principle. Historically, systems based on the medical model have discouraged persons with disabilities from becoming actively involved in decision making - administrative concerns have often taken precedence over patient concerns. Consumer participation can be advanced by the appointment of consumer representatives to decision making and advisory bodies. Another way of recognizing the principle of consumer participation is by fostering the development of consumer controlled service delivery systems.

Lack of social support and employment opportunities are effective barriers against greater consumer participation and involvement. Legislation can help reduce these barriers and provide frameworks for full participation. Our systems and institutions have to change to allow for full participation. Service delivery and committee structures need to accommodate the consumers of services. The BCCPD believes it is time for consumers to be recognized as equal partners in health care delivery. People with mental health disabilities, like any other group in the disabled community, must be recognized as active and responsible participants in the development of legislation and care systems which meet our needs.

QUESTIONS

1 a) Are you in favour of a two-step process for involuntary patients with the first step being examination and assessment and the second being admission? If not, what option would you prefer?

-- BCCPD is in favour of a two-step process for involuntary patients.

Comment: The first certificate should be issued by a doctor and the second certificate should be issued by a psychiatrist. The provision of information and rights advice to the individual is mandatory throughout the examination and assessment process. Examination and assessment should be conducted in a safe and familiar environment where possible. A person should have the opportunity to request the support of friends and family at this time.

1 b) What should be the duration of detention (admission and renewal) certificates?

-- BCCPD recommends the following duration of detention certificates:
admission -- up to 7 days
first renewal -- 14 days
second renewal -- 14 days
third and subsequent renewals -- 30 days
After each renewal there must be a review.

Comment: Involuntary admission and detention should be for the shortest time possible. Medical professionals have a duty to explain to the patient all proceedings and to make every effort to ensure that the person is aware of his or her rights. Psychiatric facilities also have a duty to restore liberty as soon as possible and to do so in a manner which reduces the impact of any potential dislocation from the community.

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2 Which type of definition of mental disorder would you prefer for the revised Mental Health Act of BC?

-- BCCPD recommends that the definition of mental disorder should be:

Mental disorder means a substantial disorder of thought, mood perception, orientation or memory that grossly impairs judgment, behaviour and the capacity to recognize reality.

Comment: The definition of mental disorder must be narrow in scope so that individual rights are not infringed.

3 Which of the involuntary admission criteria regarding harm would you prefer to have in the revised BC Act? Would you prefer that persons suffering deterioration through neglect be provided for under mental health or guardianship legislation? Do you prefer to include deterioration criteria for both involuntary admission and involuntary examination/psychiatric assessment or only for the latter?

-- BCCPD prefers the following involuntary admission criteria regarding harm:
In the opinion of the psychiatrist, the person is likely to cause imminent and serious bodily harm to himself/herself or to others.

-- BCCPD recommends that persons suffering deterioration through neglect be provided for under guardianship legislation.

-- BCCPD recommends that deterioration not be a criterion for either involuntary admission or involuntary examination/psychiatric assessment.

Comment: The Mental Health Act should not be designed to anticipate every possibility and situation a mentally ill person may encounter. Guardianship legislation has a wider scope and can better address areas of concern such as deterioration.

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4 Which of the modifiers discussed should be included in the involuntary admission criteria of the revised BC Act?

-- BCCPD recommends that the only modifier that should be included in the involuntary admission criteria is "recent evidence" of violent behaviour or threatened violent behaviour.

Comment: Qualifiers should narrow the criteria. The modifier "recent evidence" can serve to narrow the criteria effectively and fairly when applied to every involuntary admission.

5 Please indicate which of the conditions should be included in the revised BC Act.

-- BCCPD recommends that the only conditions that should be included in the new BC Act should be "Not suitable for admission as a voluntary patient."

Comment: There must be an emphasis in the Mental Health Act on informed consent and the right to be a voluntary patient. A person cannot be involuntarily admitted unless he is "not suitable for voluntary admission".

6 a) What should be the maximum period a person can be detained for involuntary examination and psychiatric assessment?

-- BCCPD recommends that the maximum period a person can be detained for involuntary examination and psychiatric assessment is 48 hours.

Comment: A person may be released before 48 hours.

6 b) Who should be authorized to order a person to undergo involuntary examination and psychiatric assessment?

-- BCCPD recommends that only a physician be authorized to order a person to undergo involuntary examination and assessment.

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Comment: Attempts should be made to contact a person's doctor or psychiatrist (and other support persons) to obtain as much information as possible regarding the person's current situation. This information may help prevent an involuntary admission.

7 **Should patients under the Mental Health Act be governed by the same general rules of informed consent as the general population? If not, what rules should apply?**

-- The position of BCCPD is that patients under the Mental Health Act should be governed by the same general rules of informed consent as the general population.

Comment: Persons who are mentally ill should enjoy the same rights and freedoms as every other Canadian. These rights should not be restricted, except in life-threatening and time-limited circumstances.

8 **What is an emergency that justifies specific intervention without consent?**

-- In most situations provision for emergency intervention occurs only after a medical assessment indicates that the patient is in a life-threatening situation, or permanent and serious impairment of the person's health may result. Treatment of an involuntary "incapable" patient should occur only if there is such an emergency or with the consent of the substitute decision-maker.

Comment: After emergency intervention, it is the duty of medical professionals to ensure that the principle of informed consent is respected. Medical personnel must recognize the right of self-determination and the need for joint decision making in all aspects of health care.

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9 What is an appropriate definition of competence?

-- BCCPD recommends that the determination should be one of "capability" rather than "competence." The capability determination must conclude that the person has the ability to understand the following:
i) the condition for which the specific treatment is proposed
ii) the nature and purpose of the specific treatment
iii) the risks and benefits involved in undergoing the specific treatment
iv) the risks and benefits involved in not undergoing the specific treatment
v) any other treatment options.

Comment: Incapability is a temporary state. Many factors may affect the capability determination. Negative factors may include anxiety, stress and the priorities of the medical establishment. Capability must be reviewed upon the presentation of each treatment suggestion.

10 a) **Who should assess the person's capability to make treatment decisions and when should this assessment be made?**

--BCCPD recommends that the assessment of a person's capability to make treatment decisions should be made by a team of the following people:
1) the patient
2) a psychiatrist
3) an independent person mutually agreed upon by the patient and psychiatrist

Comment: The capability determination needs the input of the patient, medical insight and an independent person to reach a complete decision. This process has serious implications and must be seen as a last resort and the least desirable way to impact upon a person's treatment. If the patient disagrees with the determination, he/she should have the matter reviewed by an independent tribunal.

10 b) **Who should make the treatment decisions?**

--BCCPD believes that if the capability team has determined that the patient is not able to make treatment decisions and a substitute decision-maker has been previously selected by the patient, then that decision-maker has the right to authorize treatment.

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-- It is important that a person, prior to any period of incapacity, select and identify a substitute decision-maker. There should be a mechanism established by which a person can record and maintain her/her treatment wishes. The substitute decision maker would follow the person's treatment plan according to the written record.

The choice of substitute decision-maker should not be reviewable, except by the patient himself/herself. If there is not an appointed substitute decision-maker, the patient should be asked to select one after having the role described. If a patient cannot select a substitute decision-maker, then someone is selected from the following list:

1) a spouse or partner
2) a child of the patient, a parent of the patient
3) a brother or sister of the patient
4) any other next of kin
5) any other person who will consent to this role
6) a public guardian

The person occurring first on the above order is the person that shall be the first selection. If the patient objects to a selection, this will be recorded with reasons and submitted to a review tribunal.

Comment: Although the informed consent of the patient is the most desirable way to make treatment decisions, substitute decision making is a way to maintain a participatory process which allows the patient to retain some control.

10 c) **What standards should apply to the substitute decision-making process?**

-- BCCPD recommends that a substitute decision-maker should be available and willing to make the decision to give or refuse consent. He/she must have had contact with the patient in the last year, and be at least 16 years of age. The measures that govern a substitute decision are:

i) expressed wishes-directives and preferences in writing (or verbally) by the patient

ii) knowledge of the patient's values, beliefs, and patterns of former decision-making

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-- In the event of a dispute over the expressed wishes, a review tribunal may:
i) clarify the expressed wishes;
ii) clarify the application of the wishes to the circumstances; or
iii) determine if there are more recent expressed wishes.

Comment: A review tribunal may not override the expressed wishes of the patient, but it may replace a substitute decision maker who was not selected by the patient if it can be shown that the person is not following the above measures that govern the decision-maker.

11 What should be the exceptions to confidentiality?

--BCCPD recommends that the exceptions to confidentiality should be:
i) where the records, or a portion of, are made subject to a court order in the course of legal proceedings;
ii) to those medical practitioners and other health professionals directly involved in the patient's treatment and who work in the same facility.

Comment: A patient's consent for access by another person to her/her file must always be sought. Written consent by the patient is necessary in order to release the file to individuals or agencies.

12 What should be the limitations to access?

--BCCPD recommends that the patient have unfettered access to his/her own medical files. The only limitation to access that my be imposed is when it is likely that harm will be done by the patient to another person as a direct result of the information on the file.

Comment: Patients access to information in their files must be allowed for the purpose of determining the reasonableness of involuntary detention, to allow for the ability to give informed consent to treatment and for any administrative or judicial proceeding involving the course of medical treatment.

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13 a) What are your preferences for review tribunal structure?

--BCCPD recommends a quasi-judicial tribunal structure that is community based and independent from the psychiatric institutions. The patient would select a nominee, the institution would select a nominee, and these two nominees would select a chairperson from a list that was compiled by the mental health community (including consumers). A code of procedure could be outlined in the Act of Regulations.

--The patient should be present at the tribunal hearing and should have prior access to all evidence and information presented to the tribunal. Any exceptions to this must be discussed prior to the hearing. The patient should have the right to be represented at the hearing by an advocate and to have witnesses give evidence. The tribunal would make their decision on the basis of the Act and Regulations and the principles of natural justice. The decision would be binding on the parties, but the patient would not relinquish his/her right to take the matter to court.

Comment: The Advocacy Access project of the BCCPD has direct experience of the appeal mechanism set out in the GAIN legislation. For the most part, GAIN tribunals are an accessible, effective, well-balanced and timely method to to deal with income assistance disputes. Recently, the Ministry of Advanced Education, Training and Technology adopted a similar model for the purposes of Vocational Rehabilitation of Disabled Persons (VRDP) appeals. The present Review Panel process is limited in its jurisdiction, often medically biased and lacking in community input. Furthermore, few checks and balances exist which will guarantee the patient a fair and impartial hearing.

13 b) What types of issues should the tribunal be called upon to decide (i.e. jurisdiction)?

--BCCPD recommends that the tribunal have jurisdiction to review:
- all decisions regarding detention
- decisions regarding any treatment plan for a patient
- decisions regarding capability assessment (or competence)
- decisions regarding transfer, use of restraints, access to information and exceptions to confidentiality

Comment: It is appropriate to attempt to resolve disputes in a timely manner. The request for a review tribunal should not be jeopardized by a patient's attempts to mediate or solve a problem prior to the tribunal hearing. If mediation is pursued and is unsuccessful, then the patient has a right to have the matter heard at the tribunal.

13 c) **Should there be provision in the Act regarding advocacy? If so, what should they include?**

--BCCPD believes that provisions for advocacy must be guaranteed through legislation. A patient must have the right to be represented, if he/she so chooses, by a trained advocate at a review tribunal (if he/she so chooses). In order for a patient to adequately enforce his/her rights, advocacy services should be independent from the psychiatric facility, and employ trained, para-legal staff who work under the supervision of lawyers.

Comment: Currently, many persons with mental health disabilities represented by advocates at Review Panels. The legal resources available cannot meet all the needs of persons with mental illness seeking legal advice and representation in this province. Without adequate advice and representation, the reality is that many persons will remain in hospital when other options may exist. Advocacy services also facilitate the development of self-help skills which in turn encourage fuller participation and self autonomy.

The BCCPD has provided advocacy services for several years, and in 1991, through the Mental Health Advocate Empowerment project, mental health issues have been targeted. We believe that mental health consumers can be trained to become effective advocates. Peer advocacy is a concept that legislation needs to recognize. The Mental Health Act should incorporate provisions to ensure that mental health patients have access to advocacy services. Further steps should be taken to ensure that broader based advocacy legislation is introduced to meet the needs of the community.

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13 d) Should there be mandatory administrative reviews for involuntary patients? If so, in what time frame (eg. shortly after admission, after every six months, etc.)?

--BCCPD recommends that there be mandatory reviews. Reviews should be:

first renewal - 14 days
second renewal - 14 days
third and subsequent renewals - no longer than 30 days at a time
discharge

Comment: The patient's direct consent may not be required to review the reasons for his/her detention.

14 Please indicate whether or not you favour the inclusion of involuntary outpatient commitment (IOC) in mental health legislation in BC. If not, do you think that the main target group for IOC can be adequately served through guardianship legislation? If you favour IOC, which of the types discussed should be considered and with what limitations?

--BCCPD is not in favour of involuntary Outpatient Commitment (IOC).

Comment: The risks of abuse of I.O.C. outweigh any possible benefit to the patient. We believe that the Mental Health Act should set strict limits to admission and detention in hospitals, and that no capacity to restrict individual liberty should exist in other mental health legislation. Co-ordinated and planned discharge, with guarantees for patient participation, eliminates the need for legislation in this area.

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CONCLUSION

Mental health legislation cannot be reviewed in isolation. A broad range of social policy and legislative initiatives impact upon the daily lives of people with mental health disabilities. The availability of affordable housing, for example, can have a profound effect on a person's ability to establish and maintain a healthy living environment. For persons with chronic mental illness who are unable to secure employment, the criteria that determine disability income benefits may ultimately determine whether sufficient financial resources for community living are available to the individual. The face of service delivery systems and the bureaucracy of government and community-based services influences the consumers ability to access essential programs. These are just a few key factors that could spell success or failure to the person with a mental health disability who is attempting to live independently in the community without fear of detention or loss of personal autonomy.

The BCCPD is aware of the many barriers facing persons with disabilities. In particular, the correlation between poverty and disability is a statistic that has not significantly diminished in the past few years. We need to challenge and break the cycles of poverty to which the disabled community are victim. We need to remove the potential of mental health legislation to combine with income security legislation to reinforce and exacerbate poverty.

Society has become more aware of the straight-jacket that the culture of institutionalization and compulsion imposes upon human rights. The Declaration of the Decade of the Disabled reflects a shift in philosophy. Corresponding shifts in legislation, policy and practice are gradually evolving but have not kept pace. Education plays an important part in this process but we need to do more. We, as persons with disabilities, must be prepared to take action as individuals and group members and strengthen our networks with the rest of the community. We must be prepared to speak out and articulate our concerns. The community, in return, must help us remove systematic discrimination and preserve the rights and dignity of all citizens.

DECLARATION ON THE DECADE OF DISABLED PERSONS

THE GOVERNMENT OF CANADA

RECALLING *the resolutions of the United Nations' General Assembly 37/52 and 37/53 which adopted the World Programme of Action concerning Disabled Persons and called upon Member States, all relevant non-governmental organizations and organizations of disabled persons to ensure early implementation of the World Programme of Action concerning Disabled Persons and mindful that Member States of the United Nations are requested to develop plans related to the World Programme of Action,*

RECALLING ALSO *the Declaration of the United Nations on the Rights of Mentally Retarded Persons and the Rights of Disabled Persons,*

RECALLING FURTHER *the Canadian Charter of Rights and Freedoms (section 15) which prohibits discrimination on the basis of any mental or physical disability,*

EMPHASIZING *the objectives of the World Programme of Action which are the promotion of effective measures for prevention of disability and impairment for the rehabilitation and for the realization of the goals of "full participation" of disabled persons in social life and development, and of "equality," meaning opportunities equal to those of the whole population and an equal share in the improvement in living conditions resulting from social and economic development,*

BEARING IN MIND *the distinction made between impairment (any loss or abnormality of psychological, physiological, or anatomical structure or function), disability (any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being), and handicap (a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is considered as normal, depending on age, sex, social and cultural factors, for that individual) and the resulting conclusion that a handicap is a function of the relationship between disabled persons and their environment,*

BEARING IN MIND ALSO *the definitions of the terms of action proposed in the World Programme as prevention (the measures aimed at preventing the onset of mental, physical and sensory impairments or at preventing impairment, when it has occurred, from having negative physical, psychological and social consequences), rehabilitation (a goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level, thus providing the person with tools to change his or her own life), equalization of opportunities (the process through which the general systems of society are made accessible to all),*

NOTING *the success of organizations of disabled persons and others in developing innovative and effective alternative means of enhancing the participation and integration of persons with disabilities in society,*

RECOGNIZING *the significant loss to the Canadian economy when the full potential and abilities of persons with disabilities are not utilized, and the real cost upon the economy due to segregation,*

NOTING IN PARTICULAR *the emergence of organizations of disabled persons and the need for participation and integration of persons with disabilities in society,*

PROCLAIMS *1983–1992 the Decade of Disabled Persons during which the objectives of the World Programme of Action concerning Disabled Persons will be implemented in accordance with this Declaration of Principles which will direct and guide our governmental actions.*

PRINCIPLES

1. *The abilities, integrity, right of choice and dignity of individuals with disabilities shall be respected in all stages of their lives.*
2. *In the development and implementation of programmes and services every effort shall be made to avoid forcing individuals to leave their families and home communities with the goal of ensuring an early and lasting integration into society of individuals with disabilities.*
3. *Services and programmes shall be aimed at integrating disabled persons into existing social and economic structures rather than segregating such persons into parallel environments.*
4. *Persons with disabilities shall be assured involvement in decision making which pertains to the design and organization of programmes and services considered necessary for the integration of disabled persons into all facets of society. In this respect there shall be a particular emphasis on rehabilitation.*
5. *Individuals with disabilities shall be assured access to fundamental elements of daily life that are generally available in the community. Wherever possible the effects of an impairment or disability on an individual's life shall not be determined by environmental factors.*
6. *Persons with disabilities shall be encouraged to engage in all aspects of society and to participate in social change to fulfill themselves and to meet their obligations as citizens.*
7. *The development of self-help organizations of persons with disabilities shall be encouraged so as to provide these citizens with a means of self-development and a voice of their own to articulate their needs, views and priorities.*
8. *A minimum standard in the provision of programmes and services to disabled persons shall be met across Canada; disparities shall be minimized despite rural isolation, poverty, indigenous status and regional economic conditions.*
9. *In the development of programmes aimed at the total population, attention shall be given to measures which could prevent or reduce the incidence of disability and impairment.*
10. *There shall be consultation among governments and all sectors of society to ensure that a coordinated effort is undertaken to allocate resources to the prevention of disability and to facilitate the rehabilitation and integration of persons with disabilities into all aspects of society.*
11. *There shall be action and public education to minimize environmental barriers, to remove systemic barriers and remedy social attitudes evolving from ignorance, indifference and fear, which impede the full participation of individuals with disabilities.*

Prime Minister of Canada