ROXANNE STEWART REFUGEE CASE
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SUPPORTING DOCUMENTS
Summaries, Reports, Articles, and Evidence

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ALL HUMAN RIGHTS AND LEGISLATIVE VIOLATIONS EXPERIENCED BY MENTAL HEALTH PATIENT, ROXANNE STEWART

ALL HUMAN RIGHTS AND LEGISLATIVE VIOLATIONS EXPERIENCED BY MENTAL HEALTH PATIENT, ROXANNE STEWART, WHETHER UNDER LOCAL LAW AND CONSTITUTIONAL RIGHTS, AND INTERNATIONAL LAW AND HUMAN RIGHTS ACTS UNDER THE UNITED NATIONS WHICH JAMAICA IS A SIGNATORY TO.

1) According to Chapter 3 of the Jamaican Constitution dealing with Fundamental Rights and Freedoms:

13. Whereas every person in Jamaica is entitled to the fundamental rights and freedoms of the individual, that is to say, has the right, whatever his race, place of origin, political opinions, colour, creed or sex, but subject to respect for the rights and freedoms of others and for the public interest, to each and all of the following, namely-

a. life, **liberty, security of the person**, the enjoyment of property and the protection of the law; **(My right to liberty and security of person is clearly being violated with the threat of forced drug treatments and involuntary hospitalization by Dr. Jacqueline Martin. The life of my unborn baby would also obviously be at risk if these drug treatments of powerful anti-psychotic drugs were forced on me)**

16. (**1**) **No person shall be deprived of his freedom of movement**, and for the purposes of this section the said freedom means the right to move freely throughout Jamaica, the right to reside in any part of Jamaica, the right to enter Jamaica and immunity from expulsion from Jamaica. **(The threat of being unjustifiably involuntarily hospitalized by Dr. Jacqueline Martin or subject to restrictive hospitalized conditions at my parents house is a violation of my right to freedom of movement)**

17. (**1**) No person shall be subjected to torture or to **inhuman or degrading punishment or other treatment.** -- **(The threat of being unjustifiably involuntarily hospitalized by Dr. Jacqueline Martin and unjustifiably being injected by several psychotropic drugs which would cause severe physical and mental distress is deemed as inhuman and degrading treatment)**

21. (**1**) Except with his own consent, no person shall be hindered in the enjoyment of his freedom of conscience, and for the purposes of this section the said freedom includes **freedom of thought and of religion,** freedom to change his religion or belief, and freedom, either alone or in community with others, and both in public and in private, to manifest and propagate his religion or belief in worship, teaching, practice and observance. **(Being deemed as psychotic because of my religious beliefs by Dr. Jacquelin Martin is a violation of my right to freedom of thought and freedom of religion)**

(**5**) **No person shall be compelled to take any oath which is contrary to his religion or belief** or to take any oath in a manner which is contrary to his religion or belief. **(I was being coerced by Dr. Jacqueline Martin to sign a form enabling her to drug me with many different psychotropic drugs that would endanger the life of my baby as well as my own physical well being even though I had told her I do not believe in abortion or termination of my pregnancy)**

(**2**) Subject to the provisions of subsection (6), (7) and (8) of this section, **no person shall be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the**

functions of any public office or any public authority. (I was being treated as a mentally and psychologically incompetent person by Dr. Jacqueline Martin simply by virtue of having a clinical diagnosis of Bipolar Disorder and not because of any psychotic symptoms or suicidal/homicidal symptoms, which is deemed as an act of discrimination)

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2) According to the Mental Health Act of Jamaica:

Section 11.-(1) **A patient shall not be given treatment in a psychiatric facility without his consent unless a duly authorized medical officer certifies that the patient's mental condition is such that he is not competent to give consent. (This principle under section 11 was violated when I was injected with Modecate/Fluphenazine without my consent even though when I was evaluated by nurses and Dr. Frank Knight, I was very much mentally competent and able to give consent)**

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3) According to the Protection of Persons with Mental Illness and the Improvement of Mental Health Care by the World Health Organization which Jamaica is a signatory country to:

Principle 1 - Fundamental freedoms and basic rights

2. All persons with a mental illness, or who are being treated as such persons, **shall be treated with humanity and respect for the inherent dignity of the human person. (My respect and dignity as a person was clearly being ignored by Dr. Jacqueline Martin while she advocated for forced treatment and medical interventions ahile I was not even allowed to speak or give an opinion on the matter)**

3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or **other abuse and degrading treatment. (The suggestion that I should be forcefully hospitalized or restricted to hospitalized conditions at my parents house while being forced to take powerful anti-psychotic and sedative drugs against my will is clearly abusive and degrading)**

4. There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of **nullifying or impairing equal enjoyment of rights. (Clearly my rights to make my own decision about my own mental health were nullified when both Dr. Jacqueline Martin and Dr. Nyamakeye Richards deemed that I was either psychotic or in need of involuntary hospitalization)**

Principle 4 - Determination of Mental Illness

1. A determination that a person has a mental illness shall be made in **accordance with internationally accepted medical standards. (During my appointments with Dr. Jacqueline Martin and Dr. Nyamakeye Richards, I was never assessed for bipolar symptoms based on the DSM-5 assessment method which is internationally recognized)**

2. **A determination of mental illness shall never be made on the basis of political, economic or social status, or membership in a cultural, racial or religious group, or for any other reason not directly relevant to mental health status. (Jacqueline Martin made the assessment that I was in a manic/psychotic episode because of my religious beliefs and deemed me "Religiose")**

3. **Family or professional conflict**, or non-conformity with moral, social,

cultural or political values or religious beliefs prevailing in a person's community, **shall never be a determining factor in the diagnosis of mental illness. (Dr. Nyamakeye Richards justified her assessment that I was in a psychotic episode by her statement that since I was in conflict with my mother and husband, it was suggestive that I was in an episode of psychosis)**

4. **A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness. (This was the basis for Dr. Nyamakeye Richards agreeing with Dr. Jacqueline Martin's course of action as well as her pronouncement that she thought I was in a psychotic episode)**

Principle 8 - Standards of Care

2. Every patient shall be protected from harm, **including unjustified medication,** abuse by other patients, **staff or others or other acts causing mental distress or physical discomfort. (Given that it is obvious on the recordings that I was not suffering from psychosis, the recommendation of Olanzapine, Diazapam, Lamectal and a higher dosage of Seroquel was clearly unjustified)**

Principle 9 - Treatment

1. Every patient shall have the right to be **treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs** and the need to protect the physical safety of others. **(This was clearly not being done by Jacqueline Martin when she was advocating for my hospitalization or restricted hospitalized conditions at my parents house even though I was not suffering from symptoms of psychosis or homicidal/suicidal thoughts or behaviors)**

4. The treatment of every patient shall be directed towards **preserving and enhancing personal autonomy. (This was clearly not being done by Jacqueline Martin when she was advocating for my hospitalization or restricted hospitalized conditions at my parents house even though I was not suffering from symptoms of psychosis or homicidal/suicidal thoughts or behaviors)**

Principle 10 - Medication

2. **All medication** shall be prescribed by a mental health practitioner authorized by law and **shall be recorded in the patient's records. (The dosage of Modecate/Fluphenazine that I was given in medical associates was not recorded in my medical records. I was informed of this by the medical records officer at medical associates when I asked to look at my records)**

Principle 11 - Consent to Treatment

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle. **(This principle was violated when I was injected with Modecate/Fluphenazine without my consent during my hospitalization at Medical Associates Hospital in 2015 and the side effects and risks of this drug was never explained to me)**

2. Informed consent is consent obtained freely, **without threats or improper inducements,** after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:

(a) The diagnostic assessment;

(b) The purpose, method, likely duration and expected benefit of the proposed treatment;

(c) Alternative modes of treatment, including those less intrusive;

(d) Possible pain or discomfort, risks and side-effects of the proposed treatment. **(This was clearly not being done while Dr. Jacqueline Martin tried to coerce me to sign a document consenting to being given the drugs Olanzapine, Daizapam, Lamectal and a higher dosage of Seroquel, and when I refused to sign, she tried to convince my father to involuntarily hospitalize me based on section 6 of the mental health care act)**

Principle 15 - Admission Principles:

1. Where a person needs treatment in a mental health facility, **every effort shall be made to avoid involuntary admission. (This was clearly not being done while Dr. Jacqueline Martin tried to convince my father to involuntarily hospitalize me even though I had no symptoms of psychosis or suicidal or homicidal thoughts or behaviors)**

Principle 19 - Access to information

1. **A patient** (which term in the present Principle includes a former patient) **shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. (I was denied the right to view or have a copy of my medical records for my hospitalizations at Medical Associates Hospital)**

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4) According to the Universal Declaration of Human Rights which according to Article 2, I am entitled to:

Article 3 – Everyone has the right to life, **liberty and security of person. (My liberty/freedom would be at risk with the threat of unjustified forced hospitalization, and the security of the life of my unborn baby would also be very much compromised by forced drug treatments unsafe for pregnancy)**

Article 5 – No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. **(Being given and injected with neuroleptic/psychotropic drugs against my will or without my consent, when I am mentally and psychologically competent enough to give my consent which cause severe physically and mentally distressing side effects would be considered cruel, inhuman and degrading treatment)**

Article 6 – Everyone has the right to recognition everywhere as a person before the law. **(I was not being regarded as a mentally competent and capable person by Dr. Jacqueline Martin as my decisions weren't being respected and I was ignored and being treated as if I were mentally and intellectually incapacitated.)**

Article 12 – No one shall be subjected to arbitrary interference with his privacy, family, home, or correspondence, not to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks. **(I was being threatened with involuntary hospitalization as well as restricted hospitalized conditions at my parents house while no provisions were being made for me to see or take care of my two year old son. Also the unjustified declaration by Dr. Nyamakeye Richards that I was in a psychotic episode is an attack on my character and reputation)**

CHAPTER 3 of the INTERPRETATION OF THE CONVENTION REFUGEE DEFINITION IN THE CASE LAW as set out by the Immigration and Refugee Board of Canada:

CHAPTER 3 - PERSECUTION

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3. PERSECUTION

3.1. GENERALLY

3.1.1. Definition

Like other terms in the Convention refugee definition, "persecution" is a word whose meaning is neither self-evident nor defined in the *Immigration and Refugee Protection Act* (IRPA). Therefore, it has fallen to the courts to identify the boundaries of the word. Case-law has not only labelled specific behaviours as instances of persecution, but also has gone some distance toward identifying general hallmarks that must be present, or criteria that must be met, in order for actions or omissions to constitute persecution.

3.1.1.1. Serious Harm

First, to be considered persecution, the mistreatment suffered or anticipated must be serious.[Note 1] And in order to determine

whether particular mistreatment would qualify as "serious", one must examine:

1. **what interest of the claimant might be harmed; and**
2. **to what extent the subsistence, enjoyment, expression or exercise of that interest might be compromised.**

This approach has been approved by the courts, which have equated the notion of a serious compromising of interest with a key denial of a core human right. Thus, in *Ward*,[Note 2] the Supreme Court said as follows:

Underlying the Convention is the international community's commitment to the assurance of basic human rights without discrimination. This is indicated in the preamble to the treaty as follows:
CONSIDERING that the Charter of the United Nations and the Universal Declaration of Human Rights - have affirmed the principle that human beings shall enjoy fundamental rights and freedoms without discrimination.

This theme … provides an inherent limit to the cases embraced by the Convention. Hathaway, - at p. 108, thus explains the impact of this general tone on the treaty on refugee law:

The dominant view, however, is that refugee law ought to concern itself with actions which deny human dignity in any key way and that the sustained or systemic denial of core human rights is the appropriate standard.

This theme sets the boundaries for many of the elements of the definition of Convention "refugee". **"Persecution", for example, undefined in the Convention, has been ascribed the meaning of "sustained or systemic violation of basic human rights demonstrative of a failure of state protection"**; see Hathaway, - at pp. 104-105. So too Goodwin-Gill, … at p. 38 observes that "comprehensive analysis requires the general notion [of persecution] to be related to developments within the broad field of human rights". This has recently been recognized by the Federal Court of Appeal in the *Cheung* case.[Note 3]

In *Chan*,[Note 4] La Forest J. (in dissent) reiterated that "[t]he essential question is whether the persecution alleged by the claimant threatens his or her basic human rights in a fundamental way." Mr. Justice La Forest also said:

These basic human rights are not to be considered from the subjective perspective of one country ... By very definition, such rights transcend subjective and parochial perspectives

and extend beyond national boundaries. This does not mean, however, that recourse to the municipal law [i.e. domestic or internal law] of the admitting nation may not be made. For such municipal law may well animate a consideration of whether the alleged feared conduct fundamentally violates basic human rights.[Note 5]

If the conduct does amount to persecution, there is no further requirement that the persecution be dramatic or appalling or horrendous,[Note 6] unless the issue in the case involves the application of section 108(4) of the IRPA (section 2(3) of the former *Immigration Act*) (see Chapter 7, section 7.2).

The requirement that the harm be serious has led to a distinction between persecution on the one hand, and discrimination or harassment on the other, with **persecution being characterized by the greater seriousness of the mistreatment which it involves**.[Note 7] Discrimination and harassment are sometimes conceived of as being distinct from persecution; alternatively, some references to persecution and discrimination imply that persecution is a subset of discrimination; but in either case, **what distinguishes persecution - whether from discrimination or non-persecutory discrimination - is the degree of seriousness of the harm.** The Court of Appeal has observed that "the dividing line between persecution and discrimination or harassment is difficult to establish."[Note 8] As to the particular susceptibilities of a given claimant, the Court in *Nejad*[Note 9] said the following:

The CRDD did recognize and the Court agrees that there may be certain circumstances in which the particular characteristics or circumstances of a claimant ... might affect the assessment of whether certain acts or treatments are persecutory. [To] ... **the extent that an agent of persecution intentionally plays upon or exploits the fact that a person suffers from a particular frailty or condition in order to cause harm,** an act not normally or inherently persecutorial, may be transformed into an act of persecution.

That is beautiful in theory, but who knows what is the intention of the persecutor? Who knows what is the particular knowledge of the persecutor? One must look at the act and the effect.[Note 10] And in this case, in particular, because of the old age of the applicants, it should have been more obvious to the CRDD panel that the effect upon them was that of persecution.

For additional material on the distinction between persecution and discrimination, see paragraph 54 of the UNHCR *Handbook*.

3.1.1.2. Repetition and Persistence

A second criterion of persecution is that the inflicting of harm occurs with repetition or persistence, or in a systematic way. This

requirement has been approved in *Ward* (quoting Hathaway).[Note 11] It also derives from the Court of Appeal decision in *Rajudeen*,[Note 12] which is much-cited on this point:

The definition of Convention refugee in the *Immigration Act* does not include a definition of "persecution". Accordingly, ordinary dictionary definitions may be considered. *The Living Webster Encyclopedic Dictionary* defines "persecute" as:
"To harass or afflict with repeated acts of cruelty or annoyance; to afflict persistently, to afflict or punish because of particular opinions or adherence to a particular creed or mode of worship."

The *Shorter Oxford English Dictionary* contains, *inter alia*, the following definitions of "persecution":

"A particular course or period of systematic infliction of punishment directed against those holding a particular (religious belief); persistent injury or annoyance from any source."

...[the evidence] establishes beyond doubt a lengthy period of systematic infliction of threats and of personal injury. The applicant was not mistreated because of civil unrest in Sri Lanka but because he was a Tamil and a Muslim.[Note 13]

The Court of Appeal later provided something of an elaboration in *Valentin*[Note 14]:

…it seems to me … that an isolated sentence can only in very exceptional cases satisfy the element of repetition and relentlessness found at the heart of persecution (cf. *Rajudeen*…) …[Note 15]

Jurisprudence also recognizes that some sentences and forms of punishment of undue proportion by the state may be considered as persecution, such as in certain cases involving military evaders.[Note 16]

These authorities notwithstanding, it would seem that persistence or repetition should not be regarded as a necessary element in all cases. Some forms of harm are unlikely to be inflicted repeatedly (e.g., female genital mutilation), or are simply incapable of being repeated (e.g., the killing of the claimant's family as a form of retribution against the claimant); nevertheless, they are so severe that their characterization as persecution seems beyond dispute.[Note 17]

In the case of *Ranjha*,[Note 18] the Court has further commented that there should not be an "exaggerated emphasis" on the need for repetition and persistence. **Rather, the RPD should analyze the quality of incidents in terms of whether they constitute "a fundamental violation of human dignity".**

3.1.1.3. Nexus

For a claim to succeed, the definition of Convention refugee requires that the persecution be linked to a Convention ground. The Supreme Court of Canada noted in *Ward* that:

… the international community did not intend to offer a haven for all suffering individuals. The need for "persecution" in order to warrant international protection, for example, results in the exclusion of such pleas as those of economic migrants, i.e. individuals in search of better living conditions, and those of victims of natural disasters, even when the home state is unable to provide assistance. …[Note 19]

In *Suvorova*, the Court commented that in determining whether a nexus exits the claimant's narrative should be considered from the perspective of all Convention grounds. The Court noted that there is an obligation to consider all possible grounds for protection raised by the facts, even if they are not raised by a claimant.[Note 20]

Indirect persecution (see Chapter 9, section 9.4) does not constitute persecution within the meaning of the definition of Convention refugee as there is no personal nexus between the claimant's alleged fear and a Convention ground. Accordingly, the Federal Court of Appeal in *Pour-Shariati* held, overruling *Bhatti*,[Note 21] a case recognizing the concept of indirect persecution, that:

We accordingly overrule Bhatti's recognition of the concept of indirect persecution as a principle of our refugee law. In the words of Nadon, J. in Casetellanos v. Canada (Solicitor General) (1994), 89 F.T.R. 1, 11, "since indirect persecution does not constitute persecution within the meaning of Convention refugee, a claim based on it should not be allowed." It seems to us that the concept of indirect persecution goes directly against the decision of this Court in Rizkallah v. Canada, A-606-90, decided 6 May 1992, [1992] F.C.J. No. 412, where it was held that there had to be a personal nexus between the claimant and the alleged persecution on one of the Convention grounds. One of these grounds is, of course, a "membership in a particular social group," a ground which allows for family concerns in on [sic] appropriate case.[Note 22]

In *Granada*[Note 23], the Court set out the only circumstances in which the family can be considered a particular social group as follows:

[16] The family can only be considered to be a social group in cases where there is evidence that the persecution is taking place against the family members as a social group: [citations omitted]. However, membership in the social group formed by the family is not without limits, it requires some proof that the family in question is itself, as a group, the subject of reprisals and vengeance…[Note 24].

3.1.1.4. Common Crime or Persecution?

Persecution has been distinguished from random and arbitrary violence[Note 25] and from suffering as a result of a criminal act or a personal vendetta.[Note 26] In a few of the cases where the claimant has been victimized by what might be characterized as a "common" crime, there has been some discussion of whether the mistreatment in question might qualify as "persecution". The Trial Division has said that most acts of persecution can be characterized as criminal, but that in an individual case the Refugee Division (now Refugee Protection Division - RPD) may nevertheless distinguish between criminal acts and persecution.[Note 27] In the case of *Alifanova*,[Note 28] the Court has further commented that

while most acts of persecution are criminal in nature, not all criminal acts can be considered acts of persecution. It continues to give the following example: "Extortion is a criminal act. Threats of bodily harm is a criminal act. Because these criminal acts are made by Kazakhs against Russians does not make the act one of persecution." Some of the cases in this area involve personal vendettas, or the misuse of official position, or the witnessing of criminal acts.

With respect to cases involving domestic abuse, the Court of Appeal in *Mayers*,[Note 29] said that the Refugee Division might find domestic violence to be persecution, but in the circumstances of the case, the Court was not required to make that finding.[Note 30] The Trial Division, in a number of cases has regarded domestic abuse as persecution.[Note 31] The cases often intertwine the discussion of whether domestic violence constitutes persecution with the question of whether victims of domestic violence constitute a particular social group. For example, in *Resulaj*,[Note 32] the Court made the following observation:

Nothing prevents a woman from being both a victim of domestic violence and a victim of crime. It is well established that a women [sic] subject to domestic violence constitute a particular social group entitled to convention refugee protection. [*Diluna; Narvaez*]

Another earlier example is *Aros*,[Note 33] where the Court noted:

Accepting that the applicant suffered physical and psychological abuse at the hands of her common law husband …, the panel made no overriding error in concluding she was not a member of a social group that faced persecution within the definition…

In assessing claims based on criminal acts, it is suggested that members inquire whether the harm is serious,[Note 34] whether there is a serious possibility of the harm's occurring, whether the harm is inflicted for a Convention reason,[Note 35] and whether state protection is available.[Note 36] The finding of state protection must be made on the basis of the evidence before the panel rather than on mere speculation.[Note 37] See also Chapter 4, section 4.7.

3.1.1.5. Agent of Persecution

Serious human rights violations may in fact issue not only from higher authorities of the state, but also from subordinate state authorities, or from persons who are not attached to the government; and whichever is the case, the Convention may apply. In order to be categorized as persecution, the harm need not emanate from the state; and the state need not be involved or be complicit in the perpetration of the harm.[Note 38]

The fact that those who inflict mistreatment are schoolchildren and schoolyard bullies is not relevant to the question of whether the mistreatment amounts to persecution.[Note 39]

Similarly, serious mistreatment inflicted by teenagers upon a minor claimant may not reasonably be regarded as mere pranks.[Note 40]

For more regarding the role of the state with respect to mistreatment of a claimant, see Chapter 6.

3.1.2. Cumulative Acts of Discrimination and/or Harassment

A given episode of mistreatment may constitute discrimination or harassment, yet not be serious enough to be regarded as persecution.[Note 41] Indeed, a finding of discrimination rather than persecution is within the jurisdiction of the RPD.[Note 42] Even so, acts of harassment, none amounting to persecution individually, may cumulatively constitute persecution.[Note 43] Where the claimant has experienced more than one incident of mistreatment, the Refugee Protection Division may err if it only looks at each incident separately.[Note 44] However, "it is insufficient for the RPD to simply state that it has considered the cumulative nature of the discriminatory acts", without any further analysis.[Note 45] Moreover, the Court has also commented on the need to consider whether the repeated incidents of harassment in the past may lead to a serious possibility of persecution in the future.[Note 46]

It is appropriate to consider both the actions of the government against the individual claimant and the overall atmosphere created by the state's intolerance.[Note 47]

See also paragraphs 53, 54, 55, 67 and 201 of the UNHCR *Handbook*.

The Federal Court in *Liang*, citing paragraphs 54 and 55 of the UNHCR *Handbook* affirmed that in the exercise of determining whether cumulative discrimination and harassment constitutes persecution it is necessary to evaluate the claimant's personal circumstances and vulnerabilities including age, health, and finances.[Note 48]

In assessing whether cumulative acts of discrimination amount to persecution it is necessary first to decide whether an individual act constitutes harassment or is discriminatory. The Federal Court in *Hund*[Note 49] concluded that it would be an error to consider acts that are erroneously characterized as discriminatory in assessing whether cumulative acts of discrimination amount to persecution. Such acts could include abandonment by one's own family, general threats made at community meetings, and relocating. Also, the "cumulative effect" should only consider incidents related to a Convention reason.

Where state protection is available for the types of events alleged as discriminatory, the cumulative assessment is not necessary.[Note 50]

In *Munderere*,[Note 51] the Federal Court of Appeal stated that "there is nothing in paragraph 53 of the *UNHCR Handbook* which could justify an expansion of the cumulative effect of incidents doctrine to events that occurred in two different countries." The Court held that, when analyzing cumulative grounds, "[a]s a matter of principle, events which occur in a

country other than that in respect of which a claimant seeks refugee status should not be considered."[Note 52] However, the Court added the following caveat: 'except where the events which occur in a country other than that in respect of which a claimant seeks refugee status are relevant to the determination of whether the country where a claimant seeks refugee status can protect him or her from persecution."[Note 53]

3.1.3. Forms of Persecution

3.1.3.1. Some Judicial Observations

It is impossible to compile an exhaustive catalogue of forms of persecution. Furthermore, whether particular harm constitutes persecution may depend upon the facts of the individual case. Nevertheless, here are some of the more instructive observations that emerge from the case law. (NOTE: The statements which follow should be approached with caution. To obtain context and understand the statements fully, the reader should consult the cases on which they are based.)

- Torture, beatings and rape are prime examples of persecution.[Note 54]
- The term "discrimination" is not adequate to describe behaviour which includes acts of violence and death threats.[Note 55]
- Death threats may constitute persecution even if the persons making the threats refrain from carrying them out.[Note 56] Whether death threats do amount to acts of persecution depends upon the personal circumstances of the claimant.[Note 57]
- When imposed for certain offences, the death penalty may not constitute persecution.[Note 58]
- **Forced or strongly coerced sterilization constitutes persecution, whether the victim is a woman[Note 59] or a man.[Note 60] Forced abortion also constitutes persecution,**[Note 61] as does the forcible insertion of an IUD.[Note 62]
- Female circumcision is a "cruel and barbaric practice", a "horrific torture", and an "atrocious mutilation".[Note 63]
- For "persecution" to exist within the meaning of the definition, it is not necessary for the subject to have been deprived of his freedom.[Note 64]
- There may be persecution even if there is no physical harm or mistreatment.[Note 65]
- **Psychological violence may be an element in persecution**.[Note 66]
- The bringing of a trumped-up charge, and interference in the due process of law, may be aspects of persecutory treatment.[Note 67]
- The fact that the claimant, along with all of his or her co-nationals, suffers curtailment of freedom of speech, in and of itself does not amount to persecution.[Note 68]
- Barring one claimant from obtaining citizenship and from taking part in political activities, and barring a second claimant (a citizen) from voting and from otherwise participating in the political process, did not constitute persecution, where the claimants enjoyed numerous other rights.[Note 69]

- Punishment for violation of a law concerning dress may constitute persecution.[Note 70]
- Denial of a right of return may constitute an act of persecution.[Note 71]
- Simple statelessness does not make one a Convention refugee.[Note 72]
- Economic penalties may be an acceptable means of enforcing a state policy,[Note 73] where the claimant is not deprived of his or her right to earn a livelihood.[Note 74]
- Where the state interferes substantially with the claimant's ability to find work, the possibility of the claimant's finding illegal employment is not an acceptable remedy.[Note 75]
- Permanently depriving an educated professional of his or her accustomed occupation and limiting the person to farm and factory work constituted persecution.[Note 76]
- By itself, confiscation of property is not sufficiently grave to constitute persecution.[Note 77]
- Serious economic deprivations may be components of persecution.[Note 78]
- Extortion may be one of the indicia of persecution, depending upon the reason for the extortion and the motivation of the claimant in paying.[Note 79]
- A child who would experience hardships including deprivation of medical care, education opportunities, employment opportunities and food would suffer concerted and severe discrimination, amounting to persecution.[Note 80]
- Education is a basic human right and a nine-year-old claimant who could have avoided persecution only by refusing to go to school was deemed to be a Convention refugee.[Note 81]
- It is not an act of persecution to ban certain groups of children from attending public schools, if they are permitted to have their own schools.[Note 82]
- Forcing a woman into a marriage violates one of her basic human rights.[Note 83]
- An impediment to the claimant's marrying in her homeland did not constitute persecution.[Note 84]
- Legal restrictions allowing certain categories of people to settle only in certain areas did not constitute persecution.[Note 85]
- A law which requires a person to forsake the principles or practices of his or her religion is patently persecutory, so long as the principles or practices in question are not unreasonable.[Note 86] Sanctions such as a short detention, fine or re-education term, which might have been imposed upon the claimant for practising his religion or belonging to a particular religious community, were serious measures of discrimination and constituted persecution.[Note 87]
- Injury to pride and political sensibilities did not amount to a violation of security of the person.[Note 88]
- Lamentable rough treatment, involving detention and interrogation, in a country that is experiencing serious terrorist activity, does not of itself amount to persecution.[Note 89]
- Minor children who are expected to provide support for other family members, after being smuggled into Canada, are not persecuted by their parents.[Note 90]
- The act of being illegally trafficked is not in itself persecution simply because the claimant is a minor.[Note 91]
- Restrictions by a state on a foreign spouse's entry into its territory that are not made on a discriminatory basis do not constitute persecution.[Note 92]

- Forcing non-religious or secular persons to adhere to strict Islamic codes will not generally amount to persecution (particularly where there is evidence of significant improvements).[Note 93]
- Insults and attacks on a conscientious objector while in prison do not constitute persecution.[Note 94]

HUMAN RIGHTS AND LEGISLATIVE VIOLATIONS EXPERIENCED BY MENTAL HEALTH PATIENT, ROXANNE STEWART SUBSTANTIATING CASE FOR PERSECTUTION (*BASED ON CHAPTER 3 of the INTERPRETATION OF THE CONVENTION REFUGEE DEFINITION IN THE CASE LAW as set out by the Immigration and Refugee Board of Canada)*

HUMAN RIGHTS AND LEGISLATIVE VIOLATIONS EXPERIENCED BY MENTAL HEALTH PATIENT, ROXANNE STEWART, WHETHER UNDER LOCAL LAW AND CONSTITUTIONAL RIGHTS, OR INTERNATIONAL LAW AND HUMAN RIGHTS ACTS UNDER THE UNITED NATIONS WHICH JAMAICA IS A SIGNATORY, SUBSTANTIATING CASE FOR PERSECUTION

SUNBSTANTIATING PERSECUTION – BASED ON CHAPTER 3 of the INTERPRETATION OF THE CONVENTION REFUGEE DEFINITION IN THE CASE LAW as set out by the Immigration and Refugee Board of Canada:

3.1.1.1. Serious Harm

First, to be considered persecution, the mistreatment suffered or anticipated must be serious.[Note 1] And in order to determine whether particular mistreatment would qualify as "serious", one must examine:

3. **what interest of the claimant might be harmed; and**
4. **to what extent the subsistence, enjoyment, expression or exercise of that interest might be compromised.**

1) According to Chapter 3 of the Jamaican Constitution dealing with Fundamental Rights and Freedoms:

13. Whereas every person in Jamaica is entitled to the fundamental rights and freedoms of the individual, that is to say, has the right, whatever his race, place of origin, political opinions, colour, creed or sex, but subject to respect for the rights and freedoms of others and for the public interest, to each and all of the following, namely-

a. life, **liberty, security of the person**, the enjoyment of property and the protection of the law; **(My right to liberty and security of person is clearly being violated with the threat of forced drug treatments and involuntary hospitalization by Dr. Jacqueline Martin. The life of my unborn baby would also obviously be at risk if these drug treatments of powerful anti-psychotic drugs were forced on me)**

SUNBSTANTIATING PERSECUTION – BASED ON CHAPTER 3 of the INTERPRETATION OF THE CONVENTION REFUGEE DEFINITION IN THE CASE LAW as set out by the Immigration and Refugee Board of Canada:

"The dominant view… is that refugee law ought to concern itself with actions which deny human dignity in any key way and that the sustained or systemic denial of core human rights is the appropriate standard."

"Persecution", for example, undefined in the Convention, has been ascribed the meaning of "sustained or systemic violation of basic human rights demonstrative of a failure of state protection";

"For "persecution" to exist within the meaning of the definition, it is not necessary for the subject to have been deprived of his freedom."

- **NOTE: Given that the mental patient, Roxanne Stewart, was not clinically incarcerated, this could still be deemed as persecution because due to stigmatization she is under the constant threat of unjustified involuntary hospitalization/psychiatric institutionalization.**

According to Chapter 3 of the Jamaican Constitution dealing with Fundamental Rights and Freedoms:

16. (**1**) **No person shall be deprived of his freedom of movement**, and for the purposes of this section the said freedom means the right to move freely throughout Jamaica, the right to reside in any part of Jamaica, the right to enter Jamaica and immunity from expulsion from Jamaica. **(The threat of being unjustifiably involuntarily hospitalized by Dr. Jacqueline Martin or subject to restrictive hospitalized conditions at my parents house is a violation of my right to freedom of movement)**

17. (**1**) No person shall be subjected to torture or to **inhuman or degrading punishment or other treatment.** -- **(The threat of being unjustifiably involuntarily hospitalized by Dr. Jacqueline Martin and unjustifiably being injected by several psychotropic drugs which would cause severe physical and mental distress and cause harm to my unborn child is deemed as inhuman and degrading treatment)**

SUNBSTANTIATING PERSECUTION – BASED ON CHAPTER 3 of the INTERPRETATION OF THE CONVENTION REFUGEE DEFINITION IN THE CASE LAW as set out by the Immigration and Refugee Board of Canada:

"the extent that an agent of persecution intentionally plays upon or exploits the fact that a person suffers from a particular frailty or condition in order to cause harm, an act not normally or inherently persecutorial, may be transformed into an act of persecution."

3.1.1.2. Repetition and Persistence

"A second criterion of persecution is that the inflicting of harm occurs with repetition or persistence, or in a systematic way."

According to Chapter 3 of the Jamaican Constitution dealing with Fundamental Rights and Freedoms:

21. (**1**) Except with his own consent, no person shall be hindered in the enjoyment of his freedom of conscience, and for the purposes of this section the said freedom includes **freedom of thought and of religion,** freedom to change his religion or belief, and freedom, either alone or in community with others, and both in public and in private, to manifest and propagate his religion or belief in worship, teaching, practice and observance. **(Being deemed as psychotic because of my religious beliefs by Dr. Jacquelin Martin is a violation of my right to freedom of thought and freedom of religion)**

(**5**) **No person shall be compelled to take any oath which is contrary to his religion or belief** or to take any oath in a manner which is contrary to his religion or belief. **(I was being coerced by Dr. Jacqueline Martin to sign a form enabling her to drug me with many different psychotropic drugs that would endanger the life of my baby as well as my own physical well being even though I had told her I do not believe in abortion or termination of my pregnancy)**

(**2**) Subject to the provisions of subsection (6), (7) and (8) of this section, **no person shall be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the functions of any public office or any public authority. (I was being treated as a mentally and psychologically incompetent person by Dr. Jacqueline Martin simply by virtue of having a clinical diagnosis of Bipolar Disorder and not because of any psychotic symptoms or suicidal/homicidal symptoms, which is deemed as an act of discrimination)**

SUNBSTANTIATING PERSECUTION – BASED ON CHAPTER 3 of the INTERPRETATION OF THE CONVENTION REFUGEE DEFINITION IN THE CASE LAW as set out by the Immigration and Refugee Board of Canada:
"Rather, the RPD should analyze the quality of incidents in terms of whether they constitute "a fundamental violation of human dignity"."

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2) According to the Mental Health Act of Jamaica:

Section 11.-(1) **A patient shall not be given treatment in a psychiatric facility without his consent unless a duly authorized medical officer certifies that the patient's mental condition is such that he is not competent to give consent. (This principle under section 11 was violated when I was injected with Modecate/Fluphenazine without my consent even though when I was evaluated by nurses and Dr. Frank Knight, I was very much mentally competent and able to give consent)**

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3) According to the Protection of Persons with Mental Illness and the Improvement of Mental Health Care by the World Health Organization which Jamaica is a signatory country to:

Principle 1 - Fundamental freedoms and basic rights
2. All persons with a mental illness, or who are being treated as such persons, **shall be treated with humanity and respect for the inherent dignity of the human person. (My respect and dignity as a person was clearly being ignored by**

Dr. Jacqueline Martin while she advocated for forced treatment and medical interventions ahile I was not even allowed to speak or give an opinion on the matter)
SUNBSTANTIATING PERSECUTION – BASED ON CHAPTER 3 of the INTERPRETATION OF THE CONVENTION REFUGEE DEFINITION IN THE CASE LAW as set out by the Immigration and Refugee Board of Canada:

3.1.1.5. Agent of Persecution

Serious human rights violations may in fact issue not only from higher authorities of the state, but also from subordinate state authorities, or from persons who are not attached to the government; and whichever is the case, the Convention may apply.

3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or **other abuse and degrading treatment.** **(The suggestion that I should be forcefully hospitalized or restricted to hospitalized conditions at my parents house while being forced to take powerful anti-psychotic and sedative drugs against my will is clearly abusive and degrading)**

4. There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of **nullifying or impairing equal enjoyment of rights.** **(Clearly my rights to make my own decision about my own mental health were nullified when both Dr. Jacqueline Martin and Dr. Nyamakeye Richards deemed that I was either psychotic or in need of involuntary hospitalization)**

Principle 4 - Determination of Mental Illness
1. A determination that a person has a mental illness shall be made in **accordance with internationally accepted medical standards.** **(During my appointments with Dr. Jacqueline Martin and Dr. Nyamakeye Richards, I was never assessed for bipolar symptoms based on the DSM-5 assessment method which is internationally recognized)**

2. **A determination of mental illness shall never be made on the basis of political, economic or social status, or membership in a cultural, racial or religious group, or for any other reason not directly relevant to mental health status.** **(Jacqueline Martin made the assessment that I was in a manic/psychotic episode because of my religious beliefs and deemed me "Religiose")**

3. **Family or professional conflict**, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, **shall never be a determining factor in the diagnosis of mental illness.** **(Dr. Nyamakeye Richards justified her assessment that I was in a psychotic**

episode by her statement that since I was in conflict with my mother and husband, it was suggestive that I was in an episode of psychosis)

4. **A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness. (This was the basis for Dr. Nyamakeye Richards agreeing with Dr. Jacqueline Martin's course of action as well as her pronouncement that she thought I was in a psychotic episode)**

Principle 8 - Standards of Care

2. Every patient shall be protected from harm, **including unjustified medication,** abuse by other patients, **staff or others or other acts causing mental distress or physical discomfort. (Given that it is obvious on the recordings that I was not suffering from psychosis, the recommendation of Olanzapine, Diazapam, Lamectal and a higher dosage of Seroquel was clearly unjustified)**

Principle 9 - Treatment

1. Every patient shall have the right to be **treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs** and the need to protect the physical safety of others. **(This was clearly not being done by Jacqueline Martin when she was advocating for my hospitalization or restricted hospitalized conditions at my parents house even though I was not suffering from symptoms of psychosis or homicidal/suicidal thoughts or behaviors)**

4. The treatment of every patient shall be directed towards **preserving and enhancing personal autonomy. (This was clearly not being done by Jacqueline Martin when she was advocating for my hospitalization or restricted hospitalized conditions at my parents house even though I was not suffering from symptoms of psychosis or homicidal/suicidal thoughts or behaviors)**

Principle 10 - Medication

2. **All medication** shall be prescribed by a mental health practitioner authorized by law and **shall be recorded in the patient's records. (The dosage of Modecate/Fluphenazine that I was given in medical associates was not recorded in my medical records. I was informed of this by the medical records officer at medical associates when I asked to look at my records)**

Principle 11 - Consent to Treatment

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle. **(This principle was violated when I was injected with Modecate/Fluphenazine without my consent during my hospitalization at Medical Associates Hospital in 2015 and the side effects and risks of this drug was never explained to me)**

2. Informed consent is consent obtained freely, **without threats or improper inducements,** after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:

(a) The diagnostic assessment;

(b) The purpose, method, likely duration and expected benefit of the proposed treatment;

(c) Alternative modes of treatment, including those less intrusive;

(d) Possible pain or discomfort, risks and side-effects of the proposed treatment. **(This was clearly not being done while Dr. Jacqueline Martin tried to coerce me to sign a document consenting to being given the drugs Olanzapine, Daizapam, Lamectal and a higher dosage of Seroquel, and when I refused to sign, she tried to convince my father to involuntarily hospitalize me based on section 6 of the mental health care act)**

Principle 15 - Admission Principles:

1. Where a person needs treatment in a mental health facility, **every effort shall be made to avoid involuntary admission. (This was clearly not being done while Dr. Jacqueline Martin tried to convince my father to involuntarily hospitalize me even though I had no symptoms of psychosis or suicidal or homicidal thoughts or behaviors)**

Principle 19 - Access to information

1. **A patient** (which term in the present Principle includes a former patient) **shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. (I was denied the right to view or have a copy of my medical records for my hospitalizations at Medical Associates Hospital)**

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4) According to the Universal Declaration of Human Rights which according to Article 2, I am entitled to:

Article 3 – Everyone has the right to life, **liberty and security of person. (My liberty/freedom would be at risk with the threat of unjustified forced hospitalization, and the security of the life of my unborn baby would also be very much compromised by forced drug treatments unsafe for pregnancy)**

Article 5 – No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. **(Being given and injected with neuroleptic/psychotropic drugs against my will or without my consent, when I am mentally and psychologically**

competent enough to give my consent which cause severe physically and mentally distressing side effects would be considered cruel, inhuman and degrading treatment)

Article 6 – Everyone has the right to recognition everywhere as a person before the law. **(I was not being regarded as a mentally competent and capable person by Dr. Jacqueline Martin as my decisions weren't being respected and I was ignored and being treated as if I were mentally and intellectually incapacitated.)**

Article 12 – No one shall be subjected to arbitrary interference with his privacy, family, home, or correspondence, not to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks. **(I was being threatened with involuntary hospitalization as well as restricted hospitalized conditions at my parents house while no provisions were being made for me to see or take care of my two year old son. Also the unjustified declaration by Dr. Nyamakeye Richards that I was in a psychotic episode is an attack on my character and reputation)**

SUNBSTANTIATING PERSECUTION – BASED ON CHAPTER 3 of the INTERPRETATION OF THE CONVENTION REFUGEE DEFINITION IN THE CASE LAW as set out by the Immigration and Refugee Board of Canada:

"Forced or strongly coerced sterilization constitutes persecution, whether the victim is a woman[Note 59] or a man.[Note 60] Forced abortion also constitutes persecution,"

- **NOTE: Given that Dr. Jacqueline Martin upon my first appointment with her was pressuring me to have an abortion, and on my second appointment unjustifiably threatened involuntary hospitalization and the forced medical treatment of several psychotropic drugs which would cause not only physical and psychological harm and distress to me but life threatening harm to my unborn child, and also was coercing me to sign a document clearing her of any legal culpability should anything happen to my unborn baby, I would claim persecution is substantiated in this case. My husband also pressuring me to have an abortion and deeming me mentally incompetent to continue the pregnancy without several harmful psychotropic drugs, this would also be deemed as persecution.**

CHAPTER 3 OF WORLD HEALTH ORGANIZATION RESOURCE BOOK ON MENTAL HEALTH

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3. Protecting, promoting and improving rights through mental health legislation

In accordance with the objectives of the United Nations (UN) Charter and international agreements, a fundamental basis for mental health legislation is human rights. Key rights and principles include equality and non-discrimination, the right to privacy and individual autonomy, freedom from inhuman and degrading treatment, the principle of the least restrictive environment, and the rights to information and participation. Mental health legislation is a powerful tool for codifying and consolidating these fundamental values and principles. Equally, being unable to access care is an infringement of a person's right to health, and access can be included in legislation. This section presents a number of interrelated reasons why mental health legislation is necessary, with special attention to the themes of human rights and access to services.

3.1 Discrimination and mental health

Legislation is needed to prevent discrimination against persons with mental disorders. Commonly, discrimination takes many forms, affects several fundamental areas of life and (whether overt or inadvertent) is pervasive. Discrimination may impact on a person's access to adequate treatment and care as well as other areas of life, including employment, education and shelter. The inability to integrate properly into society as a consequence of these limitations can increase the isolation experienced by an individual, which can, in turn, aggravate the mental disorder. Policies that increase or ignore the stigma associated with mental disorder may exacerbate this discrimination.

The government itself can discriminate by excluding persons with mental disorders from many aspects of citizenship such as voting, driving, owning and using property, having rights to sexual reproduction and marriage, and gaining access to the courts. In many cases, the laws do not actively discriminate against people with mental disorders, but place improper or unnecessary barriers or burdens on them. For example, while a country's labour laws may protect a person against indiscriminate dismissal, there is no compulsion to temporarily move a person to a less stressful position, should they require some respite to recover from a relapse of their mental condition. The result may be that the person makes mistakes or fails to complete the work, and is therefore dismissed on the basis of incompetence and inability to carry out allocated functions. **Discrimination may also take place against people with no mental disorder at all if they are mistakenly viewed as having a mental disorder or if they once experienced a mental disorder earlier in life. Thus protections against discrimination under international law go much further than simply**

outlawing laws that explicitly or purposefully exclude or deny opportunities to people with disabilities; they also address legislation that has the *effect* of denying rights and freedoms (see, for example, Article 26 of the *International Covenant on Civil and Political Rights* of the United Nations).

3.2 Violations of human rights

One of the most important reasons why human-rights-oriented mental health legislation is vital is because of past and ongoing violations of these rights. Some members of the public, certain health authorities and even some health workers have, at different times and in different places, violated – and in some instances continue to violate – the rights of people with mental disorders in a blatant and extremely abusive manner. In many societies, the lives of people with mental disorders are extremely harsh. Economic marginalization is a partial explanation for this; however, **discrimination and absence of legal protections against improper and abusive treatment are important contributors. People with mental disorders are often deprived of their liberty for prolonged periods of time without legal process (though sometimes also with unfair legal process, for example, where detention is allowed without strict time frames or periodic reports).** They are often subjected to forced labour, **neglected in harsh institutional environments and deprived of basic health care. They are also exposed to torture or other cruel,**

Examples of inhuman and degrading treatment of people with mental disorders

The BBC (1998) reported how in one country, people are locked away in traditional mental hospitals, where they are continuously shackled and routinely beaten. Why? Because it is believed that mental illness is evil and that the afflicted are possessed by bad spirits.

An NGO that campaigns for the rights of people with mental disorders, has documented neglect and ill-treatment of children and adults in institutions all over the world. Instances of children being tied to their beds, lying in soiled beds or clothing, and receiving no stimulation or rehabilitation for their condition are not uncommon.

Another NGO has reported that certain countries continue to lock up patients in "cage beds" for hours, days, weeks, or sometimes even months or years. One report indicated that a couple of patients have lived in these devices nearly 24 hours a day for at least the last 15 years. People in caged beds are also often deprived of any form of treatment including medicines and rehabilitation programmes.

It is also well documented that in many countries, people with mental disorders live with their families or on their own and receive no support from the government. The stigma and discrimination associated with mental disorders means that they remain closeted at home and cannot participate in public life. The lack of community-based services and support also leaves them abandoned and segregated from society.

inhumane or degrading treatment, including sexual exploitation and physical abuse, often in psychiatric institutions.

Furthermore, some people are admitted to and treated in mental health facilities where they frequently remain for life against their will. Issues concerning consent for admission and treatment are ignored, and independent assessments of capacity are not always undertaken. This means that many people may be compulsorily kept in institutions, despite having the capacity to make decisions regarding their future. On the other hand, where there are shortages of hospital beds, the failure to admit people who need inpatient treatment, or their premature discharge (which can lead to high readmission rates and sometimes even death), also constitutes a violation of their right to receive treatment.

People with mental disorders are vulnerable to violations both inside and outside the institutional context. Even within their own communities and within their own families, for example, there are cases of people being locked up in confined spaces, chained to trees and sexually abused.

3.3 Autonomy and liberty

An important reason for developing mental health legislation is to protect people's autonomy and liberty. Legislation can do this in a number of ways. For example, it can:

- Promote autonomy by ensuring mental health services are accessible for people who wish to use such services;
- Set clear, objective criteria for involuntary hospital admissions, and, as far as possible, promote voluntary admissions;
- Provide specific procedural protections for involuntarily committed persons, such as the right to review and appeal compulsory treatment or hospital admission decisions;
- **Require that no person shall be subject to involuntary hospitalization when an alternative is feasible;**
- Prevent inappropriate restrictions on autonomy and liberty within hospitals themselves (e.g. rights to freedom of association, confidentiality and having a say in treatment plans can be protected); and
- Protect liberty and autonomy in civil and political life through, for example, entrenching in law the right to vote and the right to various freedoms that other citizens enjoy.

In addition, legislation can allow people with mental disorders, their relatives or other designated representatives to participate in treatment planning and other decisions as a protector and advocate. While most relatives will act in the best interests of a member of their family with a mental disorder, in those situations where relatives are not closely involved with patients, or have poor judgement or a conflict of interest, it may not be appropriate to allow the family member to participate in key decisions, or even to have access to confidential information about the person.

The law, therefore, should balance empowering family members to safeguard the person's rights with checks on relatives who may have ulterior motives or poor judgement.

Persons with mental disorders are also at times subject to violence. Although public perceptions of such people are often of violent individuals who are a danger to others, the reality is that they are more often the victims than the perpetrators. Sometimes, however, there may be an apparent conflict between the individual's right to autonomy and society's obligation to prevent harm to all persons. This situation could arise when persons with a mental disorder pose a risk to themselves and to others due to an impairment of their decision-making capacity and to behavioural disturbances associated with the mental disorders. In these circumstances, legislation should take into account the individuals' right to liberty and their right to make decisions regarding their own health, as well as society's obligations to protect persons unable to care for themselves, to protect all persons from harm, and to preserve the health of the entire population. This complex set of variables demands close consideration when developing legislation, and wisdom in its implementation.

3.4 Rights for mentally ill offenders

The need to be legally fair to people who have committed an apparent crime because of a mental disorder, and to prevent the abuse of people with mental disorders who become involved in the criminal justice system, are further reasons why mental health legislation is essential. Most statutes acknowledge that people who did not have control of their actions due to a mental disorder at the time of the offence, or who are unable to understand and participate in court proceedings due to mental illness, require procedural safeguards at the time of trial and sentencing. But how these individuals are handled and treated is often not addressed in the legislation or, if it is, it is done poorly, leading to abuse of human rights.

Mental health legislation can lay down procedures for dealing with people with mental disorders at various stages of the legal process (see section 15 below).

3.5 Promoting access to mental health care and community integration

The fundamental right to health care, including mental health care, is highlighted in a number of international covenants and standards. However, mental health services in many parts of the world are poorly funded, inadequate and not easily accessible to persons in need. Some countries have hardly any services, while in others services are available to only certain segments of the population. Mental disorders sometimes affect people's ability to make decisions regarding their health and behaviour, resulting in further difficulties in seeking and accepting needed treatment.

Legislation can ensure that appropriate care and treatment are provided by health services and other social welfare services, when and where necessary. It can help make mental health services more accessible, acceptable and of adequate quality, thus giving persons with mental disorders better opportunities to exercise their right to receive appropriate treatment. For example, legislation and/or accompanying regulations can include a statement of responsibility for:

- Developing and maintaining community-based services;
- Integrating mental health services into primary health care;

- Integrating mental health services with other social services;
- Providing care to people who are unable to make health decisions due to their mental disorder;
- Establishing minimum requirements for the content, scope and nature of services;
- Assuring the coordination of various kinds of services;
- Developing staffing and human resource standards;
- Establishing quality of care standards and quality control mechanisms; and
- Assuring the protection of individual rights and promoting advocacy activities among mental health users.

Many progressive mental health policies have sought to increase opportunities for persons with mental disorders to live fulfilling lives in the community. Legislation can foster this if it: i) prevents inappropriate institutionalization; and ii) provides for appropriate facilities, services, programmes, personnel, protections and opportunities to allow persons with mental disorders to thrive in the community.

Legislation can also play an important role in ensuring that a person suffering from a mental disorder can participate in the community. Prerequisites for such participation include access to treatment and care, a supportive environment, housing, rehabilitative services (e.g. occupational and life skills training), employment, non-discrimination and equality, and civil and political rights (e.g. right to vote, drive and access courts). All of these community services and protections can be implemented through legislation.

Of course, the level of services that can be made available will depend on a country's resources. Legislation that contains unenforceable and unrealistic provisions will remain ineffective and impossible to implement. Moreover, mental health services often lag behind other health care services, or are not provided in an appropriate or cost-effective manner. Legislation can make a big difference in securing their parity with other health care services, and in ensuring that what is provided is appropriate to people's needs.

Provision of medical insurance is another area where legislation can play a facilitating role. In many countries, medical insurance schemes exclude payment for mental health care or offer lower levels of coverage for shorter periods of time. This violates the principle of accessibility by being discriminatory and creating economic barriers to accessing mental health services. By including provisions concerning medical insurance, legislation can ensure that people with mental disorders are able to afford the treatment they require.

4. Separate versus integrated legislation on mental health

There are different ways of approaching mental health legislation. In some countries there is no separate mental health legislation, and provisions related to mental health are inserted into other relevant legislation. For example, issues concerning mental health may be incorporated into general health, employment, housing or criminal justice legislation. At the other end of the spectrum, some countries have consolidated mental health legislation, whereby all issues of relevance to mental health are incorporated into a single law. Many countries have combined these approaches, and thus have integrated components as well as a specific mental health law.

There are advantages and disadvantages to each of these approaches. Consolidated legislation has the ease of enactment and adoption, without the need for multiple amendments to existing laws. The process of drafting, adopting and implementing consolidated legislation also provides a good opportunity to raise public awareness about mental disorders and educate policymakers and the public about human rights issues, stigma and discrimination. However, consolidated legislation emphasizes segregation of mental health and persons with mental disorders; hence, it can potentially reinforce stigma and prejudice against persons with mental disorders.

The advantages of inserting provisions relating to mental disorders into non-specific relevant legislation are that it reduces stigma and emphasizes community integration of those with mental disorders. Also, by virtue of being part of legislation that benefits a much wider constituency, it increases the chances that laws enacted for the benefit of those with mental disorders are actually put into practice. Among the main disadvantages associated with "dispersed" legislation is the difficulty in ensuring coverage of all legislative aspects relevant to persons with mental disorders; procedural processes aimed at protecting the human rights of people with mental disorders can be quite detailed and complex and may be inappropriate in legislation other than a specific mental health law. Furthermore, it requires more legislative time because of the need for multiple amendments to existing legislation.

There is little evidence to show that one approach is better than the other. A combined approach, involving the incorporation of mental health issues into other legislation as well as having a specific mental health law, is most likely to address the complexity of needs of persons with mental disorders. However, this decision will depend on countries' circumstances.

When drafting a consolidated mental health legislation, other laws (e.g. criminal justice, welfare, education) will also need to be amended in order to ensure that provisions of all relevant laws are in line with one another and do not contradict each other.

5. Regulations, service orders, ministerial decrees

Mental health legislation should not be viewed as an event, but as an ongoing process that evolves with time. This necessarily means that legislation is reviewed, revised and amended in the light of advances in care, treatment and rehabilitation of mental disorders, and improvements in service development and delivery. It is difficult to specify the frequency with which mental health legislation should be amended; however, where resources allow, a 5- to 10-year period for considering amendments would appear appropriate.

Example: Amending all laws related to mental health in Fiji

During the process of mental health law reform in Fiji, 44 different Acts were identified for review to ensure that there were no disparities between the new mental health law and existing legislation. In addition, the Penal Code and Magistrates Court rules were reviewed and a number of sections identified as needing change in order to maintain legal consistency.

WHO Mission Report, 2003

In reality, frequent amendments to legislation are difficult due to the length of time and the financial costs of an amendment process and the need to consult all stakeholders before changing

the law. One solution is to make provisions in the legislation for the establishment of regulations for particular actions that are likely to need constant modifications. Specifics are not written into the legislation but, instead, provision is made in the statute for what can be regulated, and the process for establishing and reviewing regulations. For example, in South African law, rules for accreditation of mental health professionals are not specified in the legislation, but are part of the regulations. Legislation specifies who is responsible for framing the regulations and the broad principles upon which these regulations are based. The advantage of using regulations this way is that it allows for frequent modifications to the accreditation rules without requiring a lengthy process of amending primary legislation. Regulations can thus provide flexibility to mental health legislation.

Other alternatives to regulations in some countries are the use of executive decrees and service orders. These are often short- to medium-term solutions where, for various reasons, interim interventions are necessary. For example, in Pakistan, an ordinance was issued in 2001 amending the mental health law, even though the National Assembly and the Senate had been suspended under a Proclamation of Emergency. The preamble to the ordinance stated that circumstances existed which made it necessary to "take immediate action" (Pakistan Ordinance No. VIII of 2001). This was required and deemed desirable by most people concerned with mental health, given the country's existing outdated law. Nonetheless, the issuance of such an ordinance needs to be ratified by the elected body within a specified time frame, as is the case in Pakistan, to ensure that potentially retrogressive and/or undemocratic legislation does not persist.

6. Key international and regional human rights instruments related to the rights of peoplewith mental disorders

The requirements of international human rights law, including both UN and regional human rights instruments, should form the framework for drafting national legislation that concerns people with mental disorders or regulates mental health and social service systems. International human rights documents broadly fall into two categories: those which legally bind States that have ratified such conventions, and those referred to as international human rights "standards", which are considered guidelines enshrined in international declarations, resolutions or recommendations, issued mainly by international bodies. Examples of the first are international human rights conventions such as the International Covenant on Civil and Political Rights (ICCPR, 1966) and the International Covenant on Economic, Social and Cultural Rights (ICESR, 1966). The second category, which includes UN General Assembly Resolutions such as Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles, 1991), while not legally binding, can and should influence legislation in countries, since they represent a consensus of international opinion.

6.1 International and regional human rights instruments

There is a widespread misconception that because the human rights instruments relating specifically to mental health and disability are non-binding resolutions, rather than obligatory conventions, mental health

legislation is therefore subject only to the domestic discretion of governments. This is not true, as governments are under obligation, under international human rights law, to ensure that their policies and practices conform to binding international human rights law – and this includes the protection of persons with mental disorders.

Treaty monitoring bodies at the international and regional levels have the role of overseeing and monitoring compliance by States that have ratified international human rights treaties. Governments that ratify a treaty agree to report regularly on the steps they have taken to implement that treaty at the domestic level through changes in legislation, policy and practice. Nongovernmental organizations (NGOs) can also submit information to support the work of monitoring bodies. Treaty monitoring bodies consider the reports, taking into account any information submitted by NGOs and other competent bodies, and publish their recommendations and suggestions in "concluding observations", which may include a determination that a government has not met its obligations under the treaty. The international and regional supervisory and reporting process thus provides an opportunity to educate the public about a specialized area of rights. This process can be a powerful way to pressure governments to uphold convention-based rights.

The treaty bodies of the European and Inter-American human rights system have also established individual complaints mechanisms, which provide the opportunity for individual victims of human rights violations to have their cases heard and to seek reparations from their governments.

This section provides an overview of some of the key provisions of international and regional human rights instruments that relate to the rights of persons with mental disorders.

6.1.1 International Bill of Rights

The Universal Declaration of Human Rights (1948), along with the International Covenant on Civil and Political Rights (ICCPR, 1966) and the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966), together make up what is known as the "International Bill of Rights".

Article 1 of the Universal Declaration of Human Rights, adopted by the United Nations in 1948, provides that all people are free and equal in rights and dignity. Thus people with mental disorders are also entitled to the enjoyment and protection of their fundamental human rights.

In 1996, the Committee on Economic, Social and Cultural Rights adopted General Comment 5, detailing the application of the International Covenant on Economic, Social and Cultural Rights (ICESCR) with regard to people with mental and physical disabilities. General Comments, which are produced by human rights oversight bodies, are an important source of interpretation of the articles of human rights conventions. General comments are non-binding, but they represent the official view as to the proper interpretation of the convention by the human rights oversight body.

The UN Human Rights Committee, established to monitor the ICCPR, has yet to issue a general comment specifically on the rights of persons with mental disorders. It has issued General

Comment 18, which defines protection against discrimination against people with disabilities under Article 26.

A fundamental human rights obligation in all three instruments is the protection against discrimination. Furthermore, General Comment 5 specifies that the right to health includes the right to access rehabilitation services. This also implies a right to access and benefit from services that enhance autonomy. **The right to dignity is also protected under General Comment 5 of the ICESCR as well as the ICCPR. Other important rights specifically protected in the International Bill of Rights include the right to community integration, the right to reasonable accommodation (General Comment 5 ICESCR), the right to liberty and security of person (Article 9 ICCPR) and the need for affirmative action to protect the rights of persons with disabilities, which includes persons with mental disorders.**

The right to health, as embodied in various international instruments

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) establishes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The right to health is also recognized in other international conventions, such as Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, Articles 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979, and Article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1996, as revised (Art. 11), the African Charter on Human and Peoples' Rights of 1981 (Art. 16), and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (Art. 10).

General Comment 14 of the Committee on Economic, Social and Cultural Rights aims to assist countries in implementation of Article 12 of ICESCR. General Comment 14 specifies that the right to health contains both freedoms and entitlements, which include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. Entitlements also include the right to a system of health protection that provides people with equality of opportunity to enjoy the highest attainable level of health. According to the Committee, the right to health includes the following interrelated elements:

(i) *Availability*, i.e. health care facilities and services have to be available in sufficient quantity.

(ii) *Accessibility*, which includes:
- non-discrimination, i.e. health care and services should be available to all without any discrimination;
- physical accessibility, i.e. health facilities and services should be within safe physical reach, particularly for disadvantaged and vulnerable populations;
- economic accessibility, i.e. payments must be based on the principle of equity and affordable to all; and

information accessibility, i.e. the right to seek, receive and impart information and ideas concerning health issues.

(iii) *Acceptability*, i.e. health facilities and services must respect medical ethics and be culturally appropriate.

(iv) *Quality*, i.e. health facilities and services must be scientifically appropriate and of good quality.

General Comment 14 further states that the right to health imposes three types or levels of obligations on countries: the obligations to *respect*, *protect* and *fulfil*. The obligation to *respect* requires countries to refrain from interfering, directly or indirectly, with the enjoyment of the right to health. The obligation to *protect* requires countries to take measures to prevent third parties from interfering with the guarantees provided under Article 12. Finally, the obligation to *fulfil* contains obligations to facilitate, provide and promote. It requires countries to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

Article 7 of the ICCPR provides protection against torture, cruel, inhuman or degrading treatment, and it applies to medical institutions, especially institutions providing psychiatric care. The General Comment on Article 7 requires governments to "provide information on detentions in psychiatric hospitals, measures taken to prevent abuses, appeals process available to persons admitted to psychiatric institutions and complaints registered during the reporting period".

A list of countries that have ratified both the ICESCR and the ICCPR can be accessed at http://www.unhchr.ch/pdf/report.pdf

6.1.2 Other international conventions related to mental health

The legally binding UN Convention on the Rights of the Child contains human rights provisions specifically relevant to children and adolescents. These include protection from all forms of physical and mental abuse; non-discrimination; the right to life, survival and development; the best interests of the child; and respect for the views of the child. A number of its articles are specifically relevant to mental health:

- Article 23 recognizes that children with mental or physical disabilities have the right to enjoy a full and decent life in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community.
- Article 25 recognizes the right to periodic review of treatment provided to children who are placed in institutions for the care, protection or treatment of physical or mental health.
- Article 27 recognizes the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.
- Article 32 recognizes the right of children to be protected from performing any work that is likely to be hazardous or to interfere with their education, or to be harmful to their health or physical, mental spiritual, moral or social development.

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) is also relevant to those with mental disorders. Article 16, for example, makes States that are party to the Convention responsible for preventing acts of cruel, inhuman or degrading treatment or punishment.

In certain mental health institutions there are a vast number of examples that could constitute inhuman and degrading treatment. These include: lack of a safe and hygienic environment; lack of adequate food and clothing; lack of adequate heat or warm clothing; lack of adequate healthcare facilities to prevent the spread of contagious diseases; shortage of staff leading to practices whereby patients are required to perform maintenance labour without pay or in exchange for minor privileges**; and systems of restraint that leave a person covered in his or her own urine or faeces or unable to stand up or move around freely for long periods of time.**

The lack of financial or professional resources is not an excuse for inhuman and degrading treatment. Governments are required to provide adequate funding for basic needs and to protect the user against suffering that can be caused by a lack of food, inadequate clothing, improper staffing at an institution, lack of facilities for basic hygiene, or inadequate provision of an environment that is respectful of individual dignity.

There is no specific UN convention that addresses the special concerns of individuals with disabilities. However, on 28 November 2001, the United Nations General Assembly adopted a resolution calling for the creation of an ad hoc committee "to consider proposals for a comprehensive and integral international convention to protect and promote the rights and dignity of persons with disabilities". Work is currently under way to draft this convention. Persons with mental disorders would be among beneficiaries.

Apart from the various international systems for monitoring human rights, there are also a number of regional conventions for the protection of human rights. These are discussed briefly below.

African Region

African (Banjul) Charter on Human and Peoples' Rights (1981) – This is a legally binding document supervised by the African Commission on Human and People's Rights. The instrument contains a range of important articles on civil, political, economic, social and cultural rights. Clauses pertinent to people with mental disorders include Articles 4, 5 and 16, which cover the right to life and the integrity of the person, the right to respect of dignity inherent in a human being, prohibition of all forms of exploitation and degradation (particularly slavery, slave trade, torture and cruel, inhuman or degrading punishment), and the treatment and the right of the aged and disabled to special measures of protection. It states that the "aged and disabled shall also have the right to

special measures of protection in keeping with their physical or moral needs". The document guarantees the right for all to enjoy the best attainable state of physical and mental health.

African Court on Human and People's Rights – The Assembly of Heads of State and Government of the Organization of African Unity (OAU) – now the African Union – established an African Court on Human and People's Rights to consider allegations of violations of human rights, including civil and political rights and economic, social and cultural rights guaranteed under the African Charter and other relevant human rights instruments. In accordance with Article 34(3), the Court came into effect on 25 January 2004 after ratification by a fifteenth State. The African Court has the authority to issue binding and enforceable decisions in cases brought before it.

European Region

European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) – The European Convention for the Protection of Human Rights and Fundamental Freedoms, backed by the European Court of Human Rights, provides binding protection for the human rights of people with mental disorders residing in the States that have ratified the Convention.

Mental health legislation in European States is required to provide for safeguards against involuntary hospitalization, based on three principles laid down by the European Court of Human Rights:

- Mental disorder is established by objective medical expertise;
- Mental disorder is of a nature and degree warranting compulsory confinement; and
- For continued confinement, it is necessary to prove persistence of the mental disorder (Wachenfeld, 1992).

The European Court of Human Rights provides interpretation of the provisions of the European Convention and also creates European human rights law. The evolving case law of the Court has led to fairly detailed interpretations of the Convention concerning issues related to mental health.

European Convention for the Protection of Human Rights and Dignity of the Human Being, with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (1996) – This Convention, adopted by Member States of the Council of Europe and other States of the European Community, was the first internationally legally binding instrument to embody the principle of informed consent, provide for equal access to medical care and for the right to be informed, as well as establishing high standards of protection with regard to medical care and research.

Recommendation 1235 on Psychiatry and Human Rights (1994) – Mental health legislation in European States is also influenced by Recommendation 1235 (1994) on Psychiatry and Human Rights, which was adopted by the Parliamentary Assembly of the Council of Europe. This lays down criteria for involuntary admission, the procedure for involuntary admission, standards for care and treatment of persons with mental disorders, and prohibitions to prevent abuses in psychiatric care and practice.

Recommendation Rec (2004)10 Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (2004) – In September 2004, the Committee of Ministers of the Council of Europe approved a recommendation which calls upon member states to enhance the

protection of the dignity, human rights and fundamental freedoms of people with mental disorders, in particular, those subject to involuntary placement or involuntary treatment.

Other European Conventions – European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1987) provides another layer of human rights protection. The 8th Annual Report of the Committee on Torture, Council of Europe, stipulated standards to prevent mistreatment of persons with mental disorders.

The revised European Social Charter (1996) provides binding protection for the fundamental rights of people with mental disabilities who are nationals of the States that are parties to the Convention. In particular, Article 15 of the Charter provides for the rights of these persons to independence, social integration and participation in the life of the community. Recommendation No R (83) 2, adopted by the Council of Ministers in 1983, is another important legal protection of persons with mental disorder who are placed in institutions as involuntary patients.

Region of the Americas
American Declaration of the Rights and Duties of Man (1948) – This provides for the protection of civil, political, economic, social and cultural rights.

American Convention on Human Rights (1978) – This Convention also encompasses a range of civil, political, economic social and cultural rights, and establishes a binding means of protection and monitoring by the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights. The Commission's recent examination of a case entitled *Congo v Ecuador* has provided an opportunity for further interpretation of the Convention in relation to mental health issues.

Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights (1988) – This Convention refers specifically to the rights of persons with disabilities. Signatories agree to undertake programmes aimed at providing people with disabilities with the necessary resources and environment for attaining the greatest possible development of their personalities, as well as special training to families (including specific requirements arising from the special needs of this group). Signatories also agree to these measures being made a priority component of their urban development plans and to encouraging the establishment of social groups to help persons with disabilities enjoy a fuller life.

Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities (1999) – The objectives of this Convention are to prevent and eliminate all forms of discrimination against persons with mental or physical disabilities, and to promote their full integration into society. It is the first international convention that specifically addresses the rights of persons with mental disorders. In 2001, the Inter-American Human Rights Commission issued a Recommendation on the Promotion and Protection of Human Rights of Persons with Mental Disabilities (2001), recommending that countries ratify this Convention. The Recommendation also urges States to promote and implement, through legislation and national mental health plans, the organization of community mental health services, in order to achieve the full integration of people with mental disorders into society.

7. Major human rights standards applicable to mental health

7.1 UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles, 1991)

In 1991, the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles, see Annex 3) established minimum human rights standards of practice in the mental health field. International oversight and enforcement bodies have used the MI Principles as an authoritative interpretation of the requirements of international conventions such as the ICESCR.

The MI Principles have also served as a framework for the development of mental health legislation in many countries. Australia, Hungary, Mexico and Portugal, among others, have incorporated the MI Principles in whole or in part into their own domestic laws. The MI Principles establish standards for treatment and living conditions within mental health facilities, and they create protections against arbitrary detention in such facilities**. These principles apply broadly to persons with mental disorders, whether or not they are in psychiatric facilities, and they apply to all persons admitted to a mental health facility – whether or not they are diagnosed as having a mental disorder. The last-mentioned provision is important because in many countries long-term mental health facilities serve as repositories for people who have no history of mental disorder or no current mental disorder, but who remain in the institution due to the lack of other community facilities or services to meet their needs. The MI Principles recognize that every person with a mental disorder shall have the right to live and work, as far as possible, in the community.**

The MI Principles have, however, been subject to some criticism. In 2003 the UN SecretaryGeneral in a report to the General Assembly noted that the MI Principles *"offer in some cases a lesser degree of protection than that offered by existing human rights treaties, for example with regard to the requirement for prior informed consent to treatment. In this regard, some organizations of persons with disabilities, including the World Network of Users and Survivors of Psychiatry, have called into question the protection afforded by the Principles (and in particular, principles 11 and 16) and their consistency with existing human rights standards in the context of involuntary treatment and detention."* (United Nations, 2003)

7.2 Standard Rules on the Equalization of Opportunities for Persons with Disabilities(Standard Rules, 1993)

The World Conference on Human Rights, which took place in Vienna in 1993, reiterated the fact that international human rights law protects people with mental and physical disabilities, and that governments should

establish domestic legislation to realize those rights. In what has come to be known as the Vienna Declaration, the World Conference declared that all human rights and fundamental freedoms are universal, and thus unreservedly include persons with disabilities.

The *Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993)* were adopted at the end of the Decade of Disabled Persons (1982-1993) by General Assembly Resolution 48/96. As a policy guidance instrument, the Standard Rules reiterate the goals of prevention, rehabilitation and equalization of opportunities established by the World Programme of Action. These 22 rules provide for national action in three main areas: preconditions for equal participation, targets for equal participation, and implementation measures. The Standard Rules are a revolutionary new international instrument because they establish citizen participation by people with disabilities as an internationally recognized human right. To realize this right, governments are expected to provide opportunities for people with disabilities and organizations made up of people with disabilities to be involved in drafting new legislation on matters that affect them. The Standard Rules call on every country to engage in a national planning process to bring legislation, policies and programmes into conformity with international human rights standards.

8. Technical standards

In addition to UN General Assembly resolutions, UN agencies, world conferences, and professional groups meeting under UN auspices have adopted a broad array of technical guidelines and policy statements. These can be a valuable source of interpretation of international human rights conventions.

8.1 Declaration of Caracas (1990)

The *Declaration of Caracas* (1990), adopted as a resolution by legislators, mental health professionals, human rights leaders and disability activists convened by the Pan American Health Organization (PAHO/WHO), has major implications for the structure of mental health services (see Annex 4). It states that exclusive reliance on inpatient treatment in a psychiatric hospital isolates patients from their natural environment, thereby generating greater disability. The Declaration establishes a critical link between mental health services and human rights by concluding that outmoded mental health services put patients' human rights at risk.

The Declaration aims to promote community-based and integrated mental health services by suggesting a restructuring of existing psychiatric care. It states that resources, care and treatment for persons with mental disorders must safeguard their dignity and human rights, provide rational and appropriate treatment, and strive to maintain persons with mental disorders in their communities. It further states that mental health legislation must safeguard the human rights of persons with mental disorders, and services should be organized so as to provide for enforcement of those rights.

8.2 Declaration of Madrid (1996)

International associations of mental health professionals have also attempted to protect the human rights of persons with mental disorders by issuing their own sets of guidelines for standards of professional behaviour and practice. An example of such guidelines is the Declaration of Madrid adopted by the General Assembly of the World Psychiatric Association (WPA) in 1996 (see Annex 5). Among other standards, the Declaration insists on treatment based on partnership with persons with mental disorders, and on enforcing involuntary treatment only under exceptional circumstances.

8.3 WHO technical standards

In 1996, WHO developed the *Mental Health Care Law: Ten Basic Principles* (see box below) as a further interpretation of the MI Principles and as a guide to assist countries in developing mental health laws. In 1996, WHO also developed *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*, which is a tool to help understand and interpret the MI Principles and evaluate human rights conditions in institutions.

8.4 The Salamanca Statement and Framework for Action on Special Needs Education(1994)

In 1994, the World Conference on Special Needs Education adopted *The Salamanca Statement and Framework for Action on Special Needs Education*, which affirmed the right to integrated education for children with mental disabilities. The *Salamanca Declaration* is of particular importance in implementing the *World Declaration on Education for All* (WDEA) and enforcing the right to education established under the ICESCR.

9. Limitation of rights

Mental Health Care Law: Ten Basic Principles

1. Promotion of mental health and prevention of mental disorders
2. Access to basic mental health care
3. Mental health assessments in accordance with internationally accepted principles
4. Provision of least restrictive type of mental health care
5. Self-determination
6. Right to be assisted in the exercise of self-determination
7. Availability of review procedure
8. Automatic periodic review mechanism
9. Qualified decision-maker
10. Respect of the rule of law

WHO, 1996

There are a number of human rights where no restrictions are permissible under any circumstances, such as freedom from torture and slavery, and freedom of thought, conscience and religion. However, limitation and derogation clauses in most human rights instruments recognize the need to limit human rights in certain instances, and within mental health there are conditions when limitations need to be applied (see Chapter 2 for examples).

The *Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights (Siracusa Principles)* set criteria that should be met when rights are restricted. Each one of the five criteria must be met, and the restrictions should be of limited duration and subject to review.

For a more detailed discussion on the role of international human rights documents in protecting the rights of persons with mental disorders, see *The Role of International Human Rights in National Mental Health Legislation* (WHO, 2001c), also available at: http://www.who.int/mental_health/resources/policy_services/en/. Also, for a summary of major provisions and international instruments related to the rights of people with mental disorders, see Annex 2.

In summary, legislation should enable the achievement of public health and health policy objectives. **Governments are under an obligation to respect, promote and fulfil the fundamental rights of people with mental disorders as outlined in binding international human rights documents. In addition, other standards such as the MI Principles, which represent an international consensus, can be used as guidelines for enacting legislation and implementing policies that promote and protect the rights of people with mental disorders.** Legislation can assist persons with mental disorders to receive appropriate care and treatment. It can protect and promote rights and prevent discrimination. It can also uphold specific rights, such as the right to vote, to property, to freedom of association, to a fair trial, to judicial guarantees and review of detentions, and to protection in such areas as housing and employment. Criminal justice legislation can ensure appropriate treatment and protection of the rights of mentally ill offenders. These are just a few examples that clearly illustrate that mental health law is more than just "care and treatment" legislation limited to involuntary admission processes and care within institutions.

The Siracusa Principles in summary

- The restriction is provided for and carried out in accordance with the law.
- The restriction is in the interest of the legitimate objective of general interest.
- The restriction is strictly necessary in a democratic society to achieve the objective.
- The restriction is necessary to respond to a public health need.
- The restriction is proportional to the social aim, and there are no less intrusive and restrictive means available to reach this social aim.
- The restriction is not drafted or imposed arbitrarily (i.e. in an unreasonable or otherwise discriminatory manner).

Yet, despite the critical role of legislation, it is not the sole or a simple solution to the myriad of problems faced in mental health, but only an enabling tool to achieve these objectives. **Even in countries with good legislation, informal systems may subvert legislative intent. For example, mental health professionals who are not familiar with the provisions of a new law may continue with "customary" practices in treatment provision, thus defeating the purpose of new, progressive mental health legislation. Without adequate training and education – and the full involvement of a number of role players – legislation may have little impact.**

A strong commitment to ethical self-regulation by mental health professionals is another important component in any system. Furthermore, over-restrictive legislation, even if it is well intentioned, can impede rather than promote access to mental health care. For example, legislative provisions related to admission or involuntary treatment might be so restrictive that they cannot be fulfilled in a given resource scenario, resulting in a lack of necessary care. The provision of adequate and appropriate care and treatment, and the promotion and protection of human rights for persons with mental disorders are of primary importance. Legislation can play an important role.

Context of Mental Health Legislation: Kev issues

- Legislation is complementary to mental health policies, plans and programmes, and can serve to reinforce policy goals and objectives.
- Persons with mental disorders are a vulnerable segment of society and they need special protections.
- Mental health legislation is necessary for protecting the rights of persons with mental disorders in institutional settings and in the community.
- Mental health legislation is more than just "care and treatment" legislation. It provides a legal framework for addressing critical mental health issues such as access to care, rehabilitation and aftercare, the full integration of people with mental disorders into the community, and the promotion of mental health in different sectors of society.
- Governments are under an obligation to respect, promote and fulfil the fundamental rights of people with mental disorders, as outlined in binding international and regional human rights documents.
- Legislative issues pertaining to mental health can be consolidated into one single statute or they may be dispersed in different legislative documents.
- Progressive mental health legislation should incorporate human rights protections, as included in international and regional human rights documents and technical standards. Legislation should also enable the achievement of public health and health policy objectives.

MENTAL HEALTH LEGISLATION & HUMAN RIGHTS PROMOTING THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES

PROMOTING THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES

"All human beings are born free and equal in dignity and rights"
-The *Universal Declaration of Human Rights*

People with mental disabilities all over the world experience human rights violation, stigma and discrimination.

"In some countries, people are locked away in traditional mental hospitals, where they are continuously shackled and routinely beaten. Why? Because it is believed that mental illness is evil and that the afflicted are possessed by bad spirits."

"Children are tied to their beds, lying in soiled beds or clothing, and receiving no stimulation or rehabilitation for their condition."

"Countries continue to lock up patients in 'caged beds' for hours, days, weeks, or sometimes even months or years…A couple of patients have lived in these devices

WHO urges governments to:

DEVELOP AND IMPLEMENT POLICIES, PLANS, LAWS AND SERVICES THAT PROMOTE HUMAN RIGHTS

- Mental health policies and laws can be an effective way of preventing human rights violations and discrimination and promoting the autonomy and liberty of people with mental disabilities.
- Yet many countries fail to put them in place: 40% of countries have no mental health policy and 64% of countries do not have any mental health legislation or have legislation that is more than 10 years old[1].
- Even where mental health policies and laws do exist, many of them focus on confinement of people with mental disabilities in psychiatric institutions and fail

to effectively safeguard their human rights.

Countries should adopt appropriate mental health policies, laws and services that promote the rights of people with mental disabilities and empower them to make choices about their lives, provide them with legal protections, and ensure their full integration and participation into the community.

Promoting the rights of people with mental disabilities

IMPROVE ACCESS TO GOOD QUALITY MENTAL HEALTH TREATMENT AND CARE

- 450 million people around the world have mental, neurological or behavioural problems yet the majority of these people don't have access to appropriate mental health treatment and care[2].
- 30% of countries don't have a specified budget for mental health. Of those that do, 20% spend less than 1% of their total health budget on mental health[3].

Some countries lack adequate services, while in others services are available only to certain segments of the population.

- 32% of countries have no community care facilities defined as "any type of care, supervision and rehabilitation of mental patients outside the hospital by health and social workers based in the community"[4].
- There are huge regional variations in the number of psychiatrists from more than 10 per 100,000 to fewer than 1 per 300,000[5].

Worldwide, 68.6% of psychiatric beds are in mental hospitals as opposed to general hospitals or other community settings[6].

Governments need to increase investment in mental health. In addition, the mental health workforce needs to be developed, ensuring that health and mental health professionals receive sufficient training on mental health at all levels of care.

Large institutions, which are often associated with human rights violations, should be replaced by community care facilities, backed by general hospital psychiatric beds and home care support.

Credit: Basic Needs Ghana

[2] *World Health Report 2001: Mental Health: New Understanding, New Hope.* Geneva, World Health Organization, 2001

[3] *Mental Health Atlas,* Geneva, World Health Organization, 2005.

[4] Ibid

PROTECT AGAINST INHUMAN AND DEGRADING TREATMENT

- **People living in mental health facilities are often exposed to inhuman and degrading treatment.**

  They are sometimes put in seclusion or restraints for extended periods of time.

  Many are over-medicated to keep them docile and 'easy to manage'.

- **People with mental disabilities are often assumed to lack the capacity to make health care decisions in their own interest. Many are inappropriately admitted to mental health facilities against their will and are provided with treated without having given consent.**

  People some facilities also have to live in filthy conditions, lacking clothes, clean water, food, heating, proper bedding or hygiene facilities.

Human rights-oriented mental health policies and laws can be an effective way of preventing violations and discrimination and promoting the autonomy and liberty of people with mental disabilities and should be put in place.

- **Free and informed consent should form the basis of treatment and rehabilitation for most people with mental disabilities. People should be consulted and involved in decisions related to their treatment and care.**

- **The improper use of seclusion and restraints should be outlawed.**

- **People have the right to living conditions that respect and promotes their dignity. They have the right to adequate food, clothing, basic hygiene standards, safety and security, stimulation including recreational, educational, and vocational activities, to confidentiality, privacy, access to information, freedom of communication**

- **Patients should be informed of their rights when interacting with mental health services and this information should be conveyed in such a way that they are able to understand it.**

- **Legal mechanisms and monitoring bodies need to be in place to protect against inhuman and degrading treatment including inappropriate and arbitrary involuntary admission and treatment. People should also have recourse to complaints mechanisms in cases of human rights violations.**

Credits: Bakary Sonko / Harrie Timmermans/Global Initiative on Psychiatry

INVOLVE MENTAL HEALTH SERVICE USERS AND FAMILIES

- As recipients of mental health services, people with mental disabilities as well as their families are the people who are most directly affected by issues related to mental health. As such, they are in the best position to highlight problems, specify their needs, and help find solutions to improving mental health in countries.
- In many countries mental health service user as well as family organizations play a critical and extremely active role in all issues and related to mental health.

  In most countries however, mental health service users as well families are totally excluded from all matters related to mental health.

Governments should encourage the empowerment of mental health service users and families by supporting the creation and/or strengthening of groups representing their interest.

- **The perspectives of mental health service users, their families and others representing their interests is crucial to securing human rights. It is essential that they form an integral part of decision-making processes and activities and be directly involved in the design and implementation of mental health policies, plans, laws and services.**

CHANGE ATTITUDES AND RAISE AWARENESS

- The myths and misconceptions surrounding mental disability acts as a barrier to treatment. People with mental disabilities and their families fail to seek the care and support that they require for fear of being stigmatized.
- Stigma associated with mental disability also results in discrimination and human rights violations. All over the world people with mental disabilities face discrimination in the areas of employment, health, education, housing, education. Many are denied basic human rights such as the right to vote, to marry and have children.

Much of the stigma surrounding mental illness could be prevented by changing attitudes and making the public aware that mental disorders are treatable.

- **Combating stigma and discrimination is not the sole responsibility of the Ministries of Health and requires a multi-sectoral approach, involving education, labour, welfare and justice sectors among others.**

- **Ministries of Health as well as mental health service user representatives or organizations, family groups, health professionals, NGOs, academic institutions, professional organizations and other stakeholders should unify their efforts in educating and changing public attitudes towards mental illness and advocating for the human rights of people with mental disabilities.**

Credit: Sylvester Katontoka

References

World Health Organization

(http://www.who.int/mental_health/en/)

- **WHO Resource on Mental Health, Human Rights and Legislation** and **WHO Checklist on Mental health Legislation (see Annex 1 of WHO Resource Book)** available in English, French, Spanish, Arabic, Chinese, Portuguese, Hindi and German at url: http://www.who.int/mental_health/policy/en/
- **WHO Instrument to Assess Human Rights Conditions in Mental Health Facilities:** the Tool Kit is currently under development. Once finalized it will be available at url: http://www.who.int/mental_health/policy/en/
- **Mental Health Atlas**, Geneva, World Health Organization, 2005. Available at url: http://globalatlas.who.int/globalatlas/default.asp
- **World Health Report 2001: Mental Health: New Understanding, New Hope.** Geneva, World Health Organization, 2001, available at url: http://www.who.int/whr/2001/en/index.html

Useful Links

- **Training Tools and Exercises** designed to increase people's knowledge and skills the area of mental health, human rights and legislation: click here (see annex 1 of the Resource Book).
- **Mental Health and Human Rights - Denied Citizens: Including the Excluded** webpage: click here
- **The WHO MIND Project** brochure: click here
- **WHO Health and Human Rights Website:** click here
- For **Best Practices** examples, a selection of **Country Summaries** and official documents: click here

Other useful information sheets: click here

- Information sheet on WHO support to countries in developing human rights oriented mental health legislation
- Information sheet on WHO support to countries to establish human rights monitoring mechanisms in mental health facilities
- Information sheet on monitoring the rights of people with mental disabilities
- Information sheet on Mental Health Legislation

Citations

Promoting the rights of people with mental disabilities. Geneva, World Health Organization, 2007

(http://www.who.int/mental_health/policy/services/en/index.html, accessed 4 September 2007; Mental Health, Human rights and Legislation Information Sheet, Sheet1).

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WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM IN Jamaica

MINISTRY OF HEALTH
JAMAICA

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM

IN JAMAICA

A report of the assessment of the mental health system in Jamaica using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).

Kingston, Jamaica

2009

World Health Organization

of Health

Ministry

Jamaica

WHO, Country office in Jamaica
Panamerican Health Organization (PAHO/WHO)
WHO Department of Mental Health and Substance Abuse (MSD)

This publication has been produced by the WHO, (Country Office) in collaboration with WHO, (Regional Office) and WHO, Headquarters. At WHO Headquarters this work has been supported by the Evidence and Research Team of the Department of Mental Health and Substance Abuse, Cluster of Noncommunicable Diseases and Mental Health.

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(ISBN)

Suggested citation: WHO-AIMS Report on Mental Health System in Jamaica, WHO and Ministry of Health, Kingston, Jamaica, 2006.

Acknowledgement

The World Health Organization Assessment Instrument for Mental Health Systems (WHOAIMS) was used to collect information on the mental health system of Jamaica.

The project in Jamaica was implemented by Dr Earl Wright, Director Mental Health & Substance Abuse services, Mrs. Michelle Richards Henry, Programme Development Officer Mental Health, Mrs. Carol Baker Burke, National Coordinator Mental Health.

Appreciation is also extended to Dr Wendel Abel Head of Psychiatry, Department of Community Health & Psychiatry, Medical Records Clerk at Bellevue Hospital and the Mental Health Team island wide.

The project was supported by the PAHO/WHO Representation in Jamaica and by the PAHO/WHO Regional Office Mental Health team.

The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHOAIMS at the following website.
http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

The project received financial assistance and/or seconded personnel from: The National Institute of Mental Health (NIMH) (under the National Institutes of Health) and the Center for Mental Health Services (under the Substance Abuse and Mental Health Services Administration [SAMHSA]) of the United States; The Health Authority of Regione Lombardia, Italy; The Ministry of Public Health of Belgium and The Institute of Neurosciences Mental Health and Addiction, Canadian Institutes of Health Research.

The WHO-AIMS team at WHO Headquarters includes: Benedetto Saraceno, Shekhar Saxena, Tom Barrett, Antonio Lora, Mark van Ommeren, Jodi Morris, Anna Maria Berrino and Grazia Motturi. Additional assistance has been provided by Alexander Kopp and Mona Sharma.

The WHO-AIMS project is coordinated by Shekhar Saxena.

Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Jamaica. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Jamaica to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Jamaica's Mental Health Policy was last revised in 1997 and is currently inadequate and requires revision and upgrading to include critical components such as human resources and human rights issues to name a few. The Mental Health Unit has the revision and upgrading of this policy as an activity on its' 2009/10 workplan.

The Strategic Plan for the years 2001 – 2006, which is 65% implemented is in the process of being reviewed and updated for the years 2009-2014. The 2001-2006 strategic plan was not fully implemented because of budgetary constraint.

The Mental Health Law was last revised in 1997 and is also on the Mental Health Unit's 2009/10 work plan to be reviewed and revised to include all human rights policies as a critical component.

The restructuring of the financing of the service is in the Mental Health Plan which has been approved by Cabinet. With the change in Government, however, the Mental Health team will now have to advise the new Minister of Health and make the necessary arrangement for the issue of the redistribution of funding from the costly mental hospital to the community mental health services to support patient care as near as possible to the community in which they live, to be made into policy and implemented. This activity is also on the unit's 2009/10 workplan.

The mental health service is divided into national and regional health authorities. Mental health is integrated into general health care with all regions having most of the essential mental health components and psychotropic medication. A major weakness of the service is the child and adolescent and forensic component of the service. Most patients are treated in the outpatient community facilities at a rate of 1034 per 100,000 population. These facilities exist throughout the island in the various communities, as part of primary health care. In Jamaica epidemiological studies show that the most prevalent disorder is that of Major Depressive Disorder. However, schizophrenia is the most prevalent disorder diagnosed and treated. There is one mental hospital in the country with a bed capacity of 32 beds per 100,000 population. The number of beds in the mental hospital has decreased by 23% in the last 5 years. The patients admitted to the mental hospital are diagnosed primarily with schizophrenia

79% and most admissions are involuntary. The average days spent in the mental hospital is 280 days. The average length of stay the acute ward is 25 days. Long stay patients account for the majority of the days spent and should be in a residential support living type facility which currently is underserved.

The majority of clinics have mental health assessment and treatment protocols and 78% of the primary health care staff have had refresher training in mental health in the last year.

The majority of clinical services are provided by nurses, which represents 6 per 100,000 under the supervision of the psychiatrists which is 1 per 100,000. There is a dearth of psychologists, social workers and occupational therapists in the island due to the unattractive remuneration in the public sector. Most psychiatrists provide both public and private services. While few psychiatrists emigrate to other countries, a significant number of nurses emigrate on a yearly basis. Consumers, non-government, community based and family associations interact closely with the mental health services.

Mental Health Education and Promotion is a stated priority for both the national and regional authorities. During the last two years there has been an active mental health promotion targeting all sectors, including primary and secondary schools. There is no legislative, financial provision for persons with mental disorders and only 1% of persons with a mental disability receive social welfare benefits.

JAMAICA OBSERVER ARTICLE:
"SUE THEM! ABEL URGES BELLEVUE PATIENTS TO TAKE GOV'T TO COURT"

Sunday, March 26, 2017

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SUE THEM! - Abel urges Bellevue patients to take Gov't to court

Bellevue patients urged to take Gov't to court for rights violation

BY KIMONE THOMPSON Features Editor, Sunday thompsonk@jamaicaobserver.com

Monday, August 15, 2011

CONSULTANT psychiatrist at the University Hospital of the West Indies Dr Wendel Abel is urging patients of Bellevue Hospital — the country's sole mental hospital — to take the Jamaica Government to the international court for violating their human rights.

Addressing the Jamaica Psychiatric Association's annual seminar at the Mona Visitor's Lodge yesterday, Dr Abel said that the practice of admitting people to a mental institution, which he described as a "human warehouse", was in contravention of international treaties that the country had signed.

"I tell you this, if a lot of these patients were smart, they could take the issue to the Inter-American Commission on Human Rights or to the United Nations and the State would be liable. It's just because a lot of our patients are not empowered (but) our human rights activists must urge and encourage (them)," he said.

"It happened in the prison system where persons are locked away. I remember the case of this gentleman, Nettleford, who was lost in the system for over 27 years and he was awarded damages of nearly $9 billion. So that's food for thought," Dr Abel said.

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There has already been a lot of agitation in the region for persons in mental hospitals to take their cases to the various commissions, the psychiatrist said, pointing to Barbados where two such persons have already made the move, but are awaiting the outcome.

"The reality is that we are one of the countries that, not only one of the countries, we were the first country that signed on to the UN principles and care for the protection of the mentally ill. In this country, we love to sign on to international conventions and we don't follow through in making the provisions, and one of the provisions state that people have a right to be treated in the community," he added.

The United Nations General Assembly adopted the principles for the protection of persons with mental illness and the improvement of mental health care in December, 1991. Among the 25 principles it espouses are fundamental freedoms and basic rights, the role of community and culture, standards of care, treatment and medication, consent to treatment, and confidentiality.

Dr Abel was one of eight psychiatrists who made presentations at yesterday's seminar. He spoke on the subject 'Integration of mental health and primary health care' and citing the high costs, the inaccessibility of services, poor health outcomes, and the rights violations, made a case against hospitalised care for the mentally ill and promoted an extension of primary health care services.

"The pattern has been that people are admitted involuntarily for years, separated from their family and community and when you look at it, the very nature of admitting persons to an institution and keeping them there for years really constitutes a violation of their fundamental human rights.

"We have people locked away for years and their human rights, their fundamental human rights are taken away," he stressed.

Quoting from the Estimates of Expenditure for the 2009-2010 fiscal year, Dr Abel said that the Government was pumping $1.2 billion per year into the State-run hospital, 80 per cent of the total mental health budget.

"And they have about 800 patients so it worked out to be $1.5 million per patient per year which is $125,000 per month per patient. And you say we don't have money?" he asked rhetorically.

The health budget for the 2011-2012 was cut by $200 million to $1 billion.

"To keep someone in a regular home in the facility doesn't cost us anywhere near there," he said.

Dr Abel operates a number of community-based group homes for the treatment of the mentally ill, but when asked to compare the maintenance costs with those of Bellevue, he declined. However, a previous Observer check revealed that patients in one of his homes paid $50,000 per month.

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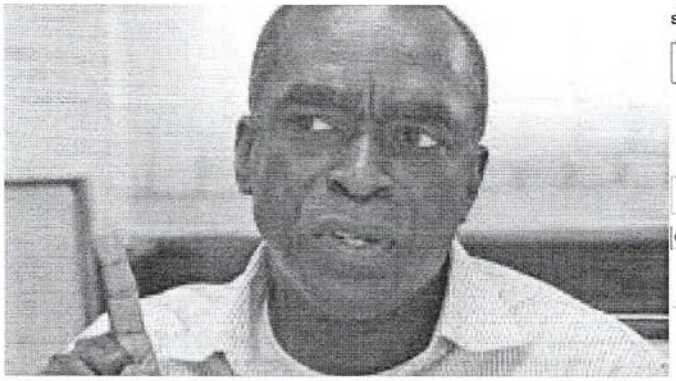
RJR NEWS ARTICLE:
"JAMAICA AT RISK FOR BREACHING HUMAN RIGHTS TREATIES FOR TREATMENT OF MENTALLY ILL"

Jamaica at risk of breaching human rights treaties for treatment of mentally ill

9:03 am, Sat May 21, 2016



Professor Wendel Abel

Head of Psychiatry at the University of the West Indies, Mona campys, Professor Wendel Abel, has agreed that Jamaica is running the risk of breaching international human rights treaties, based on its treatment of mentally ill patients in facilities.

He's arguing that one main treaty mandates certain treatment of mentally ill patients, but this is not happening in several instances.

The issue was one of the concerns raised by the Auditor General's Department, in its Performance Audit Report on the Health Ministry's Management of Mental Health Services.

The report outlined that at the Bellevue Hospital, more then 80 per cent of patients were stable, and should have been at home with their families.

Professor Abel warns that continued institutionalisation after being discharged could be deemed a violation of their rights. This is because Jamaica is a signatory to the United Nations Convention on the rights of persons with disabilities.

"Part of this convention acknowledged that people with mental illness have the right to be treated in the least restricted manner and a lot of these people who have been admitted to these mental institutions have been admitted involuntarily, so they are taken there, they are locked away, their rights are taken away and they are there for years - and we have seen this occur in several Latin American countries where people have decided to challenge the state and have successfully been awarded damages...." he said

Abel, who was a guest on Beyond the Headlines, is also recommending more community treatment of mentally ill persons, to avoid breaches of international conventions, and to fix the system and argues that it would be more cost effective for the government.

"It is costing the state about J$1.5 million dollars per person per year to keep them in the Bellvue Hospital. In the community we could be treating them for a fraction of that ..."he said.

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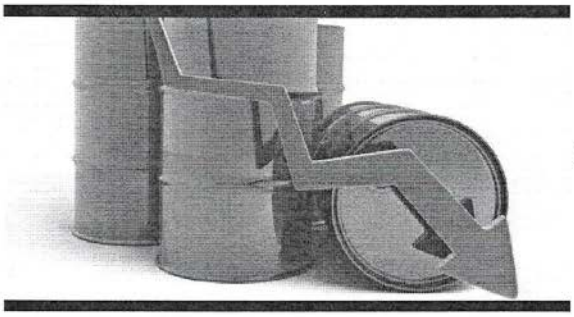

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JAMAICA OBSERVER ARTICLE:
“MENTAL HEALTH SHAME”

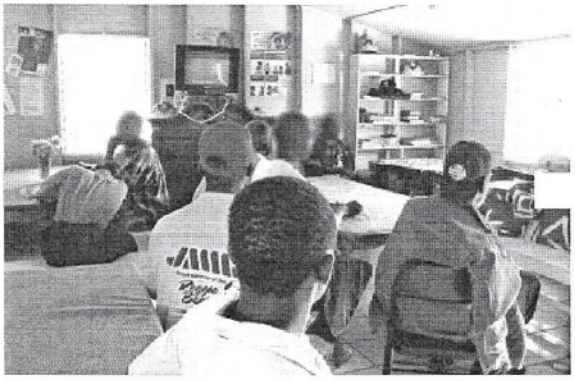
News

Mental health shame

Ja's lack of facilities said in breach of int'l treaties

BY KIMONE THOMPSON Features Editor - Sunday thompsonk@jamaicaobserver.com

Sunday, February 06, 2011



Men who are part of the progarmme at the Open Arms Drop-in Centre operated by Bellevue Hospital watch TV in the multi-purpose room.

JAMAICA is said to be in contravention of the international treaties on human rights for not having a mental health facility dedicated to the criminally insane.

But it's not just the criminally insane whose rights are being abused, says co-founder of the mental health support group Mensana, Carol Narcisse. It's all categories of people with mental illnesses.

"Before you even get to forensics, the rights of people with mental illness to access appropriate care and in a timely manner are being contravened daily. There are no facilities, and where we do have facilities the access to care is a major concern. There are very few care facilities.

Article 12 of the International Covenant on Economic, Social and Cultural Rights says everyone has the right to the highest attainable standard of physical and mental health, and article 25 of the universal declaration on human rights says everyone has the right to a standard of living adequate for the health and well-

being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. However, Narcisse said the country is in breach.

"Jamaica is in serious breach of the right of the mentally ill to appropriate health and appropriate services based on their disability," she said.

Consultant forensic psychiatrist Dr Clayton Sewell agreed. Using the example of Stephen Fray, who in April 2009 attempted to hijack a plane at Sangster International Airport, and who was sentenced to 83 years in prison for the act, Dr Sewell said had the crime been committed elsewhere, Fray would have been sent to a forensic mental health hospital instead of prison.

In a psychiatric evaluation, Fray, then 21 years old, was found to be schizophrenic.

"If Fray was Canadian and had done that in Canada, he would not end up in prison. He would have been sent to a forensic mental health hospital. I don't think it speaks well of the Jamaican forensic mental health services and how the issue was disposed of in court, especially for him to serve such a lengthy sentence," Sewell told the Sunday Observer in a recent interview.

"In fact, I think it's a violation of the human rights convention to which Jamaica is a signatory," added Sewell who works with mentally ill persons accused of crimes and who are locked away in our nation's prisons.

He described the psychiatric services in prison as "rudimentary". The medication is limited, there are little or no activities geared towards rehabilitation, and the psychiatrists who treat the inmates are only available on a part-time basis.

"(Mentally ill inmates) get limited medication, limited rehabilitation, if at all, so what you will find is that once (Fray) and others like himself are released they will be a shadow of their former selves because he will lose a lot of social skills. He will get medication, but never enough to make him close to what he was before he went to prison," said Dr Sewell.

"He's not the first one to have faced that kind of disposal from the courts. There have been many others before and once they remain the way they are, there will be others after him," the doctor added.

Repeated attempts over the past two weeks to get comments from Bellevue CEO Dr David Dobson, the South East Health Regional Health Authority (under whose authority Bellevue falls), and the Ministry of Health on the general state of the mental health care system were unsuccessful.

Other Caribbean nations such as Trinidad, Barbados and The Bahamas have forensic mental health facilities. The Sandilands Rehabilitation Centre in The Bahamas has a maximum security unit that accommodates patients remanded by the courts. In Barbados, the Black Rock Psychiatric Hospital has a forensic psychiatric unit, and there is one at St Ann's Hospital in Trinidad and Tobago.

There was once a wing at Bellevue Hospital for forensic psychiatric cases but it was closed and the inmates sent to prison, the Sunday Observer has learnt.

"Jamaica should be ashamed of itself because it can do better. It has the resources to do better, it has the people with the know-how to do better, and it has sufficient best practices to draw on to do better... There is absolutely no political will," Narcisse said.

For the past five months, the University Hospital of the West Indies (UHWI) has been running a forensic mental health clinic which sees about three patients per week who were referred either by the courts, lawyers or fellow psychiatrists.

While it is useful, Sewell said it is not nearly enough.

There are other deficiencies in terms of facilities. UHWI's Ward 21 is the only institution that caters to children and adolescents with mental disorders on an inpatient basis, and only about four or five of its 20 beds — excluding the eight in the substance abuse unit — are for that group. The 800-bed Bellevue Hospital has a wing for geriatric patients, but the facility is oversubscribed, despite the health ministry's stated policy shift from institutionalised care to community mental health services.

Ambulances are also in very short supply, and certain drugs are often not available.

"We do have a challenge with ambulances," consultant psychiatrist at Bellevue Dr Myo Oo admitted. "Mental health officers and the crisis team try their best to respond based on the situation. We have a crisis line for 24 hours and then calls are screened based on severity."

"From time to time we have issues with transport. It's usually a bus or an ambulance that takes the team out for visits but from time to time it may not be in operation or can't manage the terrain," added Dr Sewell.

A source with knowledge of the operations of the Kenneth Royes Rehabilitation Centre in Spanish Town told the Sunday Observer that "pretty often" some medications are "unavailable to the clients so they sometimes relapse".

When that happens, the patients get an injection to sedate them, our source said.

The Kenneth Royes Centre is a wing of Bellevue with the responsibility of rehabilitating acute patients so they will be able to live and function normally in society. It uses arts and craft as well as farming and cattle rearing as occupational therapy. It has 44 patients and is located on the same lands formerly used by the old leper colony.

"Unfortunately, we haven't been able to achieve that so much," the source said of the intended objectives.

The Spanish Town centre is also hampered by the number of geriatric patients on its roll.

Of the UHWI, which receives up to 60 per cent government subsidy, Dr Sewell acknowledged that "the 20-bed unit is no longer sufficient", given the demand. He said, however, that there are plans to expand and improve the St Andrew facility.

Patients are usually admitted for between 14 and 28 days, but the unit also has several categories of outpatient clinics and programmes.

Major hospitals and some government health centres also offer mental health clinics on particular days but the gaps in the system are wide, a major reason mentally ill people roam the streets.

To its credit, in 2006 Bellevue opened the Open Arms Drop-in Centre to address the high number of street people in the city — half of whom staff members say are mentally ill. It operates a day centre for homeless adults and a dormitory facility for males. Patients are fed three times per day, given medication if necessary, and they have access to showers, laundry facilities and clean clothes.

But as far as Sewell is concerned, it is just a drop in the proverbial bucket.

"The facilities in Jamaica are not in keeping, arguably, with the human rights standards to which we have agreed," Dr Sewell said, assessing the general conditions.

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ARTICLE ON MODECATE (FLUPHENAZINE)

Modecate (fluphenazine)

Modecate and Modecate concentrate injections both contain the active ingredient fluphenazine decanoate, which is a type of medicine called a phenothiazine antipsychotic. (NB. Fluphenazine is also available without a brand name, ie as the generic medicine.)

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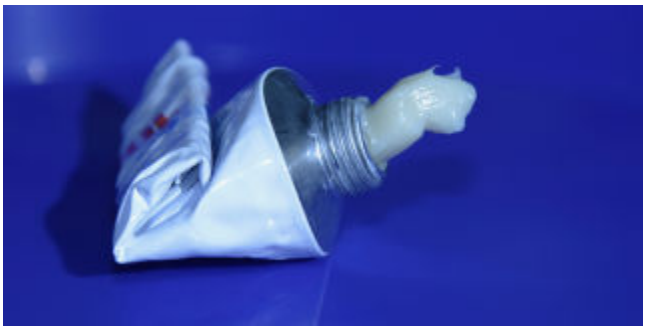

Protopic ointment (tacrolimus)

15 August 2012

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What is it used for?

- **Long-term treatment of schizophrenia and other paranoid psychoses.**

How does it work?

Modecate and Modecate concentrate injections both contain the active ingredient fluphenazine decanoate, which is a type of medicine called a phenothiazine antipsychotic. (NB. Fluphenazine is also available without a brand name, ie as the generic medicine.)

Fluphenazine is sometimes described as a neuroleptic or a 'major tranquilliser', though this last term is fairly misleading, as this type of medicine is not just a tranquilliser, and any tranquillising effect is not as important as its main mechanism of action in psychiatric illness.

Fluphenazine works by blocking dopamine receptors in the brain. Dopamine is a natural compound called a neurotransmitter, and is involved in transmitting messages between brain cells. Dopamine is a neurotransmitter known to be involved in regulating mood and behaviour, amongst other things.

Psychotic illness, and particularly schizophrenia, is thought to be caused by overactivity of dopamine in the brain. Fluphenazine blocks the receptors that dopamine acts on, and this prevents the overactivity of dopamine in the brain. This helps to control psychotic illness.

Fluphenazine improves disturbed thoughts, feelings and behaviour in psychotic illness such as schizophrenia. It produces a calming effect and controls aggression, delusions and hallucinations.

How is it given?

- **Modecate and Modecate concentrate injections are depot injections.** The injection is administered into the muscle of the buttock, where it forms a reservoir of medicine that is slowly released into the bloodstream. This means that you don't need to remember to take a dose of the medicine every day. The injection is usually given every two to five weeks, depending on the dose required.
- You should not suddenly stop treatment with this medicine unless your doctor tells you to, even if you feel better and think you don't need it any more. This is because the medicine controls the symptoms of the illness but doesn't actually cure it. This means that

if you suddenly stop treatment your symptoms could come back. For this reason, you should make sure that you always keep your appointment for your next injection. Stopping the medicine suddenly may also rarely cause withdrawal symptoms such as nausea, vomiting, sweating, insomnia or involuntary movements such as twitching or tremor, though this is unlikely after stopping this injection, because the level of the medicine in your blood will gradually decrease over several weeks.

Warning!

- **This medicine may cause drowsiness and blurred vision.** If affected do not drive or operate machinery.
- It is recommended that you avoid drinking **alcohol** while having treatment with this medicine because it may enhance drowsiness.
- Antipsychotic medicines can sometimes affect the ability of the body to control its core body temperature. This is more likely to be a problem in elderly people and can result in heat stroke in hot temperatures and hypothermia in cold temperatures. It is important to avoid situations that can result in you overheating or getting dehydrated. Ask your doctor or pharmacist for more advice.
- Antipsychotic medicines are associated with an increased risk of getting a blood clot in a vein (deep vein thrombosis) or in the lungs (pulmonary embolism). For this reason, you should consult a doctor immediately if you get any of the following symptoms, which could suggest you have a blood clot: stabbing pains and/or unusual redness or swelling in one leg, pain on breathing or coughing, coughing up blood or sudden breathlessness.
- **You should tell your doctor if you experience any abnormal movements, particularly of the face, lips, jaw and tongue, while having treatment with this medicine. These symptoms may be indicative of a rare side effect known as tardive dyskinesia,** and your doctor may ask you to stop using this medicine, or decrease your dose.
- Consult your doctor immediately if you experience the following symptoms while having treatment with this medicine: **high fever, sweating, muscle stiffness, faster breathing and drowsiness or sleepiness. These symptoms may be due to a rare side effect known as the neuroleptic malignant syndrome, and if so your treatment should be stopped.**

Use with caution in

- Elderly people.
- Decreased kidney function.
- Liver disease.
- Severe disease affecting the lungs or airways.
- Heart disease, such as heart failure, recent heart attack, very slow heart rate (bradycardia) or irregular heart beats (arrhythmias).
- Personal or family history of a type of abnormal heart rhythm, seen on a heart monitoring trace (ECG) as a 'prolonged QT interval'.

- People with disturbances in the normal levels of salts (electrolytes) in their blood, for example low magnesium, calcium or potassium levels.
- Elderly people with dementia. (Antipsychotic medicines have been shown to increase the risk of stroke in this group of patients. Fluphenazine is not licensed or recommended for treating behavioural disturbances in elderly people with dementia).
- People with risk factors for having a stroke, for example smoking, diabetes, high blood pressure, or a type of irregular heartbeat called atrial fibrillation.
- People with a personal or family history of blood clots (venous thromboembolism), for example in a vein of the leg (deep vein thrombosis) or in the lungs (pulmonary embolism).
- People with other risk factors for getting a blood clot, for example smoking, being overweight, taking the contraceptive pill, being over 40, recent major surgery or being immobile for prolonged periods.
- Diabetes. People with diabetes should monitor their blood sugar levels more closely whilst taking this medicine. This medicine may increase the blood sugar levels in the body.
- Epilepsy.
- People with conditions that increase the risk of convulsions, eg brain damage or withdrawal from alcohol.
- Parkinson's disease.
- Abnormal muscle weakness (myasthenia gravis).
- People with a personal or family history of closed angle glaucoma.
- Men with an enlarged prostate gland (prostatic hypertrophy).
- People with an underactive or overactive thyroid gland.
- People who are allergic to other phenothiazine medicines, such as prochlorperazine or trifluoperazine.
- People exposed to organophosphorus insecticides.

Not to be used in

- **People in unresponsive unconscious states (comatose states).**
- People with severe narrowing of the blood vessels in the brain (cerebral atherosclerosis) - this may be seen in people with a history of stroke or mini-stroke (TIA).
- Tumour of the adrenal gland (phaeochromocytoma).
- Kidney failure.
- Liver failure.
- Severe heart failure.
- Severe depression.
- People with disturbances in the normal numbers of blood cells in their blood.
- This medicine is not recommended for children.

This medicine should not be used if you are allergic to one or any of its ingredients. Please inform your doctor or pharmacist if you have previously experienced such an allergy.

If you feel you have experienced an allergic reaction, stop using this medicine and inform your doctor or pharmacist immediately.

Pregnancy and breastfeeding

Certain medicines should not be used during pregnancy or breastfeeding.
However, other medicines may be safely used in pregnancy or breastfeeding providing the benefits to the mother outweigh the risks to the unborn baby. Always inform your doctor if you are pregnant or planning a pregnancy, before using any medicine.

- The safety of this medicine during pregnancy has not been established. It should not be used in pregnancy, particularly in the first and third trimesters, unless considered essential by your doctor. If the medicine is used during the third trimester it could cause side effects or withdrawal symptoms in the baby after birth and the baby may need extra monitoring because of this. Seek further medical advice from your doctor.
- This medicine may pass into breast milk. As it could cause drowsiness and potentially other side effects in a nursing infant, it is recommended that women who need treatment with this medicine should not breastfeed. Seek further medical advice from your doctor.

Side effects

Medicines and their possible side effects can affect individual people in different ways. The following are some of the side effects that are known to be associated with this medicine. Just because a side effect is stated here does not mean that all people using this medicine will experience that or any side effect.

- Redness, swelling or pain at the injection site.
- **Abnormal movements of the hands, legs, face, neck and tongue, eg tremor, twitching, rigidity (extrapyramidal effects).**
- Anxiety, restlessness and agitation (akathisia).
- Increased salivation or dry mouth.
- Rhythmical involuntary movement of the tongue, face, mouth and jaw, which may sometimes be accompanied by involuntary movements of the arms and legs (tardive dyskinesia - see warning section above).
- **Drowsiness.**
- **Blurred vision.**
- Constipation.
- Increased heart rate (tachycardia).
- Irregular heart beats (arrhythmias).
- A drop in blood pressure (hypotension) that may cause dizziness.
- Interference with the body's temperature regulation (this is more common in elderly people and may cause heat stroke in very hot weather or hypothermia in very cold weather).
- Headache.
- Difficulty sleeping (insomnia).
- **Feelings of being mentally dulled or slowed down.**
- Difficulty passing urine, increased need to pass urine, or urinary incontinence.
- Skin reactions such as rashes, itching, increased sensitivity to sunlight.

- Sexual problems, such as erectile dysfunction.
- Seizures (convulsions).
- High blood prolactin (milk producing hormone) level (hyperprolactinaemia). Sometimes this can lead to symptoms such as breast enlargement, production of milk and stopping of menstrual periods.
- High temperature combined with falling levels of consciousness, paleness, sweating and a fast heart beat (neuroleptic malignant syndrome). Requires stopping the medicine and immediate medical treatment - see warning section above.
- Uncontrolled rolling of the eyes and neck (oculogyric crisis). Requires immediate treatment.
- Disturbances in the normal numbers of blood cells in the blood. Tell your doctor if you get a fever, sore throat, mouth ulcers or other signs of infections while taking this medicine, as these symptoms could suggest a problem with your white blood cells. Your doctor may want you to have a blood test to check the numbers of blood cells in your blood.
- Jaundice or liver problems (tell your doctor straight away if you notice any yellowing of your eyes or skin while taking this medicine).
- Abnormal blood clot in the blood vessels (venous thromboembolism - see warning section above).

The side effects listed above may not include all of the side effects reported by the medicine's manufacturer.

For more information about any other possible risks associated with this medicine, please read the information provided with the medicine or consult your doctor or pharmacist.

How can this medicine affect other medicines?

It is important to tell your doctor or pharmacist what medicines you are already taking, including those bought without a prescription and herbal medicines, before you start treatment with this medicine. Similarly, check with your doctor or pharmacist before taking any new medicines while having treatment with this one, to make sure that the combination is safe.

There may be an increased risk of drowsiness and sedation if fluphenazine is used with any of the following (which can also cause drowsiness):

- **alcohol**
- barbiturates, eg **amobarbital**, **phenobarbital**
- benzodiazepines, eg **diazepam**, **temazepam**
- MAOI antidepressants, eg **phenelzine**
- sedating antihistamines, eg **chlorphenamine**, **hydroxyzine**
- sleeping tablets, eg **zopiclone**
- strong opioid painkillers, eg **morphine**, **codeine**
- tricyclic antidepressants, eg **amitriptyline**.

Medicines that increase the risk of a type of abnormal heart rhythm, seen as a 'prolonged QT interval' on an ECG, should be avoided in combination with fluphenazine. These medicines include the following:

- antiarrhythmics (medicines to treat abnormal heart beats), eg **amiodarone**, **procainamide**, **disopyramide**, **sotalol**
- the antihistamines **astemizole**, **mizolastine** or **terfenadine**
- **arsenic trioxide**
- **atomoxetine**
- certain antidepressants, eg **amitriptyline**, **imipramine**, **maprotiline**
- certain antimalarials, eg **halofantrine**, **chloroquine**, **quinine**, **mefloquine**, **Riamet**
- **certain antipsychotics, eg thioridazine, pimozide, sertindole , haloperidol**
- **cisapride**
- **dronedarone**
- **droperidol**
- intravenous **erythromycin** or **pentamidine**
- **methadone**
- **moxifloxacin**
- **saquinavir**.

There may also be an increased risk of a prolonged QT interval if medicines that can alter the levels of salts such as potassium or magnesium in the blood, eg diuretics such as **furosemide**, are taken in combination with fluphenazine.

There may be an increased risk of side effects such as dry mouth, constipation, confusion or heat stroke (in hot and humid conditions) if other medicines that can have anticholinergic effects, such as the following, are taken by people having fluphenazine injections:

- anticholinergic medicines for Parkinson's symptoms, eg **procyclidine**
- antihistamines, eg **brompheniramine**, **chlorphenamine**
- other antipsychotic medicines
- antisickness medicines, eg **promethazine**, **meclozine**, **cyclizine**
- antispasmodic medicines, eg **hyoscine**
- MAOI antidepressants, eg **phenelzine**
- medicines for urinary incontinence, eg **oxybutynin**, **flavoxate**, **tolterodine**, **propiverine**, **trospium**
- muscle relaxants, eg **baclofen**
- tricyclic antidepressants, eg **amitriptyline**.

Fluphenazine may enhance the blood pressure-lowering effects of **medicines that lower blood pressure**, including medicines used to treat high blood pressure (antihypertensives) and medicines that lower blood pressure as a side effect, eg benzodiazepines. If you are taking medicines that lower blood pressure you should tell your doctor if you feel dizzy or faint after starting treatment with this medicine, as your doses may need adjusting.

Fluphenazine may reduce the blood pressure lowering effect of **guanethidine**.

Fluphenazine may oppose the effect of **levodopa** and medicines for Parkinson's disease that work by stimulating dopamine receptors in the brain, for example **ropinirole, pergolide, bromocriptine**.

Fluphenazine may oppose the effect of **anticonvulsant medicines** used to treat epilepsy.

Fluphenazine may increase blood sugar levels and disturb the control of diabetes. People with diabetes may need an adjustment in the dose of their **antidiabetic medication**.

There may be an increased risk of extrapyramidal-type side effects (abnormal body movements) if this medicine is used in combination with lithium or metoclopramide.

Fluphenazine injection should not be used in combination with **clozapine**.

Other medicines containing the same active ingredient

Fluphenazine depot injections are also available without a brand name, ie as the generic medicine.

Last updated 14.08.2012

ARTICLE BY DR. PETER BREGGIN:
“Antipsychotic Drugs and Tardive Dyskinesia (TD)”

Antipsychotic Drugs and Tardive Dyskinesia (TD) Resources Center

for prescribers, scientists, professionals, patients, and families

By Peter R. Breggin, MD

Tardive dyskinesia (TD) is a complex neurological disorder caused by antipsychotic (neuroleptic) drugs. It has many variations and afflicts both muscle control and mental processes. Among those given antipsychotics, TD occurs in very high rates in all age groups and is usually persistent and irreversible.

TD Resources Center Sections

What is Tardive Dyskinesia?

Introduction

Tardive dyskinesia (TD) is a group of involuntary movement disorders caused by drug-induced damage to the brain and often associated with physical or emotional suffering. TD is caused by all drugs that block the function of dopamine neurons in the brain. This includes all antipsychotic drugs in common use as well as a few drugs used for other purposes. TD can vary from a disfiguring grimace to a totally disabling array of spasms and often bizarre movements of any part of the body. See the Videos section for examples of TD. **Unless identified at an early stage and the offending drugs stopped, these disorders nearly always become permanent.**

Antipsychotic drugs are also called *neuroleptics*. Prescribers often promote them in a misleading fashion as antidepressants, mood stabilizers, bipolar drugs, sleeping pills, and behavior control drugs in children. Recent ones include Risperdal (risperidone), Abilify (aripiprazole), Geodon (ziprasidone), Invega (paliperidone), Latuda (lurasidone), Rexulti (brexpiprazole), Risperdal (risperidone), Saphris (asenapine), Seroquel (quetiapine), and Zyprexa (olanzapine). Older antipsychotics include Haldol (haloperidol) and Thorazine (chlorpromazine).

For a more complete list of antipsychotic or neuroleptic drugs, go here.

In recent years, Risperdal (risperidone) has most commonly come to my attention as a medical expert, especially in harming children, and this website contains extra information about Risperdal and its manufacturer Johnson and Johnson (J&J).

As a psychiatrist, the scientific information on this website is built upon many decades of clinical experience, research, publications, educational efforts, and work as a medical expert in legal cases. Now I wish to share this information in one convenient place for TD victims and their families, for their attorneys and other medical experts, and for any citizens, scientists and professionals concerned about this worldwide epidemic of medication-induced brain damage and dysfunction.

Rates of TD are Extremely High

TD commonly begins to appear within 3-6 months of exposure to the drugs, but cases have occurred from one or two doses. The risk of getting TD is very high in all age groups, including children. It afflicts 5% to 8% per year of younger adults treated with antipsychotics. The rates are cumulative in the first few years so that by three years 15% to 24% of patients will be afflicted. Rates escalate in the age group 40-55 years old, and among those over 55 are staggering, in the range of 25%-30% per year. (For more about rates in each age group, see the Scientific Literature section, groups 1 through 3.)

Newer "Atypical" Antipsychotics Have Similar TD Rates

Drug companies have made false or misleading claims that newer antipsychotic drugs or so-called atypicals are less likely to cause TD than the older ones. Recent research, much of it from a large government study called CATIE, have dispelled this misinformation. Considering how huge the TD rates are, a small variation among drugs would be inconsequential. All the

antipsychotic drugs with the possible exception of the deadly Clozaril, cause TD at tragically high rates. Since all these drugs are potent dopamine blockers, there should have been no doubt from the beginning that they would frequently cause TD. (See the Scientific Literature section, group 4.)

What TD Looks Like

TD can impair any muscle functions that are partially or wholly under voluntary control such as the face, eye muscles, tongue, neck, back, abdomen, extremities, diaphragm and respiration, swallowing, and vocal cords. Coordination and posture can be afflicted. TD can cause tremors, tics, and paresthesias (e.g., burning sensations, numbness).TD can also afflict the autonomic nervous system, especially impairing gastrointestinal functioning.

Classic Tardive dyskinesia

Classic TD involves either rapid, jerky movements (choreiform) or slower, serpentine movements (athetoid). In the extreme, a patient may look as if he or she is playing a guitar in a wild rock band. He may be unable to sit or stand straight, or be unable to control constant head bobbing. Hands and feet or fingers and toes may curl uncontrollably.

Tardive Dystonia

A second form of TD, tardive dystonia, involves painful muscle contractions or spasms, often the neck, and sometimes leading to overall rigidity of the body. (See the Scientific Literature section, group 7.)

Tardive Akathisia, Dementia and Psychosis

A third form of TD, tardive akathisia, involves psychomotor agitation, an inner torture that drives the person to move about compulsively seeking relief. Tardive akathisia can cause psychosis, a general worsening of the person's condition and life, suicide, and violence. (See the Scientific Literature section, group 8.) There are many additional forms of TD including *tardive psychosis* and *tardive dementia*. (See the Scientific Literature section, groups 5 & 6.) The various tardive disorders can exist separately or in combination.

Masking: Antipsychotics Mask the Symptoms they Cause

Unfortunately, antipsychotic drugs not only cause TD, they mask the manifestation of the symptoms, so that the patient grows worse without initially realizing it. The TD disorder then breaks out, often amid emotional anguish from its effects, at a time with the drugs can no longer suppress it or the individual tries to withdraw from the drug.

Physical Exhaustion

Tardive dyskinesia frequently leads to exhaustion. The exhaustion is often overlooked by diagnosticians, but it grossly impairs the quality of life.

Humiliation

TD commonly causes humiliation with social withdrawal. The emotional suffering in the form of shame, loneliness and isolation cannot be exaggerated.

Catastrophic Impact on the Brain, Mind and Lifespan

TD also leads to shortened lifespan and frequently causes cognitive dysfunction and dementia. Antipsychotic drugs, without or without TD, can cause shrinkage (atrophy) of the brain and take years of the victim's life. (See the Scientific Literature section, groups 5 and 6.) Most people with TD are also afflicted with a loss of cognitive functioning.

Educating Clinicians, Patients and Families

Clinicians, patients and families must be able recognize the symptoms of TD in order to identify potential TD and to take appropriate action in stopping the medication. All health care providers must be prepared to educate patients and their families about the dangers of tardive dyskinesia.

Overlooked and Confusing Signs of TD

TD can afflict one muscle group such as the tongue or fingers or it can affect many muscle groups. It can cause a generalized hypertension or rigidity of the entire musculature of the body. It can manifest itself in varying ways at varying times. Like most or all neurological disorders, manifestations of TD vary enormously depending on the individual's general physical condition and mental condition. It often improves during relaxation and worsens during stress, fatigue, illness, or lack of sleep. Although it can make it difficult to fall asleep, it usually disappears when the individual falls asleep.

TD symptoms may change from one muscle group to another over a period of minutes, days, weeks or even months or years. In the beginning, TD may afflict the tongue and eye muscles. Years later, it may change to afflicting the neck and shoulders and not the tongue and eyes. One set of symptoms may grow worse over the years, another set may grow less severe, and yet others may appear. Sometimes, TD symptoms first appear months or years after the last drug exposure. When symptoms of TD have been present for several weeks or months, the disorder, while commonly changing its manifestations, rarely disappears entirely.

TD frequently causes severe exhaustion, even when limited to one area, such as the jaw, neck, or feet. Victims often fail to report exhaustion or fatigue unless they are asked, and then it may turn out to be a dominant part of the disability that vastly limits their activities, such as walking, doing housework or visiting.

Especially in the *dystonic* forms, the pain can be very severe, and the physical stress can cause serious orthopedic problems, including erosion of the cervical spine from muscle spasms in the neck or claw-like joint distortions due to flexion contractures of the hands or feet.

Many people try to cover up their TD by making their movements look intentional. A person who grimaces may pretend to be smiling. An individual whose arm rises uncontrollably may make it look as if he or she is stroking or combing their hair with their hand. They may not be aware of what they are doing.

Patients and Diagnosticians Fail to Recognize Symptoms

Individuals frequently have little or no perception or understanding of the severity of their tardive dyskinesia. Typically, abnormal tongue movements go unnoticed, even while the individuals are aware of biting their tongue or the inner side of their cheeks, or having difficulty articulating or swallowing. Even more gross abnormal movements can be ignored, especially if they are not physically painful. This failure to recognize TD in oneself has been described in the scientific literature section, and may be an aspect of what I call medication spellbinding or intoxication anosognosia—the failure to recognized drug intoxication and other harms associated with psychoactive substances. It is probably related to frontal lobe dysfunction caused by drugs.

Without being grossly apparent to the untrained eye, TD can interfere with balance, walking, running, playing, and gross and fine motor coordination. Commonly, the individuals cannot clap their hands, patty cake, drum their fingers or write in a rapid and coordinated manner. Children suffering from TD frequently experience these disabilities, along with postural difficulties. Out of difficulty, fatigue or embarrassment, children stop playing as much.

Doctors, including neurological consultants, frequently fail to do thorough TD examinations or to accept the possibility that patients have TD. (See the Scientific Literature section, group 14.) A careful, informed physical examination of a patient, lasting at least 30 minutes, will frequently disclose more symptoms than reported to the doctor by the individual or the family, such as a curling of the tongue on extension from the mouth or while lying in the open mouth, a mildly spastic gait, or difficulty with balance on quick turns. Hand movements, such as curling fingers, may become more obvious while the individual is walking. Blinking may appear when the individual is focusing on something else such as writing a sentence or reading aloud. Slow movements may be more difficult than rapid ones, so that the individual has greater difficulty walking slowly than walking rapidly, which may give the misimpression of exaggerating their problem. Climbing stairs often displays difficulties not apparent when walking on flat surface.

Neuroleptic Malignant Syndrome (NMS)

NMS is caused by antipsychotic drugs and other dopamine blockers but is not considered a form of tardive dyskinesia. However, if the individual survives NMS, residual symptoms can include anything associated with TD. Approximately 20% of patients will die if the disorder is not recognized, the offending drug stopped, and supportive measures instituted. (See the Scientific Literature section, group 9.)

The classic signs of neuroleptic malignant syndrome are (1) fever, (2) rigidity or any other extrapyramidal reaction (including a wide variety of abnormal movements and spasms, Parkinsonism and TD-like symptoms), (3) altered mental status, and (4) autonomic dysfunction,

such as rapid respirations, elevated pulse, unstable blood pressure, chills, sweating, and incontinence.

NMS is frequently called “rare” but some studies show it occurs in up to 3% of hospitalized patients, making it a very common and yet potentially crippling or deadly disorder. The common idea that patients must show “rigidity” is false, but most show some sign of neurological impairment typically found in patients exposed to antipsychotic drugs. The idea that patients can be “carefully” restarted on the drug is a prescription for disaster.

NMS should be viewed as a disorder that occurs in many shapes and varying intensities. It can become chronic, especially if the offending agent or aggravating drugs are continued.

The NMS diagnosed is frequently missed or dismissed. I have been a medical expert in a number of cases where doctors have failed to diagnose NMS and severely harmed their patients by continuing the causative drug. Any patient on antipsychotic drugs or other dopamine blockers should be thoroughly evaluated for NMS if they develop a fever, changes in heart rate or pulse, any of various neurological symptoms, or new or worsened mental dysfunction. Even an unrelated physical disorder, especially infections such as pneumonia, should raise the question of whether an underlying NMS caused the vulnerability.

More about the Heavy Toll of TD

TD commonly ruins the lives of the afflicted individuals as well as the lives of those who love and care for them.

TD can lead to demoralizing chronic pain, such as teeth grinding and tongue biting, and dystonic spasms of the neck, hands or feet.

TD is typically stigmatizing, leading to demoralization, humiliation, and social isolation. Loudly grinding teeth, squinting eye spasms or rapid blinking, abnormal speech, or facial grimaces can ruin an individual’s confidence and cause social withdrawal. Those who are afflicted will often be shy and embarrassed about discussing how ashamed they are to appear in front of friends or strangers.

TD commonly leads to full disability, so that the victim cannot work, whether or not the associated psychiatrists and neurologists consider it disabling. It commonly disrupts intimate relationships on every level. The individual often becomes irritable and less affectionate, causing additional suffering to family and loved ones.

Concentration and attention can be impaired by the stress of TD, by abnormal movements that are distracting, and by mental disability caused by the associated brain dysfunction. Victims often report difficulty relaxing enough or positioning themselves well enough to easily or comfortably read and watch television. Hobbies such as cooking, sewing, golfing, fishing and hiking may become impossible.

Signs of related brain injury include impairments of attention, concentration, and memory. Especially in more severe or long-lasting cases, there can be signs of dementia and psychosis (*tardive dementia* and *tardive psychosis*, see the Scientific Literature section, groups 5 and 6). Individuals may become highly anxious and paranoid. Distrust of all physicians and healthcare providers is a natural consequence of the betrayal felt by TD victims.

The millions of cases in the US result in inestimable costs to society.

Six of Dr. Breggin's Many Tardive Dyskinesia Legal Cases

- **$1.5 million Zyprexa & Risperdal child TD trial** (2014)
- **$700,000 settled Risperdal Tardive Dyskinesia** (2014)
- **$1.6 Million Tardive Dyskinesia Malpractice Verdict** (2005)
- **Menninger Clinic case: Patient dies in clinical trial of antipsychotic drug**
- **$6.7 Million for Tardive Dyskinesia Caused by J&J's Risperdal** (2000)
- **Landmark Victory in First Canadian Tardive Dyskinesia Trial** (2000)
- **Appeals Court Shocks Defense: Raises TD award to $2 Million** (1998)

Observations on Recovery from Tardive Dyskinesia

Although most tardive dyskinesia (TD) cases are permanent, many people experience a partial or even whole recovery from TD symptoms gradually over months and years. At present, no medical approaches are consistently useful and many drug interventions can worsen the condition.

Botox can alleviate some dystonic spasms but has its limitations. I have found that it is usually most helpful for patients to stop all psychoactive substances, although some patients benefit from the judicious use of sedatives like benzodiazepines to calm their nervous system or analgesic medications to relieve the pain associated with dystonia.

I try to help people focus on the basics of healthy living, including good nutrition, moderate exercise, and worthwhile activities and relationships. In my clinical practice, I have found that individuals do best by also seeking their own preferred alternative approaches including massage, acupuncture, mindfulness training, yoga, Chinese medicine, various exercise routines, and non-psychoactive supplements.

When individuals want psychotherapy, I often emphasize spiritual coaching, along with the more common therapeutic emphasis on self-insight. If possible, I work with a couple or family to help each member deal with the stresses associated with TD and to maintain or develop the quality of their love relationship.

I have been able to help some individuals find new internal strengths, revitalizing old aspirations or ideals, and building loving relationships. I have seen people live surprisingly satisfying lives as they learn to focus their minds on more productive ways of thinking, feeling and acting, in a manner I describe in my book *Guilt, Shame and Anxiety: Understanding and Overcoming Negative Emotions*. However, in making these observations, I want to emphasize that my success depends more on my patient than on my therapy. Also, a substantial number of people do improve over time as a natural course of the disorder, and I encourage hope for this eventuality, while improving one's overall health and emotional outlook.

Meanwhile, I am trying my best to stop my colleagues from prescribing these toxic chemicals and I urge people to avoid starting on them. If an individual is taking them, when at all possible it is best to carefully taper off them with as much personal and professional support as possible as I describe in my book, *Psychiatric Drug Withdrawal*.

TRANSCRIPT:
RECORDED APPOINTMENT WITH DR. JACQUELINE MARTIN – FEBRUARY 9, 2017

Recorded Segment of

Appointment with Dr. Jacqueline Martin

February 9th, 2017

Persons Present:

Mrs. Roxanne Stewart Johnson (Patient)

Mr. Arturo Stewart (Patient's father)

Dr. Jacqueline Martin (Psychiatrist)

Dr. Martin: The nurse comes with the medicine and Roxanne says "I not tekin' it" Wha- what the nurse can do. What can the nurse do? If one night Roxanne says "Yuh giving me too much medicine! Yuh going to kill my baby! Yuh going to kill me off!" Wha- what can the nurse do... At Medical (Associates). She won't be able to manage Roxanne's like that. To calm her down. She won't get her to take the medicine. You understand my point? Roxanne?

Mr. Stewart: Roxanne?

Roxanne: Yeah, I understand

Dr. Martin: I see you nodding.

Roxanne: I understand.

Mr. Stewart: The question I would ask though Roxanne ... Is simply this, ahmm... What assurance is... that you're willing to give... us... that... this um... The question of admission as suggested by the doctor... Martin. At home... is one which would that would not lead to...

Dr. Martin: More frakkaa. (laughs)

Mr. Stewart: Yes. Frakkaa. Because... The home... the the the thing is this. Where we live, Roxanne was born there. Marcia was pregnant with Roxanne there. She was actually born in... Nuttal hospital. But that's - so she came, as a babe. And so and so... where Benjamin has come.

Dr. Martin: Mmhmm.

Mr. Stewart: And Darryl was there from he was 9 months old.

Dr. Martin: Mmhmm.

Mr. Stewart: So if they have lived there over the years, and I've been a freemason for... over 20 years.

Dr. Martin: Oh so you mean that if she comes there she's going to say...

Mr. Stewart: (I'm not a new freemason)

Dr. Martin: All of these things... so you understand

Roxanne: Oh he's saying that I might experience more psychosis... At the house? Is that what you're saying?

Dr. Martin: Well the bottom line is, she's going to be more medicated. So some of what... is affecting her now is not going to happen.

Mr. Stewart: The thing is this though that at home, right? She has the... the privilege of having Benjamin sleeping beside her... Alright, so you prefer if we do it at home.

Mr. Stewart: Yes! Yes.

Dr. Martin: Than in the hospital. Ok, than ANY hospital?

Mr. Stewart: I wouldn't want to suspend...

Dr. Martin: Than ANY hospital? Pre- prefer home to ANY hospital?

Mr. Stewart: Yes, I wouldn't want to subject her to ward 21. And I understand where she is, as far as that is concerned.

Dr. Martin: Mmhmm...

Mr. Stewart: We went pretty close to that once.

(**Dr. Martin:** Okay.)

But...

Dr. Martin: So would you put her at Medical (Associates)?

Mr. Stewart: Fortunately there was no space.

Dr. Martin: Or would you prefer your house? As a first trial?

Mr. Stewart: As a first trial I prefer my house.

Dr. Martin: Ok. So we'll do that.

Mr. Stewart: I pref- Because if, if she stays at my house, she has... she has the- well... presumably we wouldn't ban her from moving around the house.

Dr. Martin: No no no... She would be fine.

Mr. Stewart: She can go and eat out of the fridge. She can sit down and watch television.

Dr. Martin: Part of it is that she is going to be sedated.

Mr. Stewart: And Benjamin

Dr. Martin: Right?

Mr. Stewart: Benjamin...

Dr. Martin: She's going to be sleepy.

Mr. Stewart: Benjamin will be able to see her... So Benjamin wouldn't have to be paying special- In fact we can't take babies into hospitals.

Dr. Martin: She will be very sleepy. So... Are you willing to do that? Are you going to sign that you're willing to do that for me? On this piece of paper?

Roxanne: Ah... Ok, what happens if I don't sign?

Mr. Stewart: No but you're an adult and you're in a contractual situation.

Dr. Martin: No. So basically what we're going to... what you're going to sign for me is many things. You're going to sign to say... I am going to-

Mr. Stewart: I'm just going to be using the bathroom.

Dr. Martin: That's fine. You're going to sign to say... that Dr. Martin has suggested hospitalization. I do not want that, but I am willing to undergo ahmm, these conditions at home. That's one, that's all. And two: that I am willing to take the medication with the full knowledge of whatever... ahm... issues may arise with the baby. Meaning you're fully informed. I've told you that as you get- Well what you're taking now could be a problem, just at this dose much less I increase it. That uhm... I can cause harm to the baby. That you are fully aware of that, and you are still willing to take the increased dose of medication.

Roxanne: Well my question is I'm hesitant to sign something. What if I do not sign? What are the consequences?

Dr. Martin: You mean either thing? That you're willing to take the medication.

Roxanne: But I don't like the idea of signing my signature

Dr. Martin: We, we have to part company, because I will have to protect myself at some point. Because if something happens, then I'm gonna hear why didn't you forcibly put her in hospital? Maybe that was never given to her as an option. I don't have anybody to say "But you know we did have that discussion." If the baby is born and something is wrong. And then somebody says "But did she know? That ahm... this could happen? That these were possibilities? Were you sure she knew? Did you offer her that, you know, she could terminate?" And then it would be an issue, so all those things are very real questions that will come back. If, IF everything goes well nobody has (unintelligible)

Roxanne: Ok.

Dr. Martin: Your dad is a lawyer

Roxanne: Right.

Dr. Martin: He knows clearly where I'm coming from.

Roxanne: Personally I'm not comfortable signing something right now. I'd like to speak with Mrs. Rizden-Foster first.

Dr. Martin: Not a problem.

Roxanne: Ok.

Dr. Martin: Not a problem. So when daddy comes back we'll (unintelligible)

(Mr. Stewart re-enters the room)

Mr. Stewart: What- what I'd like to ask you Roxanne, there are couple questions I'd like to ask you.

Dr. Martin: Let me just tell you what transpired when... (unintelligible) Ahm... I told Roxanne that she would have to sign two things for me. One that hospitalization was offered to her, at ward 21. And that she refused that, but she was willing she is willing to undergo hospitalization conditions and medication at home. That was one. And that two: That she'd be signing to say that she's aware that we'd we'd be increasing medication. Granted, the dose that she's on now can do harm. But she's aware that with any further increase, that there is the possibility that something may happen to the baby. And that she was fully informed of that. As I said to her, you're very clear where I'm going? Roxanne is willing to do the admission at home and she's willing to take more medication. But she's not willing to sign. So her question to me is, if she doesn't sign then what will happen? And I said to her, well if you don't sign we part company. Because I'm not going to write a prescription without it documented that she had full information and you're aware of what you're signing. And it goes a step further. Even if Roxanne came in here by herself I would still tell her to bring somebody else. Because then the argument may come up that Roxanne was not in her right mind when I gave her this document to sign. So I have committed an injustice. Right? So that's the document that both of you would have to sign. Roxanne says she needs to talk to ahm... Suzann right? Rizden-Foster before she signs anything. I don't have a problem with that.

Under the law if Roxanne is a threat to herself or anybody else. She can be involuntarily admitted. Clearly that can't come from me because somebody else would have to sign. The suggestion can come from me. But the consent would have to come from you or her mother. And in fact to be...

Mr. Stewart: But we're not next of kin.

Dr. Martin: You see, you hear where I'm going? And in fact, to be totally frank, it would actually have to come from her husband. I mean the law would allow for a lot of things. He's not physically here and if it had to be done right now... In fact it could be done at the hospital under the "Section." Under Section 6 of the Mental Health Act. But Roxanne cannot remain in this state. Right? This isn't going to get better. This is going to get worse. Apart of what is happening is what we expect because she has bi-polar disorder and she's pregnant. And pregnancy flares bi-polar disorder.

Mr. Stewart: But why is it it didn't happen when she was pregnant the first time?

Dr. Martin: Because she didn't have as much stressers.

Mr. Stewart: Oh she didn't have as much stressers.

Roxanne: I wasn't working at the time.

Mr. Stewart: Oh yes.

Dr. Martin: She didn't have as much stressers. She didn't have as much stressers. So I believe she probably did go a bit high or she did go a little low. But it was manageable. Now there is just, she's just

starting out with too many stressers. And the thing is... she may be quite fine, ahm... once she gets some medication. We may be able to look at- and she stabilizes, we may be able to lower it, throughout the pregnancy.

Mr. Stewart: Well that is what I was- a question I was looking to ask.

Dr. Martin: BUT, there's the issue though. We lowering it throughout the pregnancy doesn't make me feel better. 'Cause where it really needs to be lowered is now. Because this is the baby making time. This is- And these are all the things that she has to be informed about. This is when the baby is being made. The first trimester is the most crucial part. Second trimester... we worry but we still have a little more lee-way. By third trimester everything is made already. We're good. We could dose you up. But this is the issue, and this is

Mr. Stewart: Like... When we said the exercise? What she said, there's exercise.

Dr. Martin: No. Not at this stage.

Mr. Stewart: She has a... She tells me she has -She tells me she has an appointment with a psychol-

Dr. Martin: No. No.

Roxanne: Yeah, Doctor Karen Richards.

Dr. Martin: But that's a marriage business that Roxanne is going there for-

Roxanne: Uh, no.

Dr. Martin: It's for everything?

Roxanne: It's for- Yeah, because she's counselled me before.

Dr. Martin: But NO. Because Roxanne has baby hormones on board. They are fuelling this. So no amount of talking alone is going to-

Mr. Stewart: But diet. What about dieting? Dieting.

Dr. Martin: I believe that Roxanne would have been-

Mr. Stewart: Eating more fruit and vegetables?

Dr. Martin: If Roxanne, wasn't having marital difficulties, I believe a lot of this would- Because I don't think even if she gets a job now I still think we're gonna have problems because the marital issue is always bigger than anything else. (unintelligible) So if that fixed suddenly I believe, you would still see some hypo-mania but we could live with it. ... So I have- She's an adult. She... Bipolar Disorder doesn't take away your rights. So I cannot- Only psychosis and dementia does. So I can't ahm... Unless she was a threat. And she's not uhm... She's not suicidal. She not a threat to herself. She seems to be taking care of Benjamin, and I guess when she figures she can't she drops him off (by you). So I do not have a reason to forcibly admit Roxanne. She has to be a voluntary process. And she's asking to go and talk to somebody before she signs. Personally I think she's wasting time. But, it has to be allowed. So I think that's where we're going to have to (unintelligible). I personally am not going to increase the medication... without some kind of-

Mr. Stewart: But when you say increase...

Dr. Martin: She's taking 400ml now.

Dr. Martin: I think Roxanne needs...

Mr. Stewart: Tonight I think is the last-

Roxanne: So you won't give me any more doses? You won't give me any more Quetiapine?

Dr. Martin: I will write- I will write the prescription that you came here on.

Roxanne: Oh, Ok. Alright.

Dr. Martin: Because I didn't initiate that. So I have no I have no problem re-writing that. But I think she needs... 600ml of Seroquel (Quetiapine). I think she needs 300 in the morning and 300 at night. And plus a mood stabilizer added to the mix. ...And I can't- I don't have a drug that is baby safe.

Dr. Martin: Not a one.

Mr. Stewart: Another question is, if, if she reduces the level of activity that she has at the moment... And this is just... In other words she's busy doing this research to...

Dr. Martin: NO! Roxanne is having this level of activity because she's bipolar.

Mr. Stewart: Ok.

Dr. Martin: That's why she's… That's why she's *having* this level of activity. That's why she has made her little I.D. thing. Because she's hypo-manic. That's why she's so religious now. Not that she's Christian, and Seventh Day, but that's why... its... magnified. Its, its the word we use: "Religiosity". She's religious. It's more than you would expect normally.

Mr. Stewart: Well Roxanne how you feel about...

Roxanne: Well... I would like her to write the prescription though for the Seroquel so I don't run out.

Dr. Martin: So I'm prepared to write the prescription for the 400. I uh... But I know that's not enough. That's what you're on now. And you also need admission.

Mr. Stewart: Well the- the admission to the home...

Dr. Martin: But she's not agreeing to sign for that.

Roxanne: I said I wanted to talk to someone first.

Dr. Martin: No- I know- That's what I said... I'm not quarrelling. I'm not... I want you to be very comfortable with what you do so that at the end of the day I can say "But Roxanne this was a JOINT decision." Right? I don't think you're at the point where I have to force it on you. And I explained why. So, I want us all to be clear. Because when you are medicated and you're back to balance, some of the same things that I'm proposing now, you'll ask me "Why didn't you do these things? Why didn't you offer me this? Why didn't you offer me that? Why didn't you explain this to me?"

Mr. Stewart: Well the explanation is good, because as I said, one of the turn-offs that we experienced Uhm... is when there's no explanation because, as you know, as you would observe ... very very intelligent. Very articulate, in fact, when we were sitting round there your, your ahm... your receptionist-

Dr. Martin: The one who is upset with me and you now? (Laughs)

Mr. Stewart: She said, she commended Roxanne on an argument- not an argument. A discussion... a debate we were having. She said "You put your points extremely well." Right? And there am I struggling to match her in terms of the argument.

Dr. Martin: And therefore when Roxanne is WELL, and balanced, and she looks back at how I conducted myself, she will flee, if it is that I have not done the right thing. I'm very clear. So let her go and talk to Suzanne. But bear in mind that... you're not only making a decision for one Roxanne. You're making a decision for two. Right? Baby doesn't have anybody else to stand up. So... you've decided you're not going to terminate, and that's fine. That's your choice. But you also have to do the best that you can do for both of you. Having decided that. So you have to get well. Right? But the baby also has to be protected. And a big part of that is... doing the screen to make sure the baby's ok and getting yourself an obstetrician.

Roxanne: Ok. But, alright, its kind of late, and this has been kinda going on.

Dr. Martin: Yeah, we're, we're finished.

Roxanne: The prescription though.

Dr. Martin: I'm going to write-No I promised you I'd write the prescription for whatever Dr. Wright wrote. 'Cuz that's Dr. Wright's prescription not mine. Right?

Mr. Stewart: You have Suzanne's number?

Roxanne: Yeah I do.

Mr. Stewart: You're able to get her on the phone.

Roxanne: Yeah.

Mr. Stewart: Well, because she left, she left work at 1 O clock today. So if you're going to see her you have to go to her home.

TRANSCRIPT:
RECORDED APPOINTMENT WITH DR. NYAMAKEYE RICHARDS – FEBRUARY 23, 2017

Appointment with

Dr. Nyamekye Richards

February 23, 2017

Persons Present:

Roxanne Stewart-Johnson

(Patient)

Dr. Richards: I see you brought the consent form?

Roxanne: Yes.

Dr. Richards: Are you through with it?

Roxanne: Yes.

Dr. Richards: Ok. Alright. Great, I'll ask her to witness for me.

Roxanne: Ok

Dr. Richards: Alright Roxanne, thanks for coming. You know, to see me today. Ummm... Dr. Earl Wright, he did speak with me about... a little about your history.

Roxanne: Ok.

Dr Richards: And I'm understanding from you that you are pregnant. Congratulations.

Roxanne: Thank you.

Dr. Richards: And that you um, would like maybe a... a holistic approach was it?

Roxanne: Yes.

Dr. Richards: To... is it that you don't think you were getting a holistic approach before?

Roxanne: Yeah, no. Definitely not.

Dr. Richards: What was the difficulty?

Roxanne: Well... I had two unpleasant experiences: One - Dr. Wright, when I went to him, I was under a lot of stress. Me and my husband are actually now separated. We just got married December 18. But he started becoming abusive or showing signs that he was going down that direction. It wasn't a safe situation, so he... well as I know it now, he's in St. Elizabeth. We were going to counselling for that and also I had to resign from my job because it was just too stressful.

Dr. Richards: What Job is that?

Roxanne: I was a graphic artist at Sportsmax Limited. On Chambers Avenue.

Dr. Richards: Yes. That's off Molynes road?

Roxanne: Yeah. And um.. so between that and being pregnant and having my son... right, and when I went to Dr. Wright, and obviously I was stressed, but its like he wasn't even willing to listen, he's like "I want to move you up from 200ml to 900ml Roxanne."

Dr. Richards: Of the Quetiapine?

Roxanne: Quetiapine, right. And I was like, but he's not even interested in getting me talk therapy. That's dangerous to just... thing and I'm pregnant like that. So anyway, then I was recommended by Saphire Longmore, who's a friend of mine. She recommended me go to Dr. Jacqueline Martin. Because she said she would put the pregnancy as a top priority. The first meeting I went to Dr. Martin...

Dr. Richards: When?

Roxanne: That must have been... alright the second meeting was the 9th of February. The first meeting was like... I don't remember the exact date.

Dr. Richards: Ok So you had at least 2 meetings.

Roxanne: I only had 2 meetings. The first meeting, she was trying to convince me to terminate the pregnancy. Yes! And then she... she said "Oh but the baby maybe has so much things wrong with it, it might not even live" and I said "Dr. Martin, let God do his will then, but I'm not going to terminate my baby." And I told her for religious purposes I don't believe in that and whatever. Then the next time she saw me, now this was the 9th of February, that was a Thursday night she said, "Because you use cus words I can tell that you're high." And she wanted to send me to ward 21 that night. She was saying "because you use cus words I can tell" and because you kicked off with your mother 2 weeks ago. That means that you need to be sent to Ward 21. She spent a good half an hour to 45 minutes, trying to convince my father to send me to ward 21 that evening. She said she wanted me on Diazapam, more Quetiapine, Lamectal and Olanzapine, Zyprexa or something like that.

Dr. Richards: And of course you would not...

Roxanne: Of course not, so after that my parents wrote this statement just in case she try anything because she was so insistent to my father to say "No! She needs to go. No! She needs to go. No! She needs to come to ward 21. She needs to come to Ward 21."

Roxanne: So after that, that was a harrowing experience. I'm pregnant and she wants me to be involuntarily hospitalized. And injected with all this list of stuff. So my dad understood why I was shocked and...

Dr. Richards: Were there any adjustments made to your medication?

Roxanne: No, she said, she agreed, because she was trying to get me to sign a document saying, ahmm... I know all the risks of these.. oh.. I know all the risks of these drugs.

Dr. Richards: Roxanne what I want to understand is that, I don't mean to cut you but do you think, based on your own history that right around this time, given all the stressors that you could be coming close to an episode at all?

Roxanne: No. I have been going down. Not up. I've been going down on my energy.

Dr. Richards: I can appreciate that.

Roxanne: Alright, cuz I'm tired, sleepy. Ahm, I'm not doing as much. You know, and stuff, and ahmm... you know.

Dr. Richards: and are you with your parents right now or are you still living...

Roxanne: No I still live in the townhouse with ahm, that me and my husband had gotten.

Dr. Richards: So you're not separated anymore?

Roxanne: Yes, we are, we are. Yeah.

Dr. Richards: (unintelligible)

Roxanne: But he... he doesn't live there.

Dr. Richards: Ok. The separation ahm... did it have anything to do with- and his behaviour, you know, this tendency towards being abusive, you know. Did that... How did that come about? You know, do you think?

Roxanne: I saw warning signs-

Dr. Richards: Your feelings, ahm your energy, could have contributed?

Roxanne: No I saw warning signs, because, the first time I was pregnant with our two year old son Benjamin, when I was pregnant with Benjamin, I saw a change in his personality. He started being very...

Dr. Richards: He's the father of the baby?

Roxanne: Yes. Mhmm, yes. And ahm, he started becoming easily jealous. I couldn't have any male friends. Right. He- One time had this male friend, Edwin Tulloch-Reid, this Cardiologist, and he said if- He's gonna go down to Edwin's office and punch him. It was... It was getting from bad to worse, and then even after I had the baby, I go over to my next door neighbour Mrs. Garrick, who also has bipolar disorder, so we became friends and that was a problem. "Why you over there?" Blah, blah, blah... And he just... started becoming emotionally distant. Like I couldn't ahm... I couldn't rely on him emotionally or go to him with my problems anymore.

Dr. Richards: And he had a problem with you speaking to other people?

Roxanne: And me speaking to other people. So he never wanted me to talk about the- cuz I had a bad birthing experience, bad birth experience, and I couldn't talk about it with him.

Dr. Richards: With Benjamin?

Roxanne: Yeah, with Benjamin. And I couldn't talk to him about it. But yet I talking to other friends to try and get support and that's a problem. Anyway, so later on, just these things, I can't have no male friends, then he wanted to move us from the church that we were at where everybody knows us, to this church where nobody knows us. So everybody's a complete stranger. He just wanted to kind of-

Dr. Richards: Isolate you.

Roxanne: Isolate everyb- right exactly from everybody. Right.

Dr. Richards: But you married him in December.

Roxanne: Yeah I married him because, well-

Dr. Richards: Things got a little better?

Roxanne: Not really, but I figure, I gone down this road already I have a- I have his son. And I'm pregnant, as a matter of fact the pregnancy happened before the wedding.

Dr. Richards: Right.

Roxanne: Right and stuff so, I said well, you're on a one track path, might as well you try stick this one out and see what, you know.

Dr. Richards: What happens.

Roxanne: But, its like... after we got married its like, almost like he felt like, well since your down on a contracted piece of paper, you can't go nowhere. So its like, whatever stuff he was hiding before, it just kind of came out. One time he was so aggressive when he was... like I was putting our wedding pictures on facebook and he just started saying he's gonna delete them. And whatever. And then I was trying to calm him down saying "Romain what's wrong, just relax." "Get OFF ME! GET OFF ME!" and it was really loud, really aggressive and I jumped out of bed. And ah... And after that he, on the Sunday, it was Christmas day, and he shoved Benjamin into the carpet. He was having an argument with me, but he was eating chicken wings at the same time, so Benjamin was following him around, and he just lost it and shoved him into the carpet.

Dr. Richards: Okay, Okay. So not to cut you again but you told me again on the phone that the Quetiapine dose that you're taking at this time, is it 200ml?

Roxanne: 400ml at night.

Dr. Richards: At night, ok. And normally, before this period, what medication would you normally be on.

Roxanne: I was on a lot of things. Ahm I was on

Dr. Richards: Most recently, what was, what were you on.

Roxanne: Right. Before I g- well before I knew I was pregnant, I was on Lexapro, I was on Concerta for my concentration, I was on 200ml of Quetiapine and I was on... Lexapro, Concerta, Quetiapine, and there's one more... There's one more one. Cuz it was four. Oh, Lithium.

Dr. Richards: What strength Lithium?

Roxanne: I can't remember.

Dr. Richards: Okay. And then on your own you decided to cut- just cut everything.

Roxanne: Well no, It wasn't really on my own, ahm, but my husband because he was fearful for the pregnancy he asked me to come off everything, because the first pregnancy I wasn't on anything, so I

came off everything and within the second night, no, within the second night, of coming off of everything, I started feeling psychosis like somethings watching me in the closet. Paranoid and things like that So I. Yeah, no I couldn't deal with that and then I called Dr. Wright and then said, ok, because, We discussed this with Dr. Wright you know. We didn't just up and take- we had an appointment, and my father and my husband both said, you know, lets try it this time round without anything. So he said fine, but that night that happened, I actually tried whatsapping and calling Dr. Wright to tell him that I can't manage without the medication. So while he was away, because he was on leave and I think he was out of the country, so Romain said, because he's a pharmacist, go back on 200ml of Quetiapine, it helped a little bit.

Dr. Richards: With Benjamin, or now?

Roxanne: Now. Go back on 200ml of the Quetiapine,

Dr. Richards: So that's 200 alone.

Roxanne: Yeah.

Dr. Richards: Okay.

Roxanne: And ahm...

Dr. Richards: That was when?

Roxanne: That was... early on, that was, shortly after we were married.

Dr. Richards: Christmas.

Roxanne: Right, around that time. And ahm... it helped a little bit, but I was still on edge and I was still frightened in the day. So he said try 400.

Dr. Richards: Right

Roxanne: And then I went to 400.

Dr. Richards: That’s where you are. Okay. Alright, Okay, so ahm... I just want you to understand that generally speaking, I'm very conservative with medication.

Roxanne: Oh great. That's a good thing.

Dr. Richards: However, when it comes to certain diagnoses, you have to be very, very careful about dosing. Right, and your diagnosis is definitely one of the ones that you have to be very careful, because the risk of relapse is very high and the disruption that comes with relapse is quite extensive and severe.

Roxanne: Right,

Dr. Richards: So when one is pregnant there is a special approach. Okay and it involves closer monitoring, matching the right medication, right to control symptoms at the right dose. Using medication that have been shown to be safest.

Roxanne: Right

Dr. Richards: in pregnancy. Its not absolute. But we've seen where they're safest in pregnancy. And fortunately, Quetiapine is one of them.

Roxanne: Quetiapine is unsafe during pregn-

Dr. Richards: Safest.

Roxanne: Oh safest, good thank God.

Dr. Richards: So you, with your husbands support made a very good decision so far. Okay? There are others that are just as safe. Okay, and so we will be looking at that. And the 400ml is not a safe dose in terms of control of symptoms.

Roxanne: Right.

Dr. Richards: So I can appreciate why my colleague Dr. Martin would have wanted to increase that medication.

Roxanne: Not a problem you know but sending me to ward 21, she did not just want me on an increase of... She wanted me on Olanzapine, she wanted me on diazapam, she wanted me on Lamectal, and then she wanted to increase this dose to 600ml, so that to me was not taking, that was not taking my pregnancy into consideration. How can I feel like that as a mother-

Dr. Richards: I can't comment on what was going on. I'm only hearing your version.

Roxanne: You can hear it from my father as well cuz he was in the, he was in the thing.

Dr. Richards: Now the other thing I wanted to say is that ahm... Part of the management would also involve you seeing a specialist. An OBGYN specialist.

Roxanne: Well no I actually have an OBGYN already.

Dr. Richards: Well what I'm actually talking about is just to hear me out... One who is specialized in maternal health.

Roxanne: Maternal health?

Dr. Richards: Maternal/Fetal health.

Roxanne: Okay.

Dr. Richards: So she has gone to do further studies in obstetrics and gynaecology as it relates to the medical management of the mother and the fetus.

Roxanne: Personally, I, I'm sorry, I'm sticking with my, my obstetrician who delivered Benjamin

Dr. Richards: Okay.

Roxanne: We have a very good bond.

Dr. Richards: She's not an obstetrician you know. Roxanne, she would just be a consultant that would assist me in your management.

Roxanne: Okay.

Dr. Richards: Its only, I'm just mentioning it to you. There's nothing being imposed. I'm just mentioning that we do have a specialist like this.

Roxanne: Okay.

Dr. Richards: She would not necessarily take over the management of the pregnancy. Just that part that deals with the fetal and maternal health as it relates to medication. And the medical aspect of it. So its a specialty of OBGYN. Focusing primarily on that.

Dr. Richards: So how far along are you in your pregnancy.

Roxanne: I am almost 13 weeks. Tomorrow, I'll be 13 weeks.

Dr. Richards: Congratulations.

Roxanne: Thank you. The baby is a little ahead, They had a ultrasound yesterday and she's... I was 12 weeks 5 days yesterday but the ultra- sound said 13 weeks 1 day. So its a little bit bigger but Benjamin was also a big baby.

Dr. Richards: And was the delivery of Benjamin a natural, vaginal, or c-section?

Roxanne: No it was c-section, and it looks like I'm gonna have a c-section for this one because apparently my ah... placenta is covering the cervix.

Dr. Richards: Is that right?

Roxanne: Yeah, yeah.

Dr. Richards: They say it might move you know so there's some hope.

Roxanne: Oh! Good, good.

Dr. Richards: They say it might move so you can

Dr. Richards: keep watching that. Okay, ahm.. cuz its still early. Alright? Okay, now the other thing I wanted to mention to you is that my personal opinion is that, the doctor, the psychiatrist who has been managing you for the longest time, especially the period leading up to the pregnancy really is most suitable to manage you now.

Roxanne: Okay, ahm you mean I should go back to Dr. Wright?

Dr. Richards: No I'm not telling you you should go back, I'm just telling you my opinion. That in my opinion, the person who's been dealing with you longest in most recent times-

Roxanne: But I've not been satisfied with his care.

Dr. Richards: I understand but I'm just telling you because of the history, its always best that they be involved.

Roxanne: But I don't get a chance to choose my doctor?

Dr. Richards: No, I'm not imposing anything on you, you know Roxanne, I'm not sure if your hearing me. I'm just telling you my opinion.

Roxanne: Okay.

Dr. Richards: But clearly, you have had a difficulty. Okay? But I'm just telling you that in my opinion it is best for the person that knows you better.

Roxanne: But he cares nothing about this pregnancy. He was going to move it from 200ml to 900 ml. He clearly does not have this pregnancy as a top priority.

Dr. Richards: And as it relates to that, when it comes to medication management right? Of your condition when your pregnant, we have to look at the risk and the benefit to both the mother and the fetus. We cannot isolate the two.

Roxanne: Right.

Dr. Richards: We have to look at what is the best management for the mother to protect her.

Roxanne: Can I say something? Can I say something? Dr. Wright, I think did not properly examine the situation, before he just made that statement. First of all he did not even think about "well Roxanne is going through a hard time because of things between herself and her husband. Why not do psychotherapy before this? And then maybe instead of increasing" He did not, he did not take into consideration the pregnancy. He did not take into consideration that I need psychotherapy. He did not take into consideration that me and my mother are not close anymore and its always problems with her. Me and my father are close but me and my mother are not. Ah.. he's not taking into consideration that. Now if you want to tell me that somebody can analyse efficiently and accurately the circumstance and make a judgement call based on that, then I would say Dr. Wright, but he was not even wanting to hear.

Dr. Richards: I see what you're saying. But I'm just saying that aside, its best, you know? That doesn't mean you would do it based on how your feeling. But you understand why I'm saying this.

Roxanne: For example, let me give you an example, I was hospitalized. I went-

Dr. Richards: Recently?

Roxanne: Ah... it was in 2015. I walked myself to medical associates because I was experiencing psychosis. I was sitting there. Eventually, they hospitalized me, they gave me Haldol. I was lucid, they were interviewing me. "What day is it? What's your name? Who is da-da-da-da.." whatever. Dr. Frank Knight, the psychiatrist, decided to inject me with Modecate. Right? 4 weeks worth of Modecate. When I woke up, I woke up with a speech impediment, my dad was scared, people were asking what is wrong? And then, you know I read up on Modecate, doctor, and Modecate is not to be given to patients who are under sedation. And as I understand it, you inject people with Modecate at that dosage who are not compliant. And I am compliant. I need my medication. I take my medication.

Dr. Richards: You walked yourself to the hospital.

Roxanne: I walked myself to the hospital. I took Romain with me, my husb- my boyfriend at the time. Cuz I was like, I can't manage this. So this man went and injected me, my face muscles slackened, my eye prescription, all the things. I had the speech impediment, I was somnolent. I couldn't manage the

baby, that was 3 months after I gave birth. So, you know what you can say "Oh, the psychiatrist who does this is best." No the psychiatrist who practices properly is best.

Dr. Richards: I agree. I agree.

Roxanne: Because that was nonsensical. And then when I went to medical associates recently to ask for my for my documents and to ask about Dr. Frank Knight, nobody wanted to tell me anything.

Dr. Richards: Recently.

Roxanne: Right, that was recently. They didn't want to tell me where he was. The didn't want to give me a phone number. Dr. Milton Hardie, my obstetrician is actually in the process of looking for him. And as a matter of fact Dr. Knight had kicked off with my mother in the hospital and as a matter of fact they went to the same church and when he found out that she was peoples warden or whatever he left the church because he was embarrassed about the kick off he had with my mother in the hospital. In medical associates downstairs one evening. So I'm not about, which psychiatrist is da-da-da. I want to know the psychiatrist who is in charge is taking care of me, taking care of what's on top of my heart, which is being a mother to my son, which is carrying this baby, which I wanted, which was planned. You know? I asked my husband, I said I'm ready for the next one. He gave me a little app on my thing to chart my ovulation, and we went for it and we're pregnant thank God. So who is taking what's on my heart into consideration.

Dr. Richards: I understand what you're saying. I was just making the point about, the person who, cuz now... when you come to someone they're getting to know you. You know and that is a long process, you know? And ahm... because its such a critical time you need someone who is with it. And I'm not with it.

Roxanne: No, you could be with it. Dr. Wright not with it.

Dr. Richards: It takes some time to get to that point where you have a very full command...

Roxanne: Dr. Wright doesn't even know my childhood background.

Dr. Richards: Let me just finish. When you have a good command of the patients history and you say, what's on your heart and what matters to you most etcetera. But the focus is the pregnancy. And ahm... you know, I will definitely be open to being apart of that management.

Roxanne: But you want to work in tandem with Dr. Wright?

Dr. Richards: No no, I mean of course we've already started speaking.

Roxanne: Sure.

Dr. Richards: You know and I certainly will continue to speak with him. You know, once your okay with that and he's available, which he has been, you know? Ahm but I do want to take a team approach.

Roxanne: Okay, but why do I need two psychiatrists?

Dr. Richards: No you don't. You don't need two psychiatrists.

Roxanne: It just seems like you want a team approach.

Dr. Richards: No no, a team approach just means you take a holistic approach which is why you came to me.

Roxanne: Right, right.

Dr. Richards: When I talk about a team, I'm talking about myself, a psychotherapist.

Roxanne: Right good.

Dr. Richards: Your parents.

Roxanne: Right good.

Dr. Richards: Your OBGYN. If you're someone who is spiritually...

Roxanne: I have a midwife by the way.

Dr. Richards: All of that, the team.

Roxanne: Oh, you'd know her.

Dr. Richards: Yourself, your husband...

Roxanne: Tioma Allison.

Dr. Richards: Tioma.

Roxanne: She recommended you.

Dr. Richards: See that is what I mean by a team approach.

Roxanne: Okay, because you know what, as your saying, as it relates to making decisions on this pregnancy based on Dr. Wright's approach, I can tell you Jacqueline Martin did none of that. She was trying to send me to ward 21 that Thursday night, the 9th of February, and she never even said, well let me look at Dr. Earl Wright's records. He has a previous history, blah blah blah. She never made any such thing, what you're suggesting, to even go look at the records. She just said "by the way you're using cus words Roxanne, that means that you're not your normal self." I said, first of all I've been using cus words for, long before, while I was on medication. My dad doesn't like it, but my mothe uses cus' words. So she doesn't care. So I'll use cus' words in front of my mum. She uses cus words as well. But my dad, he's more of a Christian man and he doesn't like cus words.

Dr. Richards: Most people don't.

Roxanne: Right, exactly. And I keep it clean and as a matter of fact, I'll tell you I was so traumatized by that appointment, while she was sending me to- I haven't cussed a cus word yet. I haven't cussed a cus- If she going to use that to go send me to ward 21.

Dr. Richards: So I think we so far seem to be on the same page. So as I said, the team, myself, you, your husband if he's available.

Roxanne: He's not. And he's threatened to inject me with Fluphenazine before.

Dr. Richards: Which is Modecate.

Roxanne: Right. And he's been. He's been antagonistic. He's vowed revenge. His mother called me a slut on whatsapp. I have it on the whatsapp. I asked him about that and he said he's not coming into this marriage back until I feel every inch of hurt I caused his mother. So...

Dr. Richards: So there's a lot of tension.

Roxanne: I have already made the decision with my parents that I am not going back to Romain. That, that its over. Its over. And I will wait the two years before we file divorce but, everybody has come to the decision now and he also knows it.

Dr. Richards: (unintelligible) And a stressful one So I know this period is a stressful one. You know and we have to take that into consideration. Now you mentioned that... Right so I said, yourself, you know, myself ahm, your parents if they're available and you're comfortable. You mentioned your dad. You said things are a little tense with your mother.

Roxanne: Yeah, we're on two different things.

Dr. Richards: Does that mean that I can still speak with her?

Roxanne: I wouldn't be comfortable with you speaking with my mum. We're not close because alright, see how my dad got my mum to sign this letter. When I told my mum, are you going to testify to say that I don't need to go to ward 21 she didn't want to write the letter because I kicked off with her and I said some bad things because it was stressful. I was like "Oh you bitch, I hope you die!" blah blah blah. She never got over that, so as far as she's concerned she would not defend me if somebody said that- want to send me into ward 21. So I said, I don't really trust her. We don't have a good relationship.

Dr. Richards: That's been how long now?

Roxanne: That was since, alright, the week it happened, it happened the Thursday night, the 9th of February. By weekend ahm, during the weekend I asked her. Oh yeah, she came over on Saturday night or Sunday night. Saturday night she came over, I asked her about making the statement. She was like "I don't know" It was my dad that made her sign the statement. He made- wrote the thing. But she never wanted to sign it. So basically I can't trust her to go in league with my. And I believe that my husband just to spite me would call Ward 21 or something and say "She's crazy! she's crazy! call-" You know, and stuff so. I believe that, I cannot trust my husband and I cannot trust my mother.

Dr. Richards: One of the things I'm going to need to find out from you though is... cuz a lot of what I'm hearing Roxanne is sounding like there is a lot of tension. And I know that the situation is such that, you know, tensions will come up, if there's a conflict or disagreement. But it does- is reminiscent of what might happen when one is slipping into an episode.

Roxanne: Oh so your saying that I'm slipping into psychosis?

Dr. Richards: I'm saying it is possible and I have to consider that.

Roxanne: Okay.

Dr. Richards: Okay, that's one thing. Right? The other thing is that.

Roxanne: So wait, the tension is what is indicative of me slipping into an episode?

Dr. Richards: It's reminiscent.

Roxanne: What do you mean reminiscent? You mean that because my husband is threatening me, my mother is not in a good relationship- that means I'm psychotic?

Dr. Richards: No I never said that. What I'm saying is that with all these different tensions happening in such close proximity, it could be that... its suggesting that you could be in an episode.

Roxanne: Wait how is it suggesting that I'm in an episode by their behaviour? How is their behaviour towards me...?

Dr. Richards: Remember, you are reporting their issues. We're not really hearing their side.

Roxanne: Okay, so you're saying that since I'm in conflict so much, that must mean that I'm going into psychosis?

Dr. Richards: I'm saying its suggestive.

Roxanne: Well no, that's basically the same thing come on.

Dr. Richards: No, I'm just telling you.

Roxanne: Alright so you are suggesting that because I am in conflict with my husband and my mother, that it is possible that I am psychotic.

Dr. Richards: Correct.

Roxanne: Okay, just making sure I have that.

Dr. Richards: The other thing I'd like to say is that in order for us to have... a... partn- this this kind of doctor relationship- doctor - patient relationship is a partnership, okay? And its important that there's chemistry. Good chemistry okay? And its important that there's trust and respect.

Roxanne: Can I ask you something.

Dr. Richards: You're not allowing me to finish.

Roxanne: Well I don't know, I'm not comfortable with this. I'm not comfortable with this.

Dr. Richards: Okay, and that's fine.

Roxanne: So I'm not sure that I'll continue.

Dr. Richards: That is fine. That's why we're here to see if we can continue and that's actually what I was getting to that if there isn't that chemistry there isn't that respect and trust it takes a little time. You may find that you are not comfortable and that this is not going to work for you.

Roxanne: Okay.

Dr. Richards: And I can see that that is very possible. Okay, so I'm just putting that on the table so that you know that maybe this won't work. Okay? Maybe it won't work because you know I will need to talk

to family and from my understanding having spoken to Dr. Earl Wright, your mother is a critical part of that situation and you're now telling me that you would not be comfortable with that.

Roxanne: No.

Dr. Richards: And if you're not comfortable then I'm not comfortable. Alright, so it may just be that may just have to call it-

Roxanne: Well thanks so much. I appreciate the appointment and everything. So, I'm still looking for somebody who... Because my problem is, is that when somebody is assuming based on the fact that I'm having trouble with my mother. Based on the fact that I'm having trouble with my husband who is being abusive to me that I must be going off the deep end, I can't work with somebody that's assuming that first thing.

Dr. Richards: Your putting words into my mouth.

Roxanne: No but you're saying that it is suggestive that I am going into a psychotic-

Dr. Richards: I never assumed that. I said it is possible.

Roxanne: You said it was suggestive.

Dr. Richards: Yes and then I said it was possible

Roxanne: so you don't want to use the word suggestive anymore?

Dr. Richards: I'm not gonna argue, all I'm saying is that.

Roxanne: I just want somebody who is empathetic to my situation. It is difficult. I gave my husband, so much money, my all for 3 and a half years before we were married, and for him to be treating me the way that he's treating me is just terrible, but then on top of that to say that I am psychotic because he has treated me that way. Or the fact that me and my mum kick off. Yes my mum was a support, my mum was as support in my teenage years but we grew distant after I came back from college. She has been the one, still the caretaker more than my father has been but in each case my mother has not been emotionally supportive to me. She doesn't validate my feelings. I went through a bad birthing experience at Andrew's were the nurses were-

Dr. Richards: Not to cut you Roxanne, but as I said, I would need to speak with her. She's been apart of the story long enough for me to quite rightly-

Roxanne: Well I know she's going to give her own slant on things. Well I'm not. I'm not.

Dr. Richards: Whenever you are open to that feel free to make another appointment.

Roxanne: Well I don't think so. I don't think so

Dr. Richards: And that's fine. That's fine

Roxanne: But I appreciate it still. I appreciate-

Dr. Richards: In terms of other doctors that you may want to try cuz I know you've been looking around I can make a list of a few other females-

Roxanne: I don't really get on with females so much. I just want a person who is understanding and stuff.

Dr. Richards: Well we all try to be understanding. I do hear from my patients that I am.

WHATSAPP CONVERSATION WITH DR. MARK RICKETTS – MARCH 3, 2017

Whatsapp Conversation March 3, 2017
Between Roxanne Stewart-Johnson and Dr. Mark Rickets

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3.

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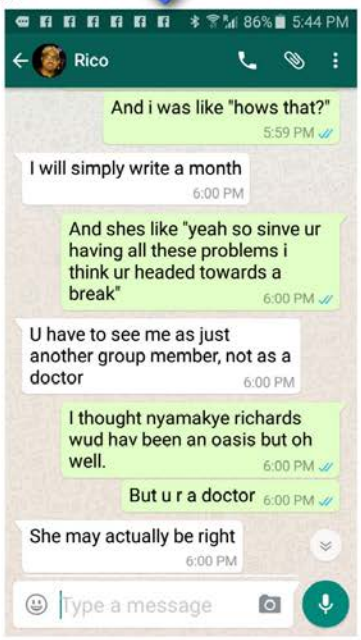

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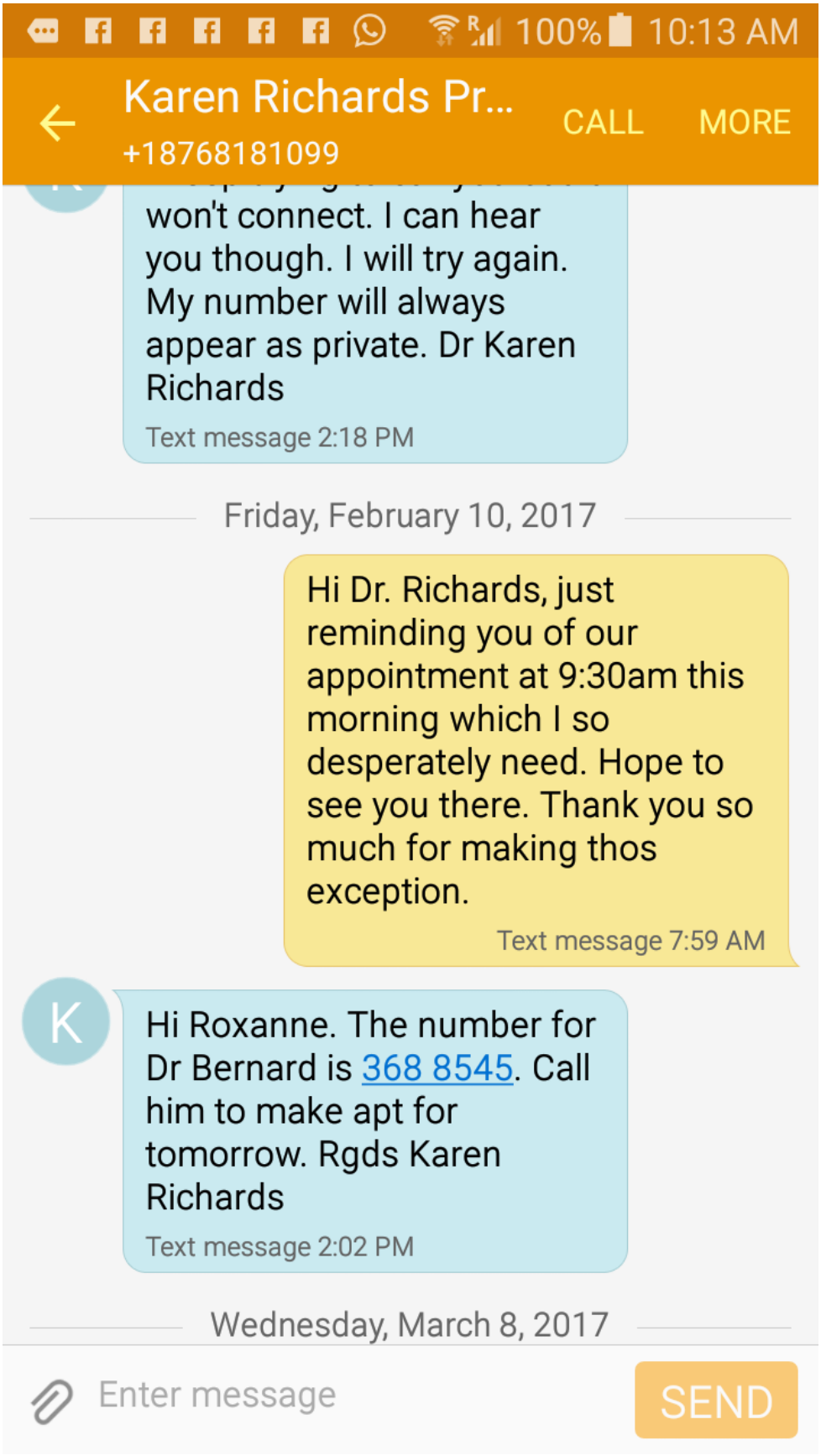
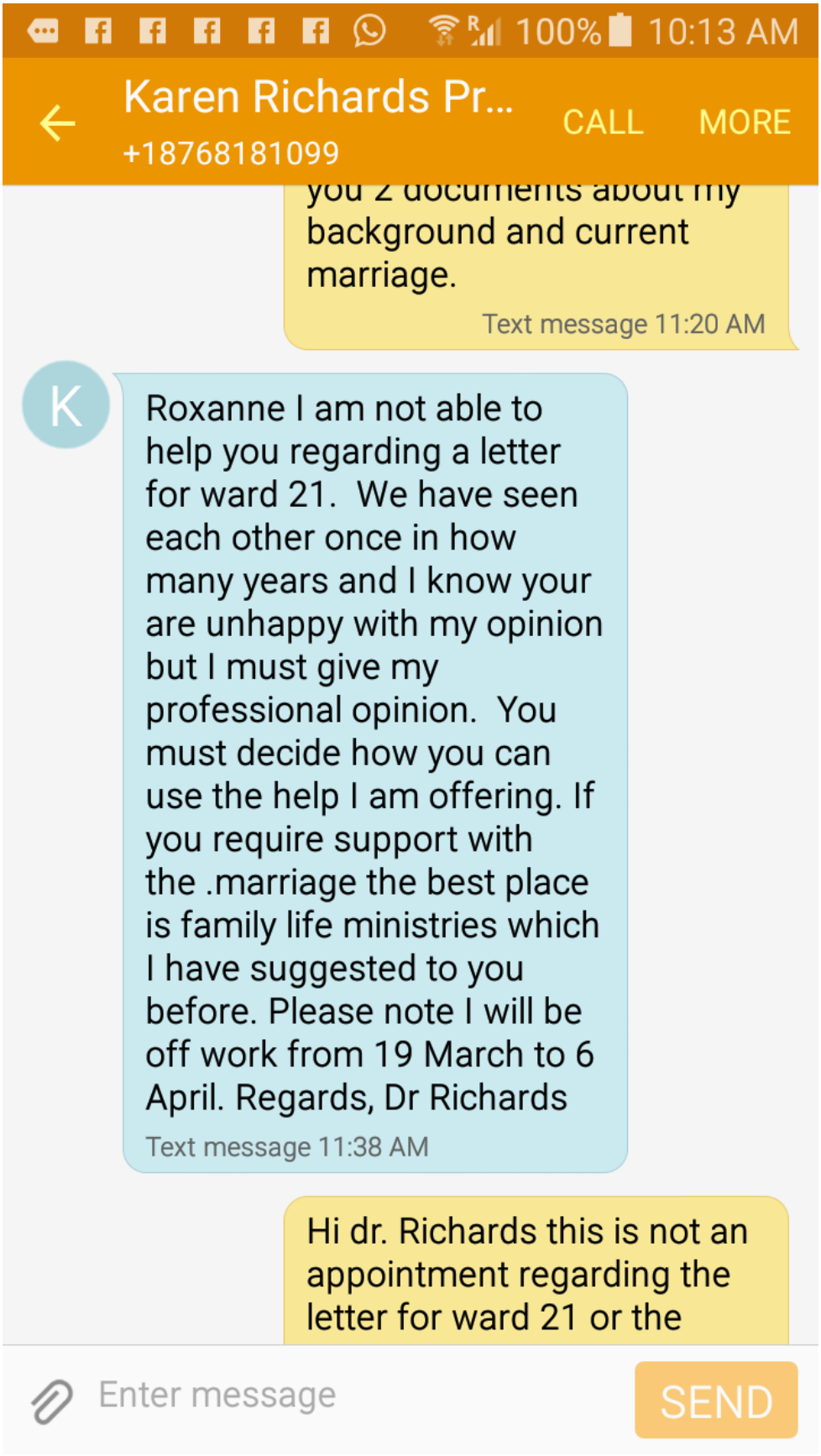
TEXT MESSAGES FROM PSYCHOLOGIST DR. KAREN RICHARDS


100% 10:13 AM
Karen Richards Pr...
+18768181099
CALL
MORE
won't connect. I can hear you though. I will try again. My number will always appear as private. Dr Karen Richards
Text message 2:18 PM
Friday, February 10, 2017
Hi Dr. Richards, just reminding you of our appointment at 9:30am this morning which I so desperately need. Hope to see you there. Thank you so much for making thos exception.
Text message 7:59 AM
K
Hi Roxanne. The number for Dr Bernard is 368 8545. Call him to make apt for tomorrow. Rgds Karen Richards
Text message 2:02 PM
Wednesday, March 8, 2017
Enter message
SEND


100% 10:13 AM
Karen Richards Pr...
+18768181099
CALL
MORE
you 2 documents about my background and current marriage.
Text message 11:20 AM
K
Roxanne I am not able to help you regarding a letter for ward 21. We have seen each other once in how many years and I know your are unhappy with my opinion but I must give my professional opinion. You must decide how you can use the help I am offering. If you require support with the .marriage the best place is family life ministries which I have suggested to you before. Please note I will be off work from 19 March to 6 April. Regards, Dr Richards
Text message 11:38 AM
Hi dr. Richards this is not an appointment regarding the letter for ward 21 or the
Enter message
SEND

WHATSAPP CONVERSATIONS BETWEEN ROXANNE STEWART AND ROMAIN JOHNSON (HUSBAND)

Whatsapp Conversation between Romain Johnson and Roxanne Stewart Johnson

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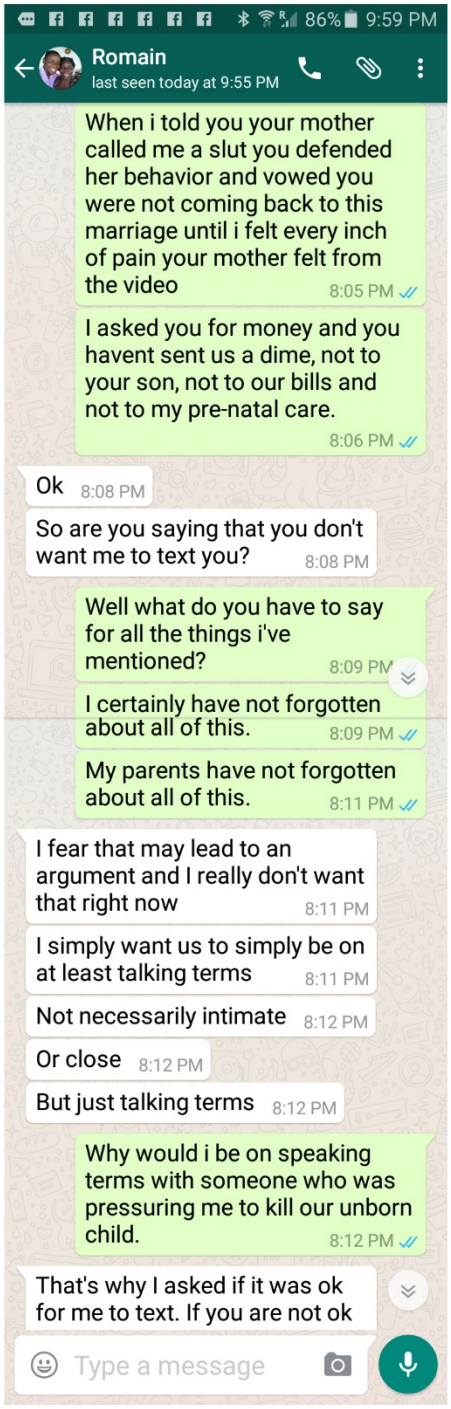

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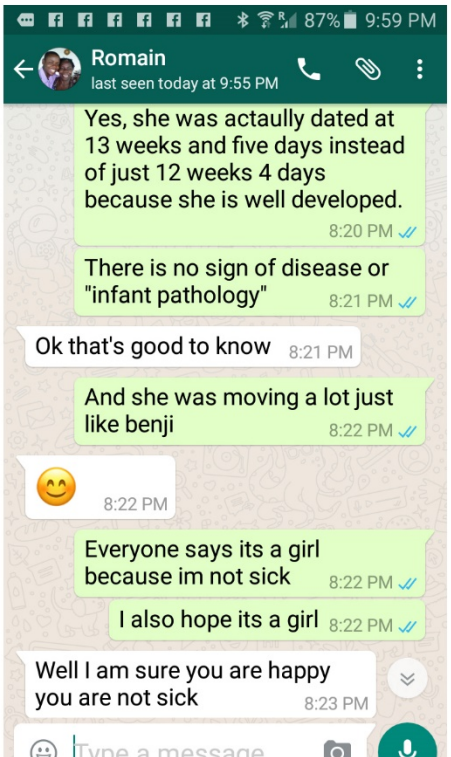

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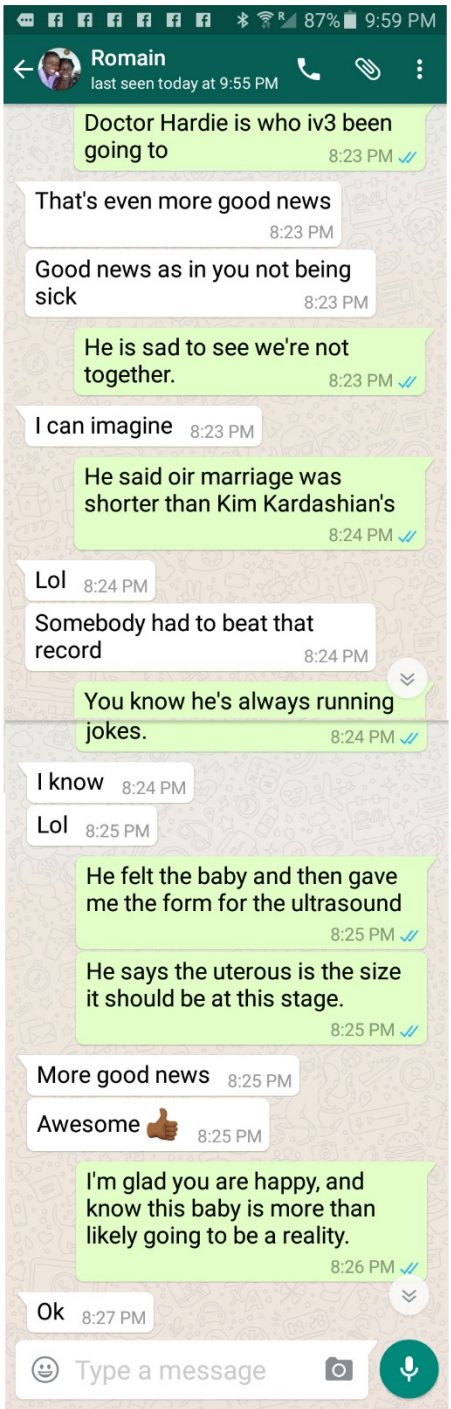
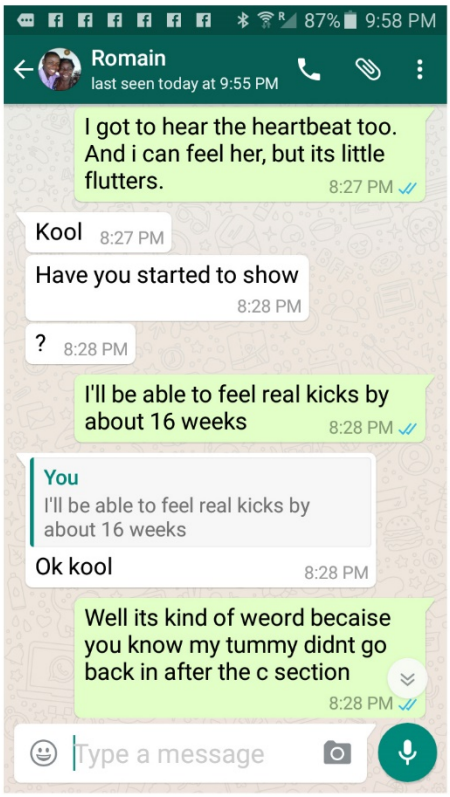

87% 9:59 PM
Romain
last seen today at 9:55 PM
Doctor Hardie is who iv3 been going to 8:23 PM
That's even more good news 8:23 PM
Good news as in you not being sick 8:23 PM
He is sad to see we're not together. 8:23 PM
I can imagine 8:23 PM
He said oir marriage was shorter than Kim Kardashian's 8:24 PM
Lol 8:24 PM
Somebody had to beat that record 8:24 PM
You know he's always running jokes. 8:24 PM
I know 8:24 PM
Lol 8:25 PM
He felt the baby and then gave me the form for the ultrasound 8:25 PM
He says the uterous is the size it should be at this stage. 8:25 PM
More good news 8:25 PM
Awesome 8:25 PM
I'm glad you are happy, and know this baby is more than likely going to be a reality. 8:26 PM
Ok 8:27 PM
Type a message

6


87% 9:58 PM
Romain
last seen today at 9:55 PM
I got to hear the heartbeat too. And i can feel her, but its little flutters. 8:27 PM
Kool 8:27 PM
Have you started to show 8:28 PM
? 8:28 PM
I'll be able to feel real kicks by about 16 weeks 8:28 PM
You
I'll be able to feel real kicks by about 16 weeks
Ok kool 8:28 PM
Well its kind of weord becaise you know my tummy didnt go back in after the c section 8:28 PM
Type a message

8


87% 9:58 PM
Romain
last seen today at 9:55 PM
We just took a selfie. 8:40 PM
8:42 PM
How was the moving of the stuff to your parents house? 8:43 PM
Sorry i was driving. I just reached auntie dales house. I'll call you after i put Benji in bed. He's already sleeping. 8:57 PM
Ok 9:02 PM
Are you still there? 9:38 PM
Yes I am 9:38 PM
Type a message

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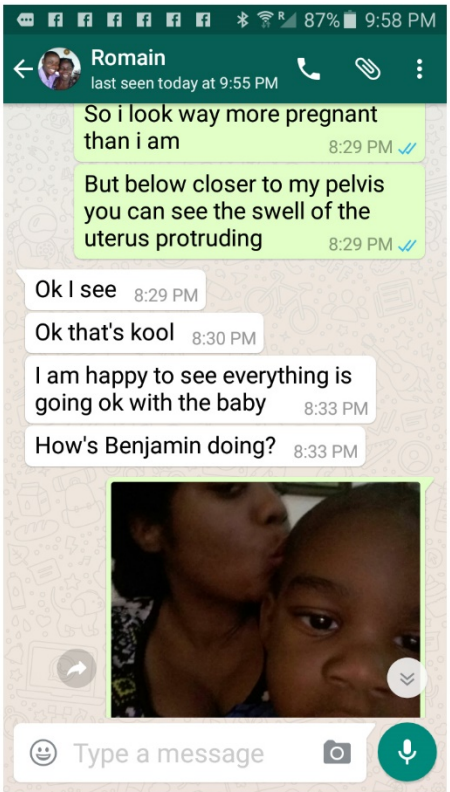
87% 9:58 PM
Romain
last seen today at 9:55 PM
So i look way more pregnant than i am 8:29 PM
But below closer to my pelvis you can see the swell of the uterus protruding 8:29 PM
Ok I see 8:29 PM
Ok that's kool 8:30 PM
I am happy to see everything is going ok with the baby 8:33 PM
How's Benjamin doing? 8:33 PM
Type a message

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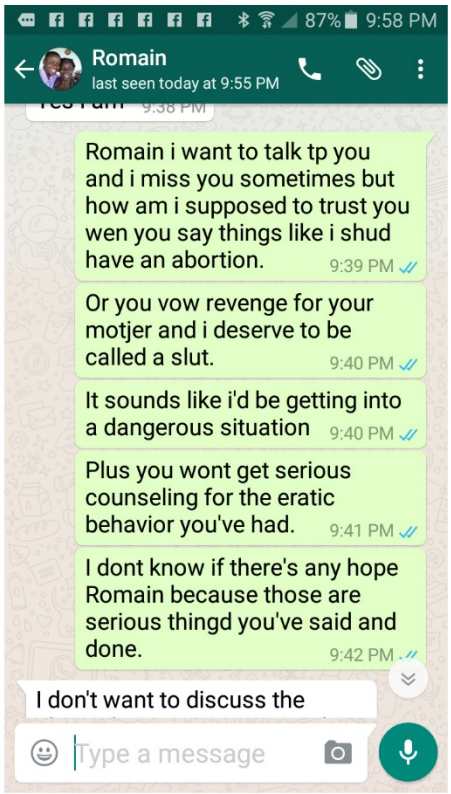
87% 9:58 PM
Romain
last seen today at 9:55 PM
Romain i want to talk tp you and i miss you sometimes but how am i supposed to trust you wen you say things like i shud have an abortion. 9:39 PM
Or you vow revenge for your motjer and i deserve to be called a slut. 9:40 PM
It sounds like i'd be getting into a dangerous situation 9:40 PM
Plus you wont get serious counseling for the eratic behavior you've had. 9:41 PM
I dont know if there's any hope Romain because those are serious thingd you've said and done. 9:42 PM
I don't want to discuss the
Type a message

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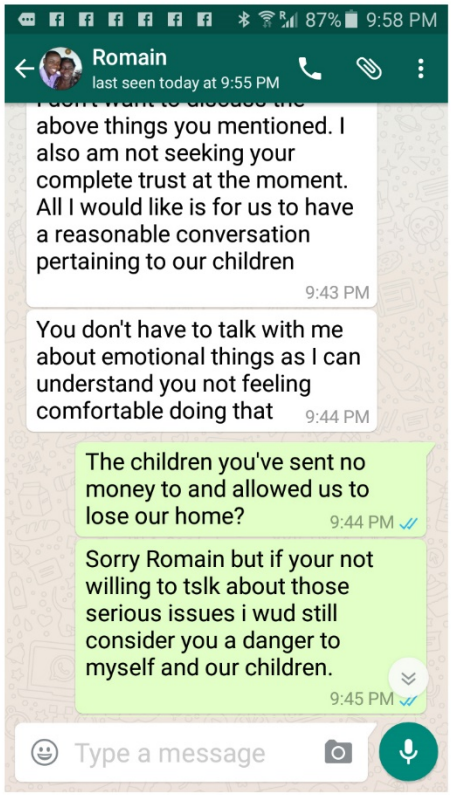

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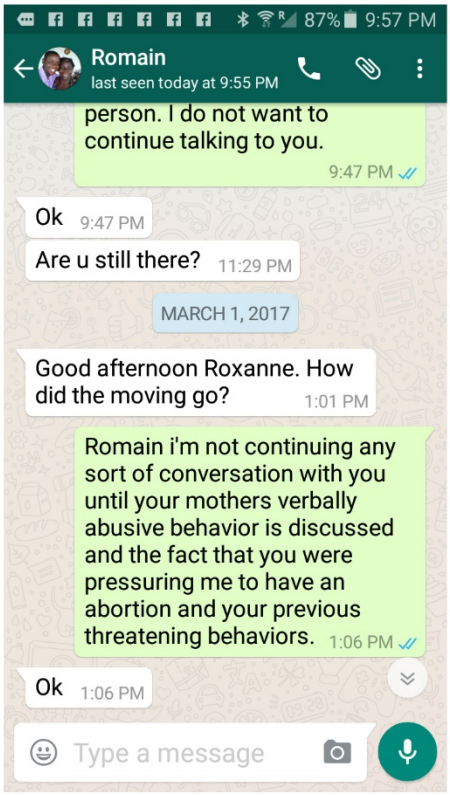

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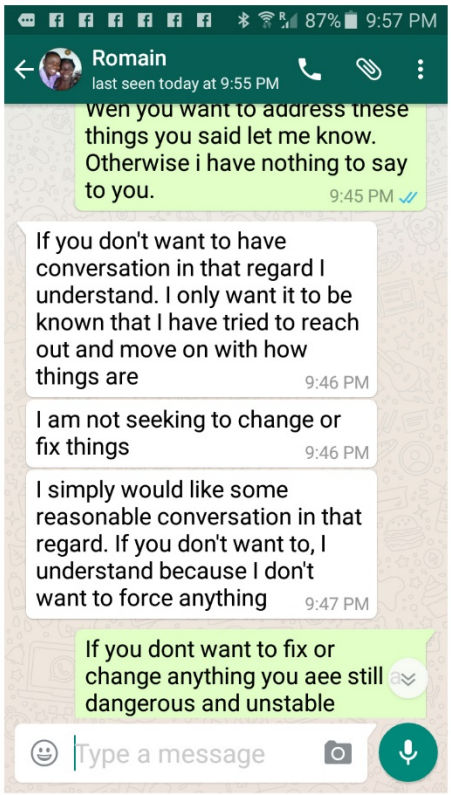

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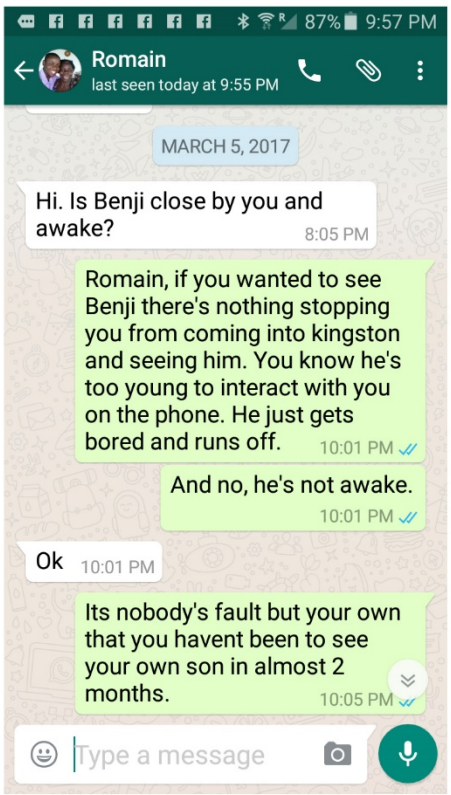

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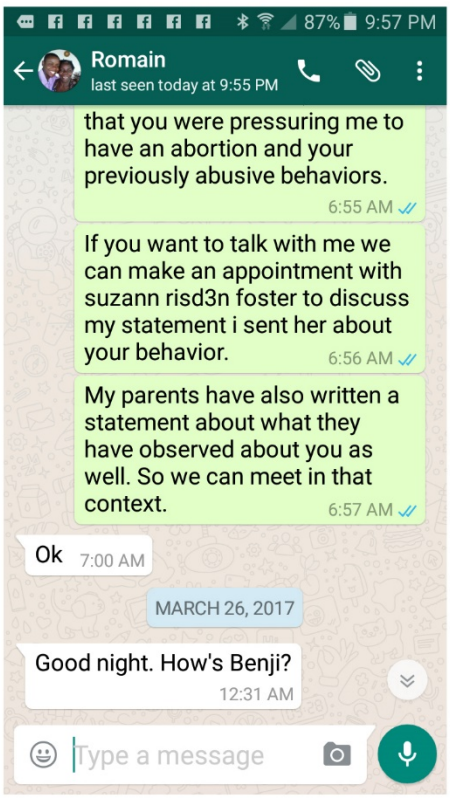

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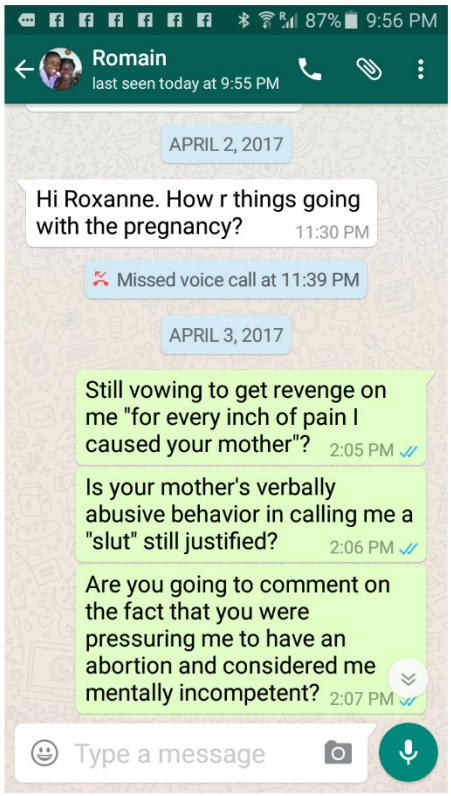

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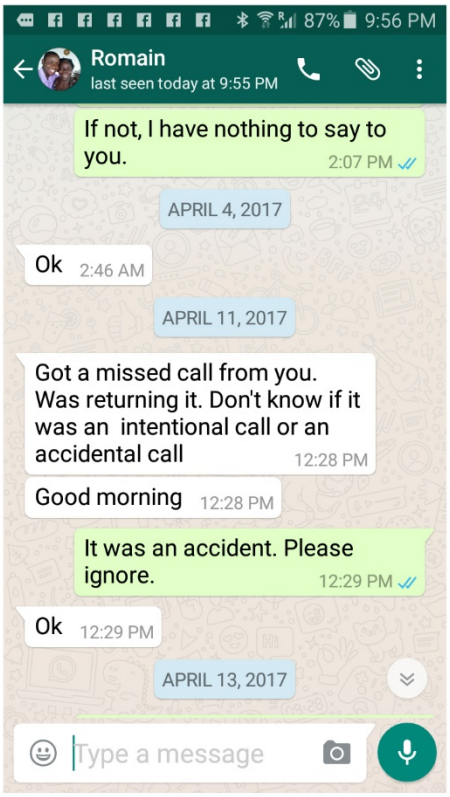

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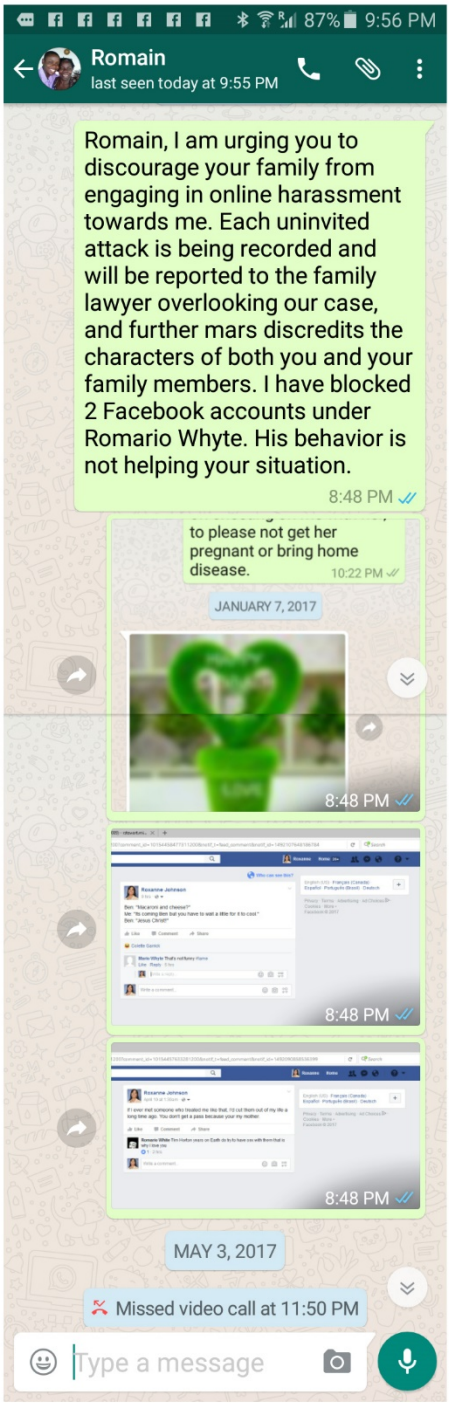

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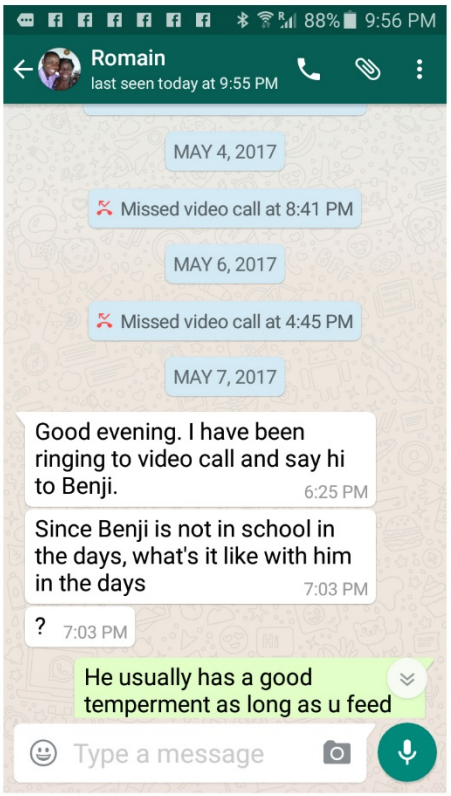

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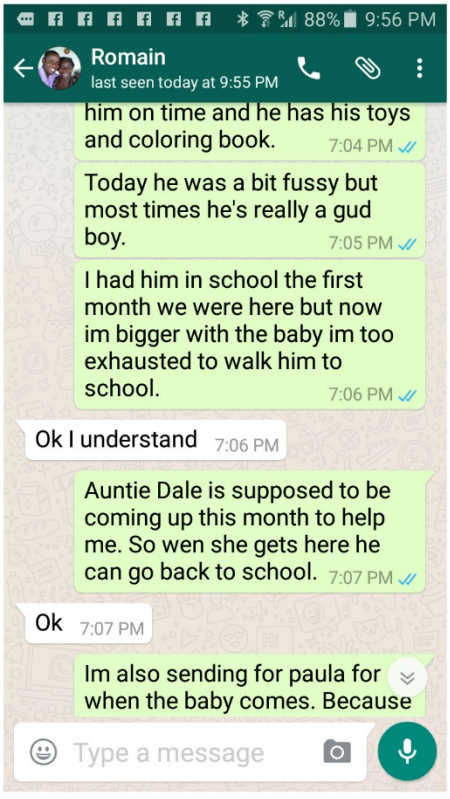

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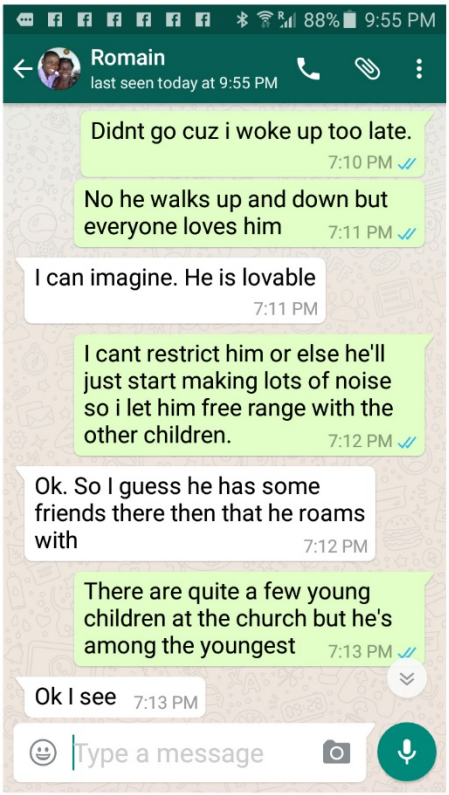

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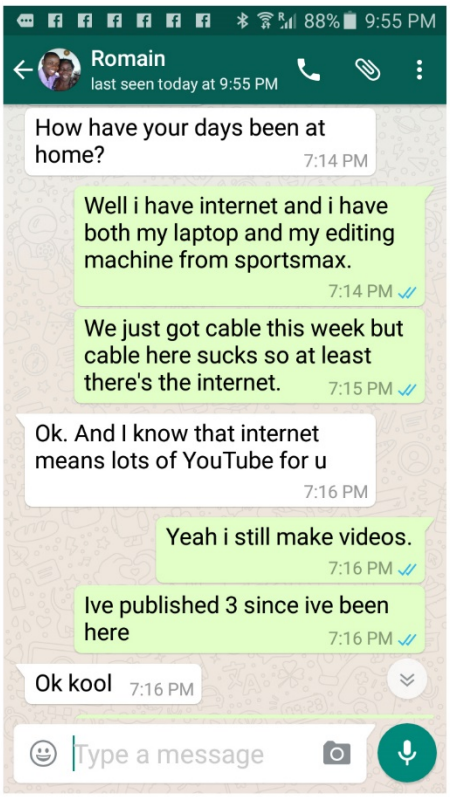

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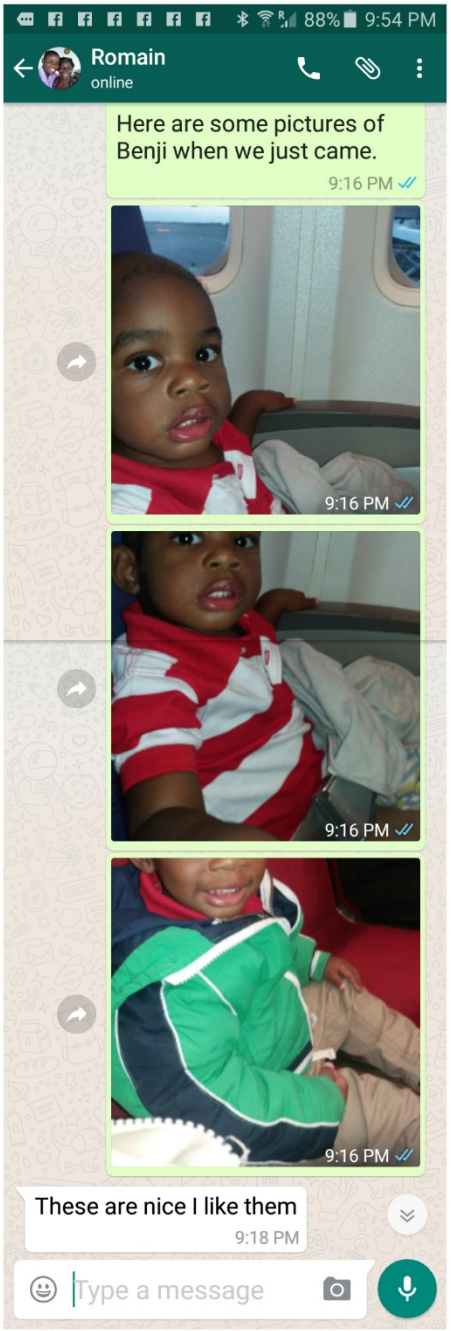

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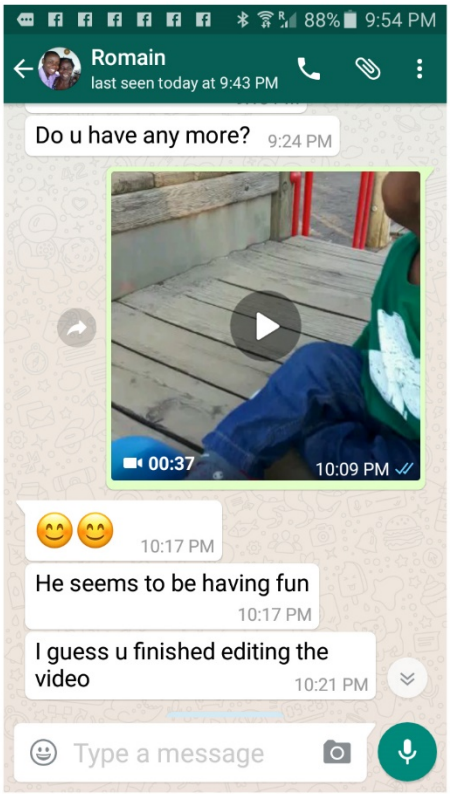
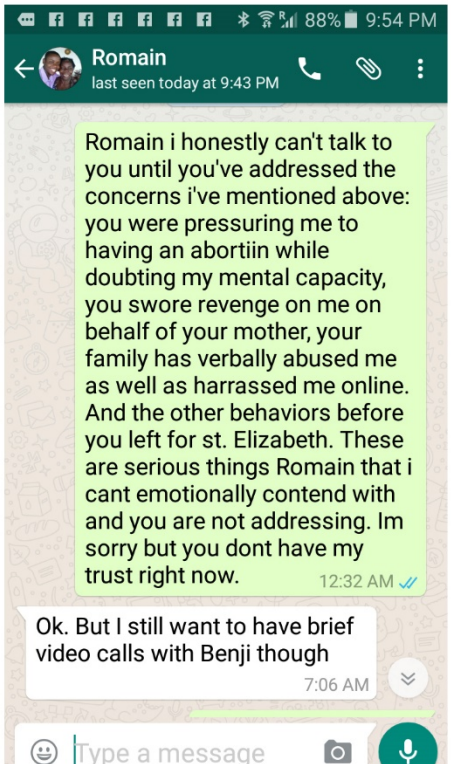

88% 9:54 PM
Romain
last seen today at 9:43 PM
Do u have any more? 9:24 PM
00:37
10:09 PM
10:17 PM
He seems to be having fun
10:17 PM
I guess u finished editing the video
10:21 PM
Type a message

27


88% 9:54 PM
Romain
last seen today at 9:43 PM
Romain i honestly can't talk to you until you've addressed the concerns i've mentioned above: you were pressuring me to having an abortiin while doubting my mental capacity, you swore revenge on me on behalf of your mother, your family has verbally abused me as well as harrassed me online. And the other behaviors before you left for st. Elizabeth. These are serious things Romain that i cant emotionally contend with and you are not addressing. Im sorry but you dont have my trust right now.
12:32 AM
Ok. But I still want to have brief video calls with Benji though
7:06 AM
Type a message

ROXANNE STEWART REFUGEE CASE
UCI: 42358610
SUPPORTING DOCUMENTS (PART 2)
Summaries, Reports, Articles, and Evidence

ROXANNE STEWART REFUGEE CASE
SUPPORTING DOCUMENTS (PART 2)
Summaries, Reports, Articles, and Evidence

Contents…

SYSTEMATIC AND PERSONAL VIOLATIONS OF HUMAN RIGHTS AS A MENTAL HEALTH PATIENT

Contents…

(Continued)

(18) MEDICAL DIAGNOSIS/RECORDS: BUTLER HOSPITAL, MEDICAL ASSOCIATES HOSPITAL

(1) CHARACTER REFERENCE DOCUMENTS FOR REFUGEE CLAIMANT, ROXANNE STEWART

Character Reference Documents for Refugee Claimant, Roxanne Stewart

1) List of Academic Achievements and Community Service Activities

2) Copy of Bachelors of Science Degree from Minnesota State University, Moorhead, Cum Laude

3) Copy of Transcript from Rhode Island School of Design (Graduate Program)

4) Copy of Home Nursing Certificate from St. John's Ambulance Brigade, 2006

5) Copy of Certificate of Baptism from Andrew's Memorial Seventh-Day Adventist Church, 2010

6) Copy of Employment Letter and Summary of Benefits from Sportsmax Limited

7) Copy of Letter of Reference for Ryerson University from former Faculty Advisor and Professor, Dr. Michael Ruth, Minnesota State University Moorhead.

8) Copy of Letter of Reference for Ryerson University from former Production Manager, Mrs. Carla Thomas-Hewitt, The Public Broadcasting Corporation of Jamaica.

List of Academic Achievements and Community Service Activities

Roxanne Melissa Stewart
266 Brock Avenue, Toronto Ontario M6K 2M2
Email: rstewart.micopr@gmail.com, Website: www.roxannejohnsonmedia.com Mobile: 647-671-8081

Bio: Roxanne Johnson is a graduate of Minnesota State University Moorhead, where she received a Bachelor of Science in Graphic Communication, graduating Cum Laude in 2004. She went on to do a year at Rhode Island School of Design's graduate program in digital media on a scholarship. Upon returning to Jamaica in 2005, she had experience working as a video editor and motion graphics producer at BlackSlate Media Group Ltd., became a co-host of the youth forum talk show "Rap Time", worked as a motion graphics producer at the Public Broadcasting Corporation of Jamaica and later went on to be a motion graphic artist at Sportsmax Ltd, where she became a news presenter for daughter channel CEEN TV.

While in Jamaica Roxanne Johnson went on to have experience in drama with the Christian drama group the Eagles, and has also done work as a voice talent for various producers.

Her goal is to continue working in television media where her skills as a writer, researcher, producer and television talent can blossom into creating socially and culturally transforming programing.

Academic History

1992 – 1997	St. Andrew High School 7 CXC Subjects
1997 - 1999	St. Andrew High School GCE 'A' levels – Art, English, Economics
2000 - 2004	B.Sc. (Graphic Communication) – Cum Laude Minnesota State University College Awards: Deans List: Spring 2002 Fall 2002 Spring 2003 Fall 2003 Spring 2004 Academic Award For Student Academic Conference 2003
Sept 2004 – April 2005	Partial Scholarship to Rhode Island School of Design Graduate student - MFA in Digital Media (incomplete) (GPA 3.45)

Independent Academic Activities

- Student Academic Conference Spring 2003:
  Independent research and presentation:

Child Soldiers (Along with website)

- Without the guidance of a tutor, undertook independent study of the course *3D Animation* – Grade achieved – A
- Without the guidance of a tutor, undertook as peer group study of the course *Organic Modeling* – Grade achieved – A

N.B. Both courses referred to above were taken for credit and formed part of the compulsory component of my major.

Community Service

- Formerly a member of The Kiwani's Club of New Kingston
- Conducted workshop in Digital Audio at the Gun-Court Rehabilitation Centre as part of Corner Stone Ministries project
- Former Sunday School Teacher – Swallowfield Chapel (2 years)
- Certified Home Nurse at the St. John's Ambulance Brigade
- Volunteered in YWCA After School Care Programme
- Volunteered – Bustamante Children's Hospital
- Volunteered – Golden Age Home (Vinyard Town) in occupational therapy programme
- Volunteered in Swallowfield Chapel's Prison Ministry
- Assistant Adventist Youth Leader in Andrew's Memorial Seventh Day Adventist Church
- Volunteer in Andrews Memorial SDA Homework Centre Programme

Minnesota State University Moorhead

This is to certify that
The Board of Trustees of the Minnesota State Colleges and Universities of Minnesota upon the recommendation of the Faculty of the

Minnesota State University Moorhead

has conferred upon

Roxanne Melissa Stewart

the degree of

Bachelor of Science

Cum Laude

Given at Moorhead, Minnesota, this fourteenth day of May, 2004.

President of the University

Chair of the Board of Trustees of the
Minnesota State Colleges and Universities

RHODE ISLAND SCHOOL OF DESIGN

Office of The Registrar
Rhode Island School of Design
Two College Street
Providence, Rhode Island 02903

FINAL GRADE REPORT

STUDENT: 0858286 Ms. Roxanne M. Stewart

COURSE SECTION	COURSE TITLE	GRAD	CREDITS	INSTRUCTOR
DM-7102-01	DIGITAL MEDIA GRAD S	W	0.00	T. Rueb
DM-7104-01	LECTURE SERIES SEMIN	W	0.00	N. Wardrip-Fruin
DM-7154-01	INTERACTIVE MULTI-ME	W	0.00	M. Domino
DM-7009-01	EXPERIMENTS IN OPTIC	W	0.00	J. Prince
DM-7151-01	SENSING	W	0.00	M. Pingree
				M. Domino

PRIOR			CURRENT			CUMULATIVE		
ATTEMPTED	COMPLETED	GPA	ATTEMPTED	COMPLETED	GPA	ATTEMPTED	COMPLETED	GPA
18.00	18.00	3.45	0.00	0.00	0.00	18.00	18.00	3.45

Ms. Roxanne M. Stewart
5 Queensway
Kingston 10
Jamaica

SPRING 2005 GRADES

THE ST. JOHN AMBULANCE ASSOCIATION & BRIGADE

JAMAICA

THIS IS TO CERTIFY THAT

ROXANNE STEWART

HAS PASSED

IN HOME NURSING

AT HEADQUARTERS, KINGSTON
ST. JOHN AMBULANCE ASSOCIATION

MAY 8, 2006

Director—Association

Valid for three years from date shown hereon.

Baptismal Vows

1. I believe in God the Father, in His Son Jesus Christ, and in the Holy Spirit.
2. I accept the death of Jesus Christ on Calvary as an atoning sacrifice for my sins, and believe that through faith in His shed blood men are saved from sin and its penalty.
3. I renounce the world and its sinful ways, and have accepted Jesus Christ as my personal Saviour, and believe that God, for Christ's sake, has forgiven my sins and given me a new heart.
4. I accept by faith the righteousness of Christ, recognizing Him as my Intercessor in the heavenly sanctuary, and claim His promise to strengthen me by His indwelling Spirit so that I may receive power to do His will.
5. I believe that the Bible is God's inspired Word, and that it constitutes the only rule of faith and practice for the Christian.
6. Loving the Lord with all my heart, it is my purpose, by the power of the indwelling Christ, to keep God's law of Ten Commandments, including the fourth, which requires the observance of the seventh day of the week as the Sabbath of the Lord.
7. I believe that my body is the temple of the Holy Spirit and that I am to honor God by caring for my body in abstaining from such things as alcoholic beverages, tobacco in all its forms, and from unclean foods.
8. I accept the doctrine of spiritual gifts, and believe that the Spirit of Prophecy is one of the identifying marks of the remnant church.
9. I believe in the soon coming of Jesus as the blessed hope, and it is my settled determination to prepare to meet Him in peace, as well as to help others to get ready for His glorious appearing.
10. I believe in church organization, and it is my purpose to support the church by my tithes and offerings, and by my personal effort and influence.
11. I accept the New Testament teaching of baptism by immersion, and desire to be so baptized as a public expression of my faith in Christ and in His forgiveness of my sins.
12. Knowing and understanding the fundamental Bible principles as taught by the Seventh-day Adventist Church, it is my purpose by the grace of God to order my life in harmony with these principles.
13. I believe that the Seventh-day Adventist Church is the remnant church of Bible prophecy, into which people of every nation, race, class, and language are invited and accepted, and I desire membership in its fellowship.

Name Roxanne Stewart Date 4/09/2010

Address 5 Queensway, Kingston 10

PRINTED BY
OPAC PRINTING SOLUTIONS LTD
132d Maxfield Ave Kingston 10 Jamaica WI
Phone (876) 926-4445 968-0712

Certificate of Baptism

"And Jesus, when he was baptized, went up straightway out of the water: and, lo, the heavens were opened unto him, and he saw the Spirit of God descending like a dove, and lighting uopn him." Mathew 3:16.

In harmony with our Lord's command

ROXANNE STEWART

was baptized at Andrews Memorial SDA Church

on the 4th *day of* SEPTEMBER, 2010

Officiating minister LORENZO KING

of the EAST JAMAICA *Conference*

Received into church fellowship

by the ANDREWS MEMORIAL *Seventh-day*

Adventist church on the 4th *day of* SEPT. 2010

Church clerk Rhona Burgen

ATTACHMENT A

JOB DESCRIPTION

JOB TITLE: **GRAPHIC DESIGNER**

DEPARTMENT: **PRODUCTION**

REPORT TO: **CREATIVE DIRECTOR/EXECUTIVE PRODUCER**

As a Graphic Designer, you should have a working knowledge of preparing and presenting visual artwork for television related materials with a clear appreciation for Non-Linear editing. Under direction, you are expected to produce materials for multimedia and television production as well as web content. This involves providing graphic design and graphic preparation of materials for use in TV broadcasting and on the Web.

A critical function is the ability to apply artistic judgment and skill in creating still or motion graphics by using a variety of graphics tools, techniques and materials. You are also expected to exercise considerable personal artistic creativity in creating electronic graphics for the television medium. Installing and maintaining software and (occasionally) troubleshooting hardware and software problems as it relates to graphics equipment is also a requirement. You are expected to keep current with technological advances in TV and web medium.

You will report to the Executive Producer/Creative Director and will be responsible for:

- Completing requested graphics in a timely manner as per set deadlines for all on-air productions
- Developing artistic and creative solutions for editing and program segments, including but not limited to openings and closings of programmes, promotions, station ID's, green screen effects, bulletin board announcements and general station needs
- Providing requested electronic graphics for all on-air productions
- Actively participating in the creation and design of sets for TV productions
- Contributing ideas and designing high quality artwork within company guidelines
- Assisting with internal as well as Outside Broadcast production workflows; must have operational knowledge and understanding of CatDV
- Work with the Creative Team in maintaining the graphic identity of the channels
- Constantly researching and keeping abreast of new software, technology and innovations within the field

You should possess:

- Certification in Graphic Design or related field
- At least 2 years work experience in a similar field
- Excellent time management skills and deadline oriented
- Exceptional creativity and innovation skills
- The ability to provide feedback, accept feedback and offer ideas
- Strong communication skills
- The ability to work methodically

Schedule: Summary of Benefits

Item 1	GRAPHIC DESIGNER
Item 2	November 23, 2015
Item 3	On a permanent basis after successfully completing your probation.
Item 4	One (1) months
Item 5	1,800,000.00 per annum
Item 6	16 days paid vacation
Other Benefits	
Sick Leave	Ten (10) working days per annum paid
Health Insurance	Sagicor Life Jamaica
Group Life Insurance	Sagicor Life Jamaica
Maternity Leave (if applicable)	Eight (8) weeks paid, four (4) weeks unpaid
Pension	Upon implementation

For SportsMax Ltd.

Calais Hayden
Human Resources Manager

I accept the offer of employment on the terms and conditions set out above.

Name of employee: **Roxanne Stewart**

Signed .....

Date ..... Nov. 20, 2015

Admissions,
Ryerson University,
350 Victoria Street,
Toronto, ON M5B 2K3,
Canada

Letter of Reference for Roxanne Stewart

To Whom It May Concern

Dear Sir/Ma'ame,

I have known Roxanne since her sophomore year at Minnesota State University Moorhead and was her Faculty Advisor and Professor during her course of study in Graphic Communications. Roxanne demonstrated in my classes a natural talent for 3D animation and showed self-discipline and dedication particularly in her independent studies on organic modelling.

During her time at Minnesota State University, she excelled academically and made Dean's List multiple times as well as was given an Academic Award. She achieved this while working two on-campus jobs as an administrative assistant and Campus Security dispatcher. Roxanne was also a presenter at MSUM's original student academic conference.

Roxanne not only grew academically but demonstrated leadership skills as the president of the International Student's Club, during which she also led the club into achieving the coveted Dragon Frost award through their teamwork and participation.

Roxanne also demonstrated her ability to develop and grow in several personal areas as well as academically. I believe she will have much to contribute to the graduate program in Communications and Culture at Ryerson University and hope you find in her the same spirit of diligence and creativity that I saw her display at Minnesota State University Moorhead.

It is without reservation that I recommend Roxanne be accepted to your school to pursue her advanced program of studies. If you require further assistance please feel free to contact me at either my email or cell phone number 313-850-6902.

Sincerely,
Dr. Michael L. Ruth, Emeritus
School of Media Arts and Digital Design
Minnesota State University Moorhead
Moorhead, MN 56563
michael.l.ruth@mnstate.edu
mike.l.ruth@gmail.com

313-850-6902 cell

Mrs. Carla Thomas-Hewitt
Letter of Reference
Production Manager, The Public Broadcasting Corporation of Jamaica
5-9 South Odeon Avenue, Kingston 10, Jamaica
Tel: 1(876)754-7225, Cel: 1(876)412-7482, email: cthomas-hewitt@pbcjamaica.org

To Whom It May Concern,
Admissions,
Ryerson University,
350 Victoria Street,
Toronto, ON M5B 2K3,
Canada

Dear Sir/Ma'ame,

I have known Roxanne since her employment with the Public Broadcasting Corporation of Jamaica in October of 2007 as a motion graphic artist. During her time at PBCJ she delivered excellent work, showcasing her talent in 3D animation, special effects and computer generated imaging. She also showed her creativity in producing musical compositions with various sound editing softwares to use as soundtracks to accompany the motion graphics and animation that she would produce for our various television productions.

In fact, Roxanne in her time at PBCJ was also given the award for Most Creative at our yearly prize giving ceremony in 2008. She was a cheerful worker and enjoyed giving her best.

In 2009, so impressed with her skills in multimedia and motion graphics were we, that we also had Roxanne hold a short in-house course to train any staff that was interested, in 3d animation software and computer generated imaging software. She was a gracious and patient tutor and members of staff came away with new found skills.

I am sure, once given the chance to embark on her graduate studies in Communications and Culture at your institution, she will give her utmost towards her area of research.

I wish Roxanne all the best and hope you find in her the unique skills and creative talents that contributed so greatly to our organization at PBCJamaica.

Sincerely,

Thomas-Hewitt

Mrs. Carla Thomas-Hewitt,
Production Manager

(2) RADIOLOGIST REPORT AND ULTRASOUNDS OF PREGNANCY

ANDREWS MEMORIAL HOSPITAL
27 Hope Road, Kingston 10. Jamaica, W.I.
Tel: (876) 926-7401-2 Fax: (876) 929-3820
Email: amh@cwjamaica.com

RADIOLOGY REPORT

PATIENT'S NAME:	**STEWART: ROXANNE**
GENDER:	**F**
AGE:	**35**
CASE NUMBER:	**98236**
LOCATION:	**OPD**
EXAMINATION NO.:	**US17/106**
REFERRING DOCTOR:	**Dr. Mais**
DATE OF EXAMINATION:	**January 3, 2016**

INDICATION (S): Dizziness and gravid, for dating viability of pregnancy.

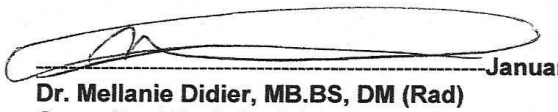
PELVIC ULTRASOUND

Patient gives an LMP of the 26th of November 2016. This corresponds to a gestational age of 5 weeks and 3 days. There is gestational sac seen within the endometrial cavity.
The gestational age via ultrasound parameters corresponds to approximately 5 weeks 0 days using the maximum dimensions. There is a yolk sac seen insitu. A fetal pole is not currently identified.
No subchorionic haemorrhage is demonstrated.
The cervix is long and the internal cervical os is closed.
There is a thick-walled focus within the left ovary with echogenic debris noted within it. There is a suggestion of peripheral vascularity to this focus. The appearances likely represent the corpus luteal cyst.

The right ovary is not clearly identified. No right adnexal masses or collections are seen.
There are pockets of left adnexal and pelvic free fluid. This may be physiological or may represent small amount of leaked fluid from the corpus luteal cyst.
Both kidneys appear unremarkable.

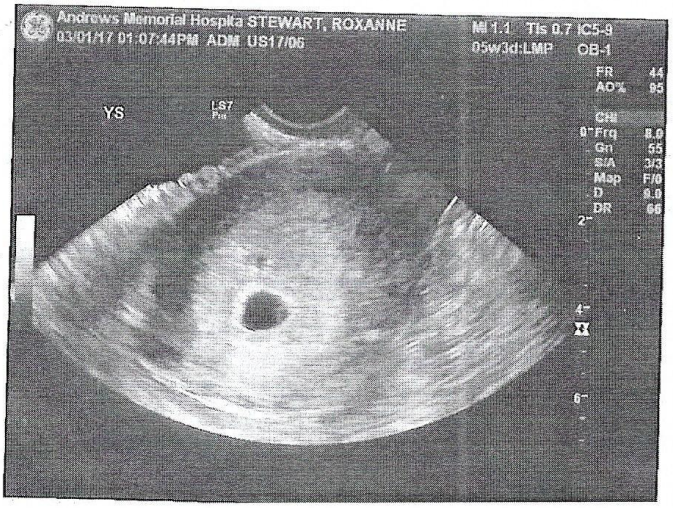
Impression: Gestational sac with a gestational age of approximately 5 weeks 0 day as described. Repeat ultrasound in 14 days may prove useful for continued monitoring of this pregnancy once the patient remains clinically stable.

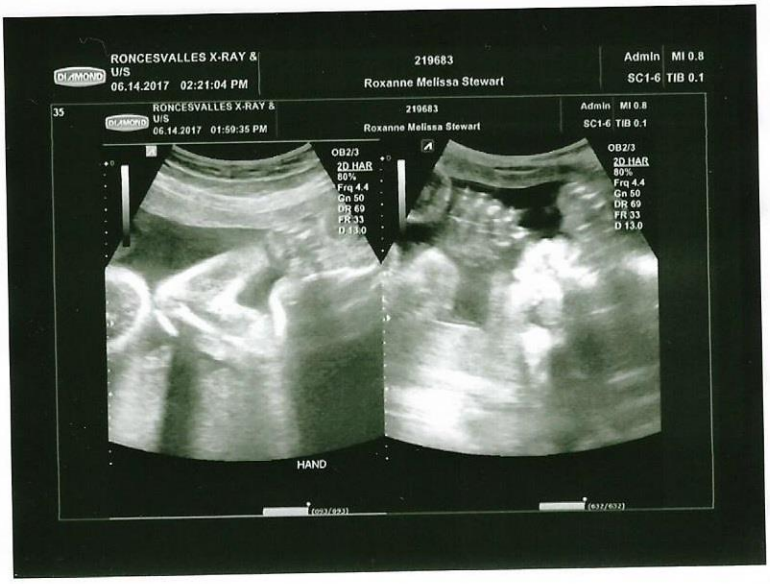
Thank you for referring your patient to us.



January 3, 2017
Dr. Mellanie Didier, MB.BS, DM (Rad)
Consultant Radiologist

MD/mw


Andrews Memorial Hospita STEWART, ROXANNE
03/01/17 01:07:44PM ADM US17/06
MI 1.1 TIs 0.7 IC5-9
05w3d:LMP OB-1
FR 44
AO% 95
CHI
Frq 8.0
Gn 55
S/A 3/3
Map F/0
D 8.0
DR 66
YS
LS7
2
4
6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Roxanne Melissa Stewart
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2D HAR
80%
Frq 4.4
Gn 50
DR 69
FR 33
D 13.0
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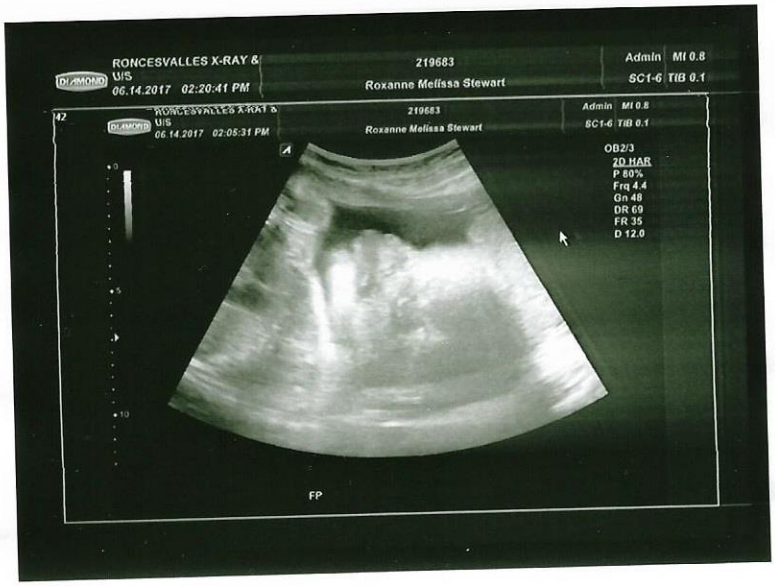
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SC1-6 TIB 0.1
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Roxanne Melissa Stewart
Admin MI 0.8
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OB2/3
2D HAR
P 80%
Frq 4.4
Gn 48
DR 69
FR 35
D 12.0
FP

(3) STATEMENTS OF ROMAIN JOHNSON'S BEHAVIOR

TO WHOM IT MAY CONCERN

Re Custody of Benjamin Romain Johnson

I Samuel Arturo Stewart of 11a Swallowfield Road, Kingston 5, Jamaica, Attorney-at-law and residing at 5 Queens Way Kingston 10, Jamaica do state as follows:

I am the father of Roxanne Melissa Stewart Johnson, Graphic Communications Consultant, who is the mother of Benjamin Romain Johnson, born on January 14, 2015 to herself and Romain Johnson his father.

From the date of his birth to December 18, 2016 Benjamin and his mother resided at my home with my wife Dr. Marcia Stewart, Roxanne's mother and myself.

During this period, Romain his father would visit from time to time but I am not aware of any monetary contribution made by Romain to the growth, development, medical and pre-school expenses of Benjamin, as my wife Marcia and myself would from time to time assist Roxanne with some of these expenses.

It is a fact that during that period Romain was a student and apparently was not able to contribute meaningfully from his earnings that he gained from part time employment, although I observed that he purchased a couple of toys for Benjamin to play with.

On December 18, 2016 Romain and Roxanne were married at a church in Mandeville, Manchester, Jamaica in a beautiful ceremony with a reception that was held at the Manchester Golf Club attended by family members and friends which Roxanne described as fulfilling her greatest dream.

The couple and their son Benjamin moved into their matrimonial home in a gated community at Oaklands, Constant Spring Road, St. Andrew, Jamaica. However from the end of the first week of the marriage, issues developed which led Roxanne to be concerned about Romain's conduct as on Christmas Day he abandoned his family and went to his parents home by himself after an incident in which he threw Benjamin to the foor.

Subsequently there were a number of other issues which led to disputes between the couple and since January 10, 2017 Romain left the matrimonial home in Oaklands and his job in Kingston, relocated himself to Black River, in St. Elizabeth where he now works and refused to visit or send any financial contribution to assist with the rent, living expenses and maintenance of his son Benjamin or his wife Roxanne, although requested to do so by his wife and reminded by me of his responsibility as a father which he acknowledged, but has not responded with even a token contribution thereto.

In one of the attempts to reconcile their differences Roxanne suggested that they should go to counselling together but he only came to Kingston for one counselling session. Roxanne offered to visit

with him in Black River but he indicated that the accommodation that he had was inadequate and that she should not visit.

Romain's parents who live in rural Jamaica in impoverished conditions do not appear able to assist Romain at this time and in fact they should also be assisted by Romain as they have had to be providing support for his sibblings who are still at school.

Roxanne who had now become emotionally distraught and totally frustrated with Romain, resigned her job and decided to terminate the lease that she had taken out for the matrimonial home and sell the furniture which she had purchased (save and except one television set purchased by Romain which she sold as well and appropriated to his contribution). Roxanne then moved in with her Aunt, Dale Cover and told me that she had specifically invited Romain to visit Benjamin at my home under the supervision of my wife and myself as soon as was convenient.

Roxanne has been the prime caregiver of Benjamin since Romain's departure and she has incurred a considerable amount of debt to do so which was predicated and agreed to be shared by Romain and herself in their marriage. Instead she has had to sell her possessions and be financially assisted by her mother and myself with the hope that she will be able to now recover from the breakdown of the marriage and use her considerable intellectual and artistic talents to earn and income to support herself and her child.

Signed by

Samuel Arturo Stewart

APRIL 5, 2017

In the presence of:

5th APRIL, 2017

SUZANNE RISDEN-FOSTER

Roxanne Stewart-Johnson
Apartment 12a, 3 Grove Park Avenue, Kingston 8,
Cell: 322-1182, Email: rstewart.micopr@gmail.com

A Statement Regarding:
Romain Johnson's Untoward, Abusive and Irresponsible Behaviour Before and During His Marriage to Roxanne Stewart

I, Roxanne Stewart-Johnson, am writing this statement detailing Romain Johnson's untoward, abusive and irresponsible behaviour which demonstrates why I, as his wife, believe he is unfit to be a father to his son Benjamin Johnson or to his unborn child, and why staying in this marriage would be unsafe and precarious for both myself and his children.

Before our marriage Romain has never been able to assist me financially, even while he was working as a pharmacy technician both before and after the birth of his son Benjamin. During our three and a half year relationship before our marriage, it was I and my family who carried the relationship financially.

Early in the year 2013, before our relationship officially begun in May, I had already given Romain $18,000.00 towards classes he had failed and had to retake for his pharmacy program. Due to the fact that Romain was suffering from what appeared to be symptoms of depression, he had much absenteeism during his university undergraduate courses which led him to being a year behind in school. This is what also led to my mother having to pay the tuition fees later for his final year of school before graduating, as the Student Loan Bureaux only finances the number of years a student is supposed to take to finish their program.

It is during the early days of our relationship in 2013 I learned from Romain that during his childhood in Trelawney, he had been the victim of much emotional, verbal and physical abuse at the hands of his parents. He had witnessed his mother being beaten violently by his step father who had broken a glass bottle in her head, and who also had a substance abuse problem particularly with Marijuana, and who's erratic unfaithful behaviour also led to a temporary separation between himself and Romain's mother, during which he threatened to burn down their home with them inside. Romain had also never known his biological father, and admitted to me that his mother, who later confirmed this herself, had only pursued a sexual relationship with his biological father for the purposes of becoming pregnant and having a child. Romain had spoken of incidences of emotional verbal abuse from his mother so severe and traumatic he actually had blocks of time during this period he cannot remember. He also spoke of incidences where his mother beat him with an extension cord as well as a belt. Romain also told me that the relationship between himself and his step-father was very strained to the point where, though his father was responsible for all the cooking in the family, Romain would not eat any meal prepared by his step-father and went through severe weight-loss. It is in the local church that Romain, his mother and his half-siblings sought refuge and comfort. But it is due to knowledge of this abusive and dysfunctional background that I felt it was no wonder that Romain suffered with symptoms of depression and was falling behind in school, and he never received counselling or therapy for the abusive experiences he suffered while living with his family in the country.

During the rest of the year 2013 after our courtship officially began in May, I carried the relationship financially between Romain and myself in our first year of dating, partially living off the approximately 1 million dollars I had earned from a freelance project with E-Learning Jamaica, also having the support of my parents who I lived with at the time. During the entire 3½ year period of our courtship before marriage, in fact, I never pressured Romain for financial support since I felt that as a student and someone coming from an impoverished socio-economic background he would not be able to give me much more than his emotional support and companionship at this time. I felt that when Romain graduated university and became a licenced Pharmacist he would then be more than able to contribute to our relationship financially.

It is also during this time that my family made several contributions to Romain and his family including 3 laptop computers (an Apple, a Hewlett-Packard, and an Acer mini) other computer accessories, and I also sent for his sisters a host of brand new clothing.

Even though Romain made no financial contributions during our first year of courtship, the relationship was a happy one, with what I felt was healthy open communication, affection and emotional support.

After I became pregnant with our son Benjamin in 2014, however, Romain's behaviour began to change. He became emotionally unsupportive, unsympathetic toward my severe morning sickness and we often had many disagreements. Romain also became very controlling, very strict in prohibiting me from having any male friends, even though he had several female friends in pharmacy school and at his part time job. At one point a friendship I had with a friend, Edwin Tulloch-Reid, led Romain to threaten that he would go to Edwin's office and punch him. Even the aspect of going to the hospital because of severe pregnancy related nausea caused arguments between us. A close friend and neighbour I had and would often visit, Mrs. Colette Garrick, also noted to me that Romain had a trust and jealousy problem. My parents attributed Romain's threat to assault my friend Edwin, to immaturity since Romain was 9 years younger than me in age.

Still we continued on in our relationship and Romain, even though working as a pharmacy technician at Liguanea Lane pharmacy, was still unable to make any financial contributions towards my ante-natal care due to his very humble salary, and the hefty bills for obstetrician appointments, ultrasounds, and hospital bill at Andrew's Memorial Hospital for the labour and c-section delivery of our son was entirely paid by my parents, as by this time the money I had earned in my freelance E-Learning Jamaica project had been exhausted, and I also was not working and so had no income.

After our son Benjamin's birth in January of 2015, myself and Romain planned for our future and looked more seriously at our intentions of getting married. By November of that year I had attained a full-time job at Sportsmax Limited as a graphic designer earning about $120,000.00 a month after taxes and was hopeful that my new salaried job, along with Romain soon to be working as a licenced pharmacist would afford us the financial independence that would allow us to get married and live in our own home.

By the time of our 3 year anniversary May 1st, 2016 Roman, myself and my mother discussed an official wedding date of December 18th 2016, which would allow Romain to graduate and take the exam to become a licenced pharmacist before we were married.

Things seemed to temporarily improve in the relationship and I was hopeful that the prospect of living in our own home as a married couple and family, financially independent of my parents would improve Romain's sense of self-worth and improve the relationship. It was also before the wedding in

approximately late November of 2016 that I became pregnant with Romain's second child. It was a pregnancy that was planned for and wanted.

In the months leading up to the wedding I saved most of my salary at Sportsmax, to be used towards paying 6 months rent and security deposit for a home for us to move into once married, and also to put towards wedding preparations. Since Romain was still not a licenced pharmacist and still earning a humble salary as a pharmacist technician, he was still unable to assist financially towards the wedding or towards future living expenses. It was during this time my mother complained he had not even contributed a token amount to the planning of the wedding after she had arranged two separate data-entry jobs in which he would have earned upwards of $50,000.00 each. I, still cognisant of Romain's impoverished family background and the very poor living conditions of his mother, step-father, and half-siblings in Trelawney, defended that since they faced such dire circumstances, Romain should be allowed to send whatever his earnings were to his mother in the country.

It is during the months leading up to the wedding that I also met Romain's uncle Cleavy Baily, his mother's paternal uncle who was dying of a chest infection at Chest Hospital in Kingston. Romain informed me that this uncle, who also had a criminal record for murder, on multiple occasions tried to sexual assault Romain's mother, and this same uncle was also successful in raping his own daughter. Romain's uncle, Cleavy Baily, had also, on multiple occasions, threatened to kill Romain's mother, step-father and siblings and they had had to make police reports about his threatening behaviour for their safety. More of Romain's past as it was revealed to me, explained his emotionally unstable and at times border-line abusive behaviour, and why he seemed to suffer from depression.

Romain also, as I discovered suffered from a severe pornography addiction and had what I thought was a chronic masturbation disorder which seemed to have become worse after our relationship became a sexual one in 2014. Though we had gotten re-baptised in the Adventist church after the birth of our son out of wed-lock, as was the regulation in the Seventh-Day Adventist church for evidence of fornication, he still pressured me for sex and was often disgruntled that I did not gratify him more sexually. This was often the cause of many disagreements. Romain had also made it known to me that as a little boy he had been molested sexually by an older young lady who baby-sat him while he was about six or seven, and I saw that as possibly having some contribution to his perverse addictions and behaviour towards me.

Finally it was after our wedding during our brief period of living together as a married couple that Romain's dysfunctional behaviour became very apparent. He was resentful towards our 23 month old son Benjamin, and though the toddler was sick with a tonsil infection and had fever, Romain would insist that he be left in his crib to cry and not be comforted in the bed with us. Romain became even more controlling and strict, insisting that for Sabbath we not be allowed to buy any food even though there was hardly anything in the house to eat. On one occasion he pretended he was going to burn me with the hot iron he was using to iron his clothes that morning, and finally on December 25th, Christmas day he shoved our son Benjamin by the head into the floor in our living room. From there, things seemed to spiral downhill as he also began to have an inappropriate relationship with a young lady he knew from university called Shanel Menzes. After several attempts to get us counselling from the pastor who married us at our wedding, and an appeal to Romain's mother that Romain needed counselling for what I saw as mental instability, the relationship between himself and Shanel Menzes continued, and as a result I made a video message on January 7th, 2017, detailing the challenges we were having in our

marriage and asking for help which I sent to friends and family through private whatsapp messages and emails. After the video message had made known to our friends and family Romain's abusive behaviours towards myself and Benjamin, it was shortly after this that Romain chose to separate from us and move to Black River, St. Elizabeth where he worked with NHF at the Black River Hospital.

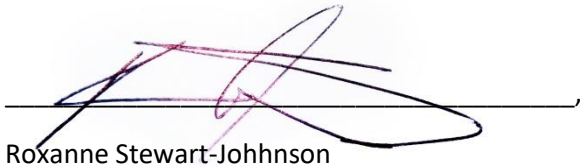
Since leaving for St. Elizabeth, because of the small monthly earnings Romain makes from his employment at Black River hospital, more than half of which goes towards his late fee payments to the Student Loan Bureaux, Romain as per usual, has not been able to make any financial contributions towards his new young family since our marriage. He has not sent any money towards our son, Benjamin's expenses or school fees, towards the rent at our residence in Oaklands, Constant Spring, or any of our utility bills. Romain has also stated that he feels no obligation to provide for us financially or come back to our marriage, even though shortly before our separation I had given him $190,000.00 towards his Student Loan arrears out of my personal savings and a loan I had taken out with COK. I have had to survive financially with the help of my parents and also by selling all of our household appliances and furniture and finally moving back with my aunt who lives in Constant Spring to release us from the $70,000.00 rent we were facing by living in the townhouse in Oaklands.

Romain's mother Mrs. White also became verbally abusive when she called me a slut via a private Whatsapp message, and Romain adamantly defended her behaviour when asked about it. Romain also swore he would not return to our marriage until I felt "every inch of pain" I had caused his mother due to the video message I had sent out to friends and family asking for help.

Romain also became threatening and antagonistic in our phone calls while he was living in St. Elizabeth, and at one time threatened to inject me with Modecate (Fluphenazine), a powerful anti-psychotic and also began pressuring me to have an abortion. I had to block him twice on my phone because he started to insult me, and I generally do not see a marriage with Romain as a safe situation for myself, our son or our unborn child.

I do not believe Romain is emotionally capable at this time of being a loving supportive father to Benjamin, and has proven that he needs some amount of psychological counselling because of his unstable abusive behavior, and the child-abuse of his past and at this time I feel it is unsafe for me to continue as a partner with him in this marriage.

Sincerely,



Roxanne Stewart-Johhnson

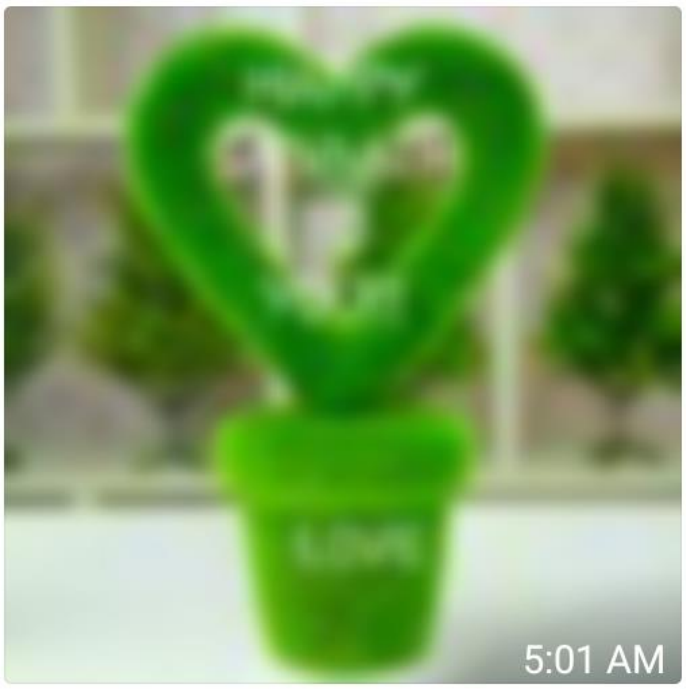
(4) ONLINE HARRASSMENT MADE TOWARDS CLAIMANT, ROXANNE STEWART, BY IMMEDIATE FAMILY OF HUSBAND ROMAIN JOHNSON

95% 8:43 PM

Mrs White
online

on cheeting on me with her, to please not get her pregnant or bring home disease. 10:22 PM

JANUARY 7, 2017



FEBRUARY 4, 2017

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April 10 at 1:30am
If I ever met someone who treated me like that, I'd cut them out of my life a long time ago. You don't get a pass because your my mother.
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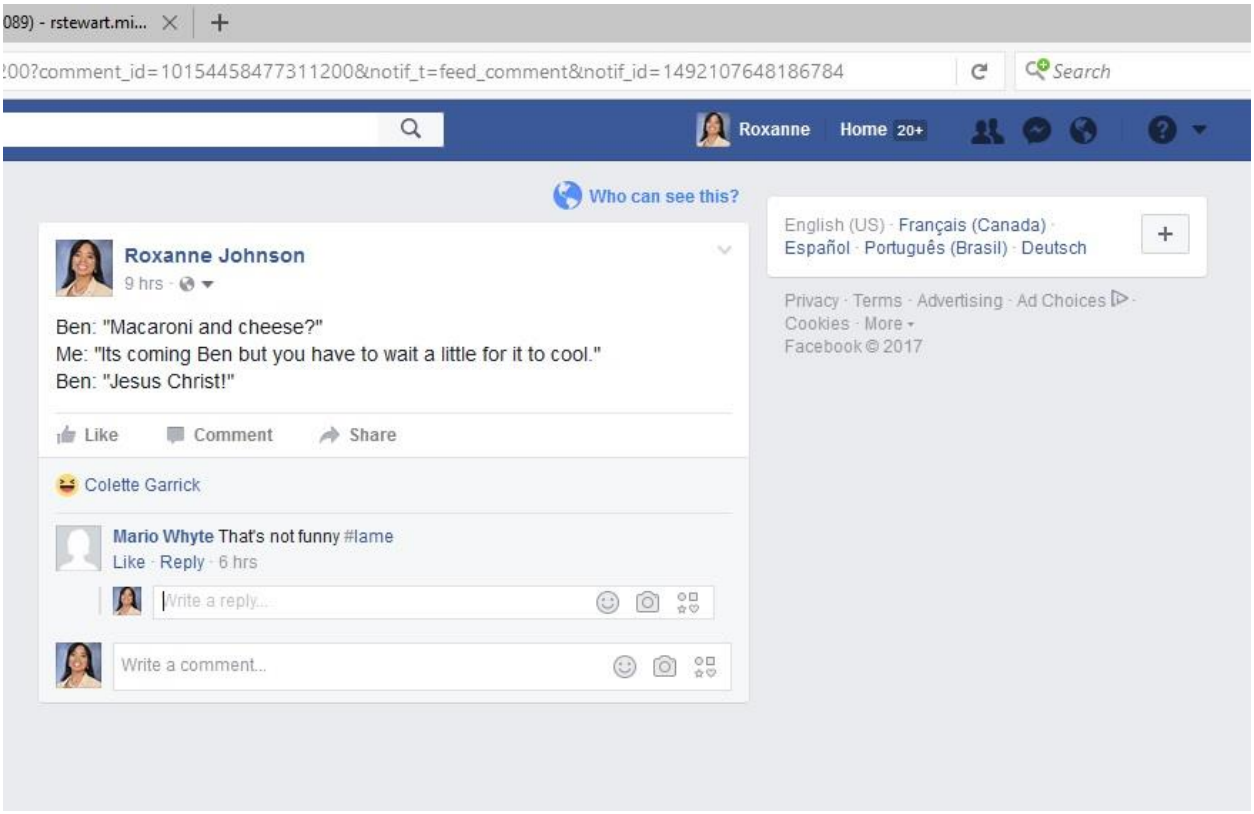
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Search
Roxanne
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Who can see this?
Roxanne Johnson
9 hrs
Ben: "Macaroni and cheese?"
Me: "Its coming Ben but you have to wait a little for it to cool."
Ben: "Jesus Christ!"
Like
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Like · Reply · 6 hrs
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English (US) · Français (Canada) · Español · Português (Brasil) · Deutsch
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(5) SUMMARY OF PROBLEMATIC ISSUES, LACK OF LEGISLATION AND HUMAN RIGHTS OBSERVATION IN JAMAICA EXPOSING CLAIMANT ROXANNE STEWART, TO SYSTEMATIC AND PERSONAL VIOLATIONS OF HUMAN RIGHTS AS A MENTAL HEALTH PATIENT

Summary of Problematic Issues and Lack of Legislation and Observation of Human Rights in Jamaica that Exposes Claimant, Roxanne Stewart, to Systematic and Personal Violations of Her Human Rights as a Mental Health Patient

1) According to an August 2011 Jamaica Observer article, Dr. Wendel Abel, consultant psychiatrist at the University Hospital of the West Indies reports that Jamaica is in contravention of international treaties the country has signed because of unjustified involuntary hospitalizations where person are locked away and their fundamental human rights taken away.

2) According to a May 2016 RJR News Article Dr. Wendel Abel also reported Jamaica is at risk of breaching human rights treaties for the treatment of the mentally ill. And in the Auditor General's Performance Audit Report on the Health Ministries Management of Mental Health Services, at Bellevue Hospital, more than 80 percent of patients were stable and should have been at home with their families.

3) In a February 2011 Jamaica Observer Article, Carol Narcisse, co-founder of the mental health support group MENSASA reported that all categories of people with mental illnesses' rights were being abused. "Jamaica is in serious breach of the right of the mentally ill to appropriate health and appropriate services based on their disability." Consultant forensic psychiatrist Dr. Clayton Sewel in assessing general conditions also said "The facilities in Jamaica are not in keeping, arguably with the human rights standards to which we have agreed."

4) In a WHO – AIMS 2009 Report on Mental Health System in Jamaica, the executive summary shows that the number of psychiatrists in the country only works out to 1 per every 100,000 persons in a population of 2.7 million. There is also a dearth of psychologists, social workers and occupational therapists in the island due to the unattractive remuneration in the public sector.

5) In a 2012 WHO Assessment of the Pharmaceutical Situation in Jamaica, the report shows Jamaica does not have an officially adopted National Pharmaceutical Policy. (NB: A National Pharmaceuticals Policy is one that aims at ensuring that people get good quality drugs at the lowest possible price, and that doctors prescribe the minimum of required drugs in order to treat the patient's illness.)

Prescribing is mostly done by doctors, but few prescribers have been recently trained in rational use of medicines.

Standard Treatment Guidelines (STG) was available in less than half of public healthcare facilities (46.4%). Not every public health facility had the VEN List, since it was only available in about 1 in each three facilities (35.7%).

(NB: Standard Treatment Guidelines ensure consistency, and treatment efficacy for patients across demographic and geographic barriers.)
The doctor is the most frequent prescriber found; nevertheless, the use of INN in public health facilities was lower than 50% and few prescribers have been recently trained in rational use of medicines.

The training of prescribers related to good prescribing practices, including the use of evidence, prescribing by the International Non-proprietary Name (INN) as well as the improvement of the availability and incentives for the use of the Standard Treatment Guideline (STG) and the Vital, Essential and Necessary (VEN) List are aspects that need to be considered as part of the rational use of medicines strategies.

6) In a December 2016 The Gleaner article, Jamaica minister of Health reported that hospitals lacked transparency and needed to be more accountable.

7) In an October 2016 Jamaica Observer Article, it was shown that the Director of Medical Associates Hospital, (a hospital where claimant Roxanne Stewart received the treatment of Fluphenazine without her consent in 2015) Dr. Michael Banbury had been charged with fraud but released due to the prosecution being abandoned.

8) The sphere of influence of psychiatrist, Dr. Jacqueline Martin (the doctor who threatened claimant, Roxanne Stewart) is also quite powerful as she sits on the board of directors for Medical Associates Hospital, is a consultant psychiatrist for the University Hospital of the West Indies, claims to be a head administrator for Ward 21 of the University Hospital of the West Indies, and is also a lecturer in the Faculty of Medical Sciences at the University of The West Indies, the most prestigious University in the country.

(6) 2012 WHO ASSESSMENT OF PHARMACEUTICAL SITUATION IN JAMAICA

Pharmaceutical Situation in Jamaica

WHO Assessment of Level II - Health Facilities and Household Survey

Technical Series:
Essential Medicines,
Pharmaceutical Policies

Pharmaceutical Situation in Jamaica

WHO Assessment of Level II - Health Facilities and Household Survey

Technical Series: Essential Medicines, Pharmaceutical Policies, Nº 5

September 2012 Washington, DC

Ministry of Health of Jamaica

Medicines and Health Technologies Project
Area of Health Systems based on Primary Health Care
Pan American Health Organization

PAHO HQ Library Cataloguing-in-Publication Data
Pan American Health Organization, Ministry of Health of Jamaica.
Pharmaceutical Situation in Jamaica. WHO Assessment of Level II - Health Facilities and Household Survey.
Washington, D.C.: PAHO, 2012.
(Technical Series: Essential Medicines, Pharmaceutical Policies, Nº 5)

ISBN 978-92-75-11697-5

I. Title. II. Series

1. Pharmaceutical services
2. Pharmacy administration
3. Health facilities
4. Data collection
5. Americas

(NLM Classification: WA730 DJ2)

Table of Contents

List of figures, tables and boxes

Acknowledgements

This WHO Pharmaceutical Situation Assessment (PSA), Level II, was conducted with the full support of the Ministry of Health (MOH) of Jamaica, including their permission and endorsement to conduct the study, with the technical and financial support from PAHO/WHO through the EU/ WHO ACP Project "Partnership on Pharmaceutical Policies."

Princess Osbourne, Director of Standards and Regulation Division/MOH, was the main investigator, Cynthia Lewis Graham, MOH was the Lead Coordinator and Andre Dennis, MOH the Assistant Coordinator. Area supervisors were Sherna Williams-Bell, Jennielyn O'Connor-Guy, Judith Atkinson-Linton, Kerryann Palmer-Black and Andre Dennis.

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Household Survey: Josie-Ann Graham, Trishana Dunbar, Monique Cameron, Kimberley Vaccianna, Terry-Ann Waite, Omar Green, Horace Green, Michielee Black, Melissa Reid, David Buckingham, Michael Gordon, Andena Peart, Jody-Ann Campbell, Peta-gaye Aitcheson, Dwight Dunkley, Cheree Campbell, Warren Wright, Christopher Abraham, Lloyd Graham, Debbie-Ann McFarlane

The data entry, analysis and report editing team included Hank Williams, Tennien Black, Tisannia Tam, Kemoya Stewart and Andrew Bennett.

The support of the directors/heads of health facilities and departments in all five survey areas was fundamental to make the study possible.

Vera Lucia Luiza and Paula Pimenta, from the PAHO/WHO Collaborating Centre on Pharmaceutical Policies from the Sérgio Arouca National School of Public Health/Oswaldo Cruz Foundation (NAF/ENSP/Fiocruz), facilitated the training of data collectors and data entry personnel and provided technical support; Adriana Ivama, Medicines and Biological Sub-regional Advisor, CPC/ PAHO/WHO, provided technical support, reviewed and supported the publication of the report. Nelly Marin Jaramillo, Regional Advisor on Pharmaceutical Policy, PAHO/WHO, coordinated the process in the Americas and facilitated the support; Enrico Cinnella, technical officer from the Essential Medicines and Pharmaceutical Policies Department, WHO, reviewed the report. Tassia Williams, PAHO/WHO CPC form intern, did proof reading. Ms. Marilyn Entwistle, PAHO/WHO Jamaica, facilitated the final review of this report; their assistance is gratefully acknowledged.

Acknowledgement/disclaimer

This document has been produced with the financial assistance of the European Union and the technical support of the Pan American Health Organization/World Health Organization. The views expressed herein are those of the authors and can therefore in no way be taken to reflect the official opinion of the European Union (EU) or the Pan American Health Organizaton/World Health Organization (PAHO/WHO).

Conflict of interest statement

None of the authors of this survey or anyone who participated or collaborated in any phase of the planning, field work, analysis or interpretation of the results had any competing financial or other interests.

Abbreviations and acronyms

ACP	African, Caribbean and Pacific
ARI	Acute respiratory infection
bd	*Bis die* (Latin for "twice a day")
CIA	Central Intelligence Agency (of the United States of America)
CRDTL	Caribbean Regional Drug Test Laboratory
DHI	Development Human Index
DTCs	Drugs and Therapeutics Committees
EML	Essential Medicines List
EU	European Union
GDP	Gross domestic product
HCL	Health Corporation Limited
HFS	Health Facility Survey
IMCI	Integrated management of childhood illness
INN	International Non-proprietary Name
J$	Jamaican dollar
JADEP	Jamaica Drugs for the Elderly Program
mg	Milligrams
ml	Milliliter
MOH	Ministry of Health
NAF/ENSP/Fiocruz	Center for Pharmaceutical Policies/Sérgio Arouca National School of Public Health/Oswaldo Cruz Foundation (Núcleo de Assistência Farmacêutica/Escola Nacional de Saúde Pública Sérgio Arouca/ Fundação Oswaldo Cruz)
NGO	Non-governmental organizations
NHF	National Health Fund
NMP	National Medicines Policy

NPP	National Pharmaceutical Policy
ORS	Oral rehydration salts
PAHO	Pan American Health Organization
PIOJ	Planning Institute of Jamaica
RDU	Rational drug use
RHA	Regional Health Authority
RUM	Rational use of medicine
SES	Socioeconomic Status
SF	Survey Formulary
STATIN	Statistical Institute of Jamaica
STG	Standard Treatment Guidelines
STI	Sexually transmitted disease
tab	Tablet
td	Twice daily
UNDP	United Nation Development Program
UNICEF	United Nations Children's Fund
URTI	Upper respiratory tract infection
US$	United States dollar
UTECH	University of Technology
UWI	University of the West Indies
UTI	Urinary tract infection
VEN List	Vital, Essential and Necessary List
WHO	World Health Organization

Foreword

In consonance with Ministry of Health's mandate of "Ensuring the provision of quality health services and to promote healthy lifestyles and environmental practices," I am honoured to present the results of the Pharmaceutical Situation Assessment in Jamaica. The publication report was developed with the technical and financial support from the collaboration of the Pan-American Health Organization/World Health Organization (PAHO/WHO), through the EU/WHO ACP Project "Partnership on Pharmaceutical Policies" and The Centre for Pharmaceutical Policies of the Oswaldo Cruz Foundation in Brazil, PAHO/WHO Collaborating Centre on Pharmaceutical Policies.

The publication report reflects the efforts of the Ministry to provide to the Jamaican citizens medicines of ensured quality and safety and to promote their rational use. The gaps identified are an important resource to inform the development of the National Pharmaceutical Policy. Importantly, it will facilitate the efforts of the Ministry of Health, its Agencies and related organizations, to continue improving the quality of care across the island.

Hon. Dr. Fenton Ferguson
Minister of Health

Executive summary

Country background - Health and pharmaceutical sector

The island of Jamaica lies about 885 km south of Miami, 145 km south of Cuba and 161 km west of Haiti and is located almost at the centre of the Caribbean Sea. It is the largest of the English-speaking Commonwealth Caribbean Islands, and the third-largest island in the region covering an area of 10,999 km^2. The island is divided into three counties and subdivided into 14 parishes.

The population of Jamaica in the year 2006 was 2,673,816. The population growth rate was 0.5% and the total fertility rate was 2.5% and females represented 50.7% of the population. The crude birth rate was 17.04 per 1,000 of population. Infant mortality rate was 19.99 deaths per 1,000 live births. Life expectancy at birth was 73.12 years and 32.5% of the population was below the age of 15 years. The average population density was estimated at 660 per square miles and 48% of the population lived in the rural areas.

Healthcare in Jamaica is provided by the Ministry of Health (MOH), the private sector and other non-governmental organizations. The health system offers primary, secondary, and tertiary care services. Approximately 38% of the population utilizes the public sector for ambulatory care, 57% use the private sector, and 5% use both sectors. Private hospitals only handle about 5% of total hospital services. Public hospitals handle the most complicated and costly cases.

The Standards and Regulation Division of the Ministry of Health (MOH), administers the Food and Drug Act of 1964, and Regulations of 1975, and thus provides the authorization for manufacturing, importation, distribution and use of pharmaceuticals. The Division ensures that all substances used as food, drugs, and cosmetics are efficacious, safe and of high quality. **Jamaica does not have an officially adopted National Pharmaceutical Policy.** There is a draft for submission to Parliament.

(NB: A National Pharmaceuticals Policy is one that aims at ensuring that people get good quality drugs at the lowest possible price, and that doctors prescribe the minimum of required drugs in order to treat the patient's illness.)

The first national essential medicines list—Vital, Essential, and Necessary (VEN) List of medicines—developed to guide the procurement and rational use of pharmaceuticals was published in 1988. It has undergone several subsequent reviews, on an average biannual basis and the last review was in December 2008. This document embraces the concept of rational drug use and serves as a guide to doctors, nurses, pharmacists, and students of these disciplines in the public health sector. The VEN List assists the maintenance of rational prescribing practices in public facilities. The third edition of the National Drug Formulary was issued in 1997.

Health Corporation Limited (HCL), a quasi-private company established in 1994 to ensure the efficient, cost-effective procurement and distribution of pharmaceuticals and medical supplies, has met approximately 70% of the essential needs of the public sector. In 2010, the HCL was merged with the National Health Fund (NHF). The public expenditure on medicines (2006/07) was 680,094,000 Jamaican

dollars (J$) (US$ 7,654,406.30), representing J$ 254.35 (US$ 2.86) per capita. In 2007, there were 516 pharmacies [117 public (83 in operation), and 399 private], 9 private manufacturers and 23 medicines distributors (1 public and 22 private).

Study

The assessment of the pharmaceutical situation, Level II, was undertaken in Jamaica from July, 2009 to May, 2010 using a standardized methodology developed by the World Health Organization (WHO). The goal of the assessment was to evaluate the pharmaceutical situation in Jamaica using outcome indicators. More specifically, the study collected information on access, affordability and availability of key medicines and geographical accessibility of dispensing facilities and **rational use of quality medicines, as well as some data on the quality of medicines at health facilities and pharmacies.** All this information was then used to evaluate whether the goals set for the pharmaceutical sector are being achieved.

The study has two components, both indicators based: health facilities and households survey. In the first approach, data related to the pharmaceutical policy outcome was collected from public healthcare facilities, public and private pharmacies and the public warehouse that supply public facilities. In the second, data came from a survey conducted at household level.

Health facility survey

Methods

The survey was conducted in five areas: North Eastern Region, South East Region – A, South East Region – B, Southern Region and Western Region. In each survey area, 5 to 6 public health care facilities and 2 to 6 private pharmacies were surveyed. In the country 1 public warehouse was surveyed.

In each facility surveyed, a set of survey forms (Annex 2) was applied. The survey commenced following ethical approval from the Ministry of Health's Ethics Committee. Local health managers were contacted for specific local approval and cooperation. The country was divided into five survey areas with a team of workers for each one. Field teams comprised 19 data collectors each (pharmacy interns), selected according to the region to which they were assigned for rotation; and 5 supervisors (regional or senior pharmacists) who oversaw data collection and verified the quality of the data collected. Data collection methods included patient and health worker interviews after oral consent, check list guided observation and clinical and administrative documents review. Data collection took place between January 25 and March 19, 2010.

Data entry was performed using designed summary forms. Analysis was done using Excel® program.

Key results

Access

Overall access indicators show that key essential medicines are largely available in public health facilities (93.3%), warehouses that supply the public health system (100%) and private pharmacies (93.3%). The average length of stock-out duration in public health facilities was 23.1 days, whereas in the warehouse it was only 8.1 days, which indicate that this picture is not stable along time. Due to good availability, most prescribed medicines (76.7%) were found as dispensed in the cross sectional approach.

Concerning geographical accessibility, few of the patients interviewed at public dispensing facilities and private pharmacies have to travel more than one hour to reach the facility.

In treating common conditions [hypertension, diabetes, urinary tract infection (UTI), worm infestation] using standard regimens, the lowest paid government worker would need between 0.1 (diabetes) and 0.8 (hypertension)[1] days' wages to purchase lowest priced generic medicines from the private sector. In the private sector, once originator brands are chosen, costs are higher and the number of days' wages necessary to purchase treatment vary from 0.4 (worm infestation) to 5.2 (hypertension). In the public sector, the medicines are provided free of charge for all conditions chosen.

Data suggests that affordability of treatment for common primary health problems is a large problem when the medication is not available in the public facility, since the burden for the lowest paid public servant in terms of working days is high for common diseases like hypertension.

Quality and regulation

Ten percent of the public dispensaries had expired medicines. Storage conditions varied from 70% of adequacy in the storerooms of public health facilities to 90% of adequacy in warehouses supplying the public sector.

Most of the private pharmacies comply with the law that requires the presence of the pharmacist. On the other hand, only 65% of public dispensaries had a pharmacist present at the time of the visit. Though the profile of most of the health workers dispensing medicines was adequate, a minority of untrained staff was found in both private (11.5%) and public sector (10.3%) facilities. **Prescribing is mostly done by doctors, but few prescribers have been recently trained in rational use of medicines.**

Use of medicines

Antibiotics were prescribed to one in every three patients (33%), and injections to one in every 12 (8%). The use of International Non-proprietary Name (INN) in public health facilities was limited to only 41.9% of the prescription medicines. **Standard Treatment Guidelines (STG) was available in less than half of public healthcare facilities (46.4%). Not every public health facility had the VEN List, since it was only available in about 1 in each three facilities (35.7%).**

(NB: Standard Treatment Guidelines ensure consistency, and treatment efficacy for patients across demographic and geographic barriers.)

The selling of prescribed medicines without prescription does not seem to be a widespread practice. Most patients know how to take their medicines in the private pharmacies (90%), while in the public dispensaries that percentage is somewhat lower (73.3%).

[1] . Lowest daily government salary = J$ 642.86 = US$ 7.24 (US$ 1.00 = J$ 88.85).

Challenges and constraints

Most of the private pharmacies comply with the legal provisions set by the government, since pharmacists were found in most of them and the profile of health workers dispensing medicines was adequate. On the other hand, 35% of public dispensaries had no pharmacist at the time of the visit. **The doctor is the most frequent prescriber found; nevertheless, the use of INN in public health facilities was lower than 50% and few prescribers have been recently trained in rational use of medicines.**

In Jamaica, there is a high availability of medicines; nevertheless, the stock-out is still a problem to be faced. The storage conditions were, except in the warehouses, not adequate enough for the public health facilities and private pharmacies.

Although it is more likely to have a pharmacist dispensing in private pharmacies (96.2%) than in public pharmacies (65.5%), untrained staff are equally likely to be found in private pharmacies and public dispensaries (around one in ten dispensers in both cases).

The training of prescribers related to good prescribing practices, including the use of evidence, prescribing by the International Non-proprietary Name (INN) as well as the improvement of the availability and incentives for the use of the Standard Treatment Guideline (STG) and the Vital, Essential and Necessary (VEN) List are aspects that need to be considered as part of the rational use of medicines strategies.

The results of the survey showed high availability of medicines; however, affordability could be a concern for those citizens who would have to source their medication in private sector. The result also shows that managerial and economic policies concerning pharmaceuticals should be improved.

Household survey

Methods

The survey was conducted Jamaica in five survey areas: North-East, South East - A, South East - B, Southern and Western. Households were selected by intentional cluster sampling within defined distances from a reference public health care facility. The reference public health care facilities were selected among those participating in the Level II Facility Survey that was run in parallel. A total of 805 household respondents were interviewed by means of a structured questionnaire made up of 43 questions. Information about medicines kept at home, used during recent acute illness and prescribed for chronic diseases were collected. Data was also collected on behaviours of people confronted with acute or chronic conditions, their opinions about medicines, as well as on the demographic and socioeconomic situation of interviewed households. Data entry was performed with EpiData software and data analysis was conducted using Microsoft Excel®.

Key results

Characteristics of surveyed households

Respondents were selected to be the most knowledgeable persons about matters related to the health of household members. The majority of respondents were between 25 and 50 years old (6 in 10) had completed primary, secondary or high school (8 in 10). Around fifty percent of households spent up to J$ 26,000 (US$ 293) in total per household over 4 weeks.

About one third of households had incurred health expenditures over the past four weeks and around half of households reported at least one recent acute or one chronic condition. The most frequent symptoms of acute illness were related to cough, runny nose, sore throat or ear-ache. The most frequently reported chronic diseases were by far hypertension and diabetes.

Geographic access and availability of medicines

Overall, indicators of geographic access to medicines suggest that the majority of surveyed households live close to a public health care facility. Nevertheless, the majority of medicines, either found in households or obtained for an acute illness, came from a private pharmacy.

Nine in ten household respondents agreed that medicines are available at private pharmacies, while only one-third of household respondents agreed that medicines are at their public health care facility.

Affordability of medicines

Overall, indicators of affordability of medicines suggest that the price households pay for medicines in the private sector is an obstacle to accessing medicines, since 26% of people with chronic conditions reported not taking prescribed medicines because they could not afford the treatment. For acute conditions, the percentage of people not taking medicines because of financial reasons is 11%. For those who paid for medicines, the average cost of a prescription for acute illness was J$ 2,969 (US$ 33), with a maximum of J$ 100,000 (US$ 1,125). The average monthly cost of medicines for chronic diseases was J$ 1,900 (US$ 21), with a maximum of J$ 100,000 (US$ 1,125).

One quarter of people with acute health conditions reported having health insurance coverage for medicines. About half of the medicines used to treat chronic conditions were covered by health insurance.

Medicine use and medicines at home

About 69% of the households with children kept medicines at home. The average number of medicines found at home was 2.7. About three quarters of these medicines had an appropriate label, validity and a primary package in good condition, especially when obtained from private pharmacies.

Medicine use and acute illnesses

Almost 8 in 10 persons with an illness perceived to be very serious sought care and took prescribed medicines. The most common prescribers were doctors. The use of injections for acute illness was very low. The main reason given for not taking medicines was not following prescription.

Medicine use and chronic diseases

The number of people with chronic disease told to take medicines and who did not take them was 20%. The main reason given for not taking medicines was not following the prescription.

Opinions about quality of care and generics

Overall, half of respondents (52%) believed that the quality of services in their public health care facility was good and 41% of respondents did not know whether brand name medicines are better than generic medicines.

Challenges and constraints

Despite the high geographical accessibility and perception of availability of medicines in the public health facilities, as well as found in the HFS, the affordability with high private expenditure on medicines is a challenge to be faced, as 26% of people with chronic conditions and 11% of people with acute conditions reported not taking prescribed medicines because they could not afford the treatment.

The perception of households related to the quality of the service in the public services and the quality of generics needs to be improved. The same applies to the need for adherence to the treatment of chronic conditions.

Recommendations

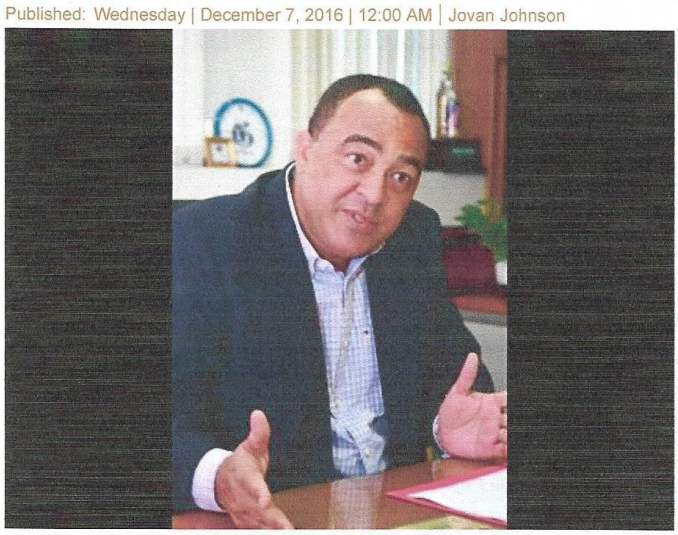
The development and official adoption of a National Pharmaceutical Policy is highly recommended to address the main challenges and constraints identified in the surveys. Affordability and price of medicines seems to be priority issues to be addressed. **Another priority area is the quality assurance of products and services in the medicines distribution at the central medical store and dispensing facilities such as pharmacies, with the development of Good Practices.**

Additionally, strategies for promoting the rational use of medicines, such as updating the VEN List based on the concept of Essential Medicines, the updating and strengthen of adherence to Therapeutic Formulary and STG as well as the promotion of Good Prescription Practices and the use of INN for prescribing and rational use of medicines for the public are very necessary.

(7) DECEMBER 2016 GLEANER ARTICLE: “Hospital Needs to Be More Accountable – Tufton”

Hospital Heads Need To Be More Accountable - Tufton

Published: Wednesday | December 7, 2016 | 12:00 AM | Jovan Johnson



Dr Christopher Tufton during an interview with The Gleaner. Patrick Planter

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By about March next year, the Government should have a better look at how it will be able to strengthen the management and accountability of health institutions such as hospitals under a 10-year plan for the health sector, Health Minister Dr Christopher Tufton has said.

Tufton complained in an interview with **The Gleaner** recently that the current structures, which were established through the National Health Services Act 1997, need to be reformed to ensure that those directly in charge of health institutions are more empowered to do their jobs while also being held more accountable.

The National Health Services Act, which established regional boards that oversee hospitals and other institutions, is among the things being reviewed to develop a 10-year strategic plan aimed at enhancing Jamaica's public-health system.

A report, Tufton said, should come before him by the first quarter of 2017.

"I'm hoping to have some sort of preliminary positions, early new year - the first quarter of next year - but we're not waiting on that to do some of the things that need to be done," he said.

The review will lead to the 10-year plan that was initiated last year. After mounting public pressure, the then administration released audits of public hospitals, which pointed to a widespread lack of basic supplies, usage of expired ones, and a general breakdown of controls and management in various institutions.

The public clamoured in vain for people to be held accountable for the failures.

PROCESS NEEDS RETHINKING

Tufton suggested that the current management structures could be shielding those with direct supervision over institutions.

"You have a regional structure that, oftentimes, is the ultimate authority to determine and oversee the functioning of the institutions, which is the hospitals and clinics. I would like us, with the experts, to rethink that process.

"We took the regional structure from the British. It was expected to be reviewed in three years. It has not been to date. The British have gone through several variations of their regional approach. In Canada, Toronto proper has three million people with one authority. We have three million people and we have four [regional authorities]," said Tufton.

According to the health minister, "To get greater value, [the answer] must be to and accountability to the institutional leadership.

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"Each hospital has a chief executive officer (CEO) and senior medical officer (SMO), and then under that, you have differing levels. To my mind, a CEO and SMO who are given the task to run a facility must understand their budget targets, performance target, and must be held accountable. There is a disconnect between management and authority," Tufton told **The Gleaner**.

He said the National Health Services Act does not give the permanent secretary the power to intervene in questionable situations. That, he said, has partly influenced how the Andrew Holness-led administration is approaching the situation.

"From this administration's perspective, we have said the institutions have to take more responsibility. When there's a an issue, if you notice under my watch, I don't jump to the front of the line to start justifying or explaining things. If there's an issue, the first point of contact must be the SMO and the CEO of that institution because, frankly, they are responsible for that institution and should be accountable."

The Inter-American Development Bank and the World Bank are helping with the work on the 10-year strategic plan.

jovan.johnson@gleanerjm.com

«Berthing demands as Jamaica attracts more cruise ships Evaluate 14-y-o rape victim urgently, urges child psychologist»

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Man Thing • 6 months ago

You are so right Minister the current structure is a waste of taxpayers money a eat a food mentality structure we the public needs more accountability, performance and management pay them more reasonable too we can't have growth with a defective health sector

1 ^ v • Share ›

Angelena • 6 months ago

Jesus Lord !!!!
I knew it would come to this. When they can't fulfill and manage their portfolio, they throw it on the poor, underpaid, overworked staff.

Especially this one, always taking up what he can't manage.

^ v • Share ›

Barb Walt • 6 months ago

That is so right. These in charge people must get daily reports of what a gwaan in the the institution, good or bad so that things can get fixed before it reach the crisis mode. A very BIG problem is the pacenter of which staff work. People in outpatient wait all day for the very minimal service. They need to communicate with the pharmacy to know if the drug they order is available before they send the patient to the pharmacy to wait half the day only to be told the drug not available and to come back tomorrow. That has happened to my poor weak uncle several times. He have to find taxi money each time. These heads of the institution must make impromptu rounds to get a grip on how the people suffa fi get some treatment. I have multiple examples. It have to get better Sir Minister!!!!!

^ v • Share ›

hypersan • 6 months ago

Brilliant

^ v • Share ›

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(8) CODE OF PROFESSIONAL ETHICS FOR PHYSICIANS AS LAID OUT BY THE MEDICAL ASSOCIATION OF JAMAICA

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Headline

Code of Professional Ethics for Physicians

Code of Professional Ethics for Physicians

The medical practioner has responsibilities to: the patient, the society, other health professionals as well as to him/herself.

The concerns most often highlighted are: the patient and physician relationship, the conduct and practice of the physician, conflicts of interest, professional relations and societal responsibilities.

All codes of conduct are built on ethical foundations. In this case:

1. Patient-physician Relationship

a. Beneficence . . . the welfare of the patient is central.
b. Non-malfeasance – "primum non nocerce" (first do not harm).
c. Autonomy – respect for right of patients to make choices.
d. Justice – avoidance of discrimination on the basis of rule, colour, religion or national origin.

2. Physicians' Conduct and Practice

a. Veracity. Always tell the truth. Do not ever represent yourself in any communications that could be considered untruthful, misleading or deceptive.
b. Maintain medical competence
i. Study ii. Application iii. Enhance skill
c. Behaviour must not diminish capability to practice optimally. Questionable conduct or unethical behaviour will be investigated.

3. Conflicts of Interest require public disclosure

Our most important role is that of patient advocates. Physicians are obligated to recognize conflicts of interest and deal with them through public disclosures.

The patient interest is paramount. Autonomy of patient is fundamental.

If not resolved, withdraw from patient care. Do no commercial promotion of medical products and services that will generate bias, create or appear to create undue influence. All treatment offered must be based solely on medical considerations and patients' needs.

Ethics

Gifts of substantial value from health care companies demand disclosure.

4. Professional Relationship
Respect and cooperate with:
· Other physicians
· Nurses
· Other Health Care Professionals

Patients must be aware of the financial requirements of their care before treatment.

Other healthcare professionals must reflect fairness, honesty, integrity, mutual respect and concerns for patients.

To provide the best care for the patient, consult, refer and cooperate with others as

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necessary.

It is incumbent on you to report to the appropriate authority, unethical or illegal behaviour by impaired physicians.

5. Societal Responsibilities
All physicians are required to uphold the dignity and honour of the profession. They must contribute to:
· Societal enhancement
· The support for and participation in all public concerns for the advancement of the human family.
· Ensure the respect for the laws that govern society.

6. Patient-Physician Relationship
· The central focus of all ethical concerns.
· The welfare of the patient IS the basis of all medical judgements.
· As patient advocate, physicians must exercise all reasonable means to ensure appropriate care.
· Relationships are built on: trust, confidentiality, honesty.
· The physician may only refuse to give care if there is no physician/patient relationship, except in emergencies.

· Either patient or physician is free to discontinue relationship but physician should first establish alternate continuing care.

7. Sexual misconduct is an abuse of professional power and a violation of patient trust.
8. A romantic relationship between physician and patient is unethical.
9. Informed consent
a) Obligation to informed consent includes knowledge that Terms are understandable.

Pertinent medical facts and recommendations must be consistent with good medical care.

b) Alternate modes to be presented.
c) Objectives, risks, benefits, possible complications and anticipated results are to be discussed

It is unethical to prescribe, provide or seek compensation FOR THERAPIES OF NO BENEFIT TO THE PATIENT.

10. Always respect the rights of patients and colleagues.
11. Patient confidences: the patient must give consent for the information to be divulged.

PHYSICIAN CONDUCT & PRACTICE

1. All medics must recognize the boundaries of their expertise and provide only those for which they are qualified by education, training and experience.

2. Participate in continuing medical education to enhance knowledge and competence.

3. Protect patient welfare in new emerging therapies.

4. Never publicize or represent yourself in an untruthful, misleading or deceptive manner to patients, public or other health care professionals.

5. The HIV Positive physician should inform all patients.

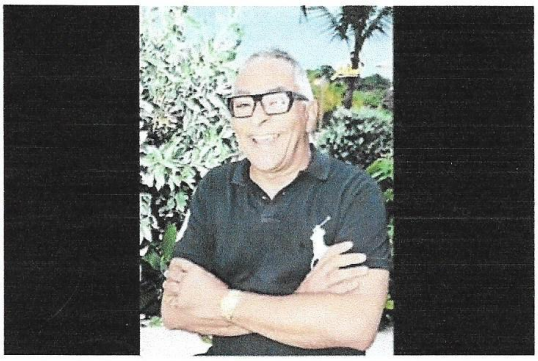
6. The impaired physician, with alcohol, drugs, mental, emotional or physical disability, should not practice medicine until the impairment no longer affects the quality of patient care.

Be guided by the "golden rule". Pay attention to standards, objectivity, competence and the science of medicine.

(9) OCTOBER 2016 JAMAICA OBSERVER ARTICLE:
“Dr. On Fraud Charges Freed”

Doctor on fraud charges freed

Friday, October 07, 2016 9 Comments



KINGSTON, Jamaica – Director of Medical Associates hospital in St Andrew Dr Michael Banbury was today freed of fraud charges in the Kingston and St Andrew Parish Court after the prosecution entered a nolle prosequi.

Prosecutor Taneshia Evans Bibbon told Senior Parish Judge Judith Pusey that the Director of Public Prosecution has ruled that the matter should be adjourned at this time as the Crown is unable to sustain the case against the doctor.

Nonetheless, Evans Bobbin indicated that further investigation will be carried out to substantiate the Crown's case, raising the possibility that it is brought back to court.

The 60-year-old doctor was arrested and charged in February with forgery, uttering forged document and conspiracy to defraud.

It is alleged that a forged shares transfer instrument was used to transfer a little over 404,000 shares from a company called Community Medical Service to the hospital.

Tanesha Mundle

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Free Jamaica • 8 months ago
Why was the case brought to the courts if there was a nolle prosequi. Surely they would know that in the first place.
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Original Foxylady ↗ Free Jamaica • 8 months ago
Plz read the article again, nolle prosequi simply means the CT is not prosecuting the man AT THIS TIME - he can be brought back in CT on same charges.
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Jas • 8 months ago
Right colour Wrong Country!
2 • Reply • Share ›

Jangas ↗ Jas • 8 months ago
What yu saying? 'Brown-man' get away easy in Jamaica? Wouldn't doubt that one bit.
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Robert Foster • 8 months ago
Wow! It's simply a matter of comparing signatures on the transfer document with those of the original shareholders. Was it signed by the original shareholders or NOT? ...Whats so difficult about that?
2 • Reply • Share ›

Dhc • 8 months ago
Put the man on front page news and charge him for fraud. Then can't prove it. The police and prosecution should be sued. But is normal behavior for them
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Derrick Hennie • 8 months ago
The prosecution must do their homework, before submitting a case, or face a possibility of a countersunk of massive proportion, wrongful arrest, defamation of character, slander, emotional distress, depression and more.
I await the next move, by whomever.
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Duke Prepre • 8 months ago
So, prosecutor Baboon does mot have a case.
1 • Reply • Share ›

Jangas • 8 months ago
Seems that the only cases that can be tied-down and slam-dunked, are ones involving J$100 slices of cheese. Anything bigger than that, and prosecutors 'tun-fool'😉. Jamaica is a trip😄!
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(10) BACKGROUND ON SPHERE OF INFLUENCE OF PSYCHIATRIST DR. JACQUELINE MARTIN

Background on Sphere of Influence on Psychiatrist, Dr. Jacqueline Martin

Dr. Jacqueline Simone Martin is a consultant psychiatrist at the University of the West Indies. She claims to also be a head administrator for Ward 21. She lectures in the Faculty of Medical Sciences at the University of the West Indies and also sits on the Board of Directors of Medical Associates Hospital.

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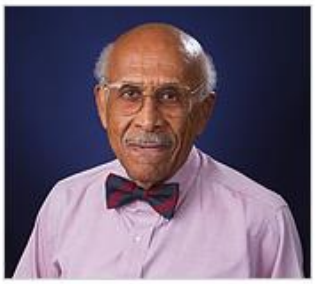

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(11) SUMMARY OF ONTARIO LEGISLATION, RIGHTS AND ORGANIZATIONS THAT WOULD SAFEGUARD AND PROTECT CLAIMANT, ROXANNE STEWART, FROM SIMILAR HUMAN RIGHTS VIOLATIONS EXPERIENCED IN JAMAICA

Summary of Ontario Legislation, Rights and Organizations that would Safeguard and Protect Claimant Roxanne Stewart from Similar Human Rights Violations Experienced in Jamaica

1) According to the Health Care Consent Act of Ontario:

Capacity

4. (1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1996, c. 2, Sched. A, s. 4 (1).

Wishes

5. (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1).

CONSENT TO TREATMENT

No treatment without consent

10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

- **(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or**
- **(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).**

Elements of consent

11. (1) The following are the elements required for consent to treatment:

1. **The consent must relate to the treatment.**
2. **The consent must be informed.**
3. **The consent must be given voluntarily.**
4. **The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).**

Informed consent

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) the person received responses to his or her requests for additional information about those matters. 1996, c. 2, Sched. A, s. 11 (2).

Treatment must not begin

18. (1) This section applies if,

(a) a health practitioner proposes a treatment for a person and finds that the person is incapable with respect to the treatment;

(b) before the treatment is begun, the health practitioner is informed that the person intends to apply, or has applied, to the Board for a review of the finding; and

(c) the application to the Board is not prohibited by subsection 32 (2). 1996, c. 2, Sched. A, s. 18 (1).

---

2) According to the Mental Health Act of Ontario:

Effect of Act on rights and privileges

6. Nothing in this Act shall be deemed to affect the rights or privileges of any person except as specifically set out in this Act. R.S.O. 1990, c. M.7, s. 6.

Conditions for involuntary admission

(1.1) The attending physician shall complete a certificate of involuntary admission, a certificate of renewal or a certificate of continuation if, after examining the patient, he or she is of the opinion that the patient,

(a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person;

(b) has shown clinical improvement as a result of the treatment;

(c) is suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment;

(e) has been found incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained; and

(f) is not suitable for admission or continuation as an informal or voluntary patient. 2000, c. 9, s. 7 (2); 2015, c. 36, s. 1.

Conditions for involuntary admission

(5) The attending physician shall complete a certificate of involuntary admission, a certificate of renewal or a certificate of continuation if, after examining the patient, he or she is of the opinion both,

(a) that the patient is suffering from mental disorder of a nature or quality that likely will result in,

(i) serious bodily harm to the patient,

(ii) serious bodily harm to another person, or

(iii) serious physical impairment of the patient,

unless the patient remains in the custody of a psychiatric facility; and

(b) that the patient is not suitable for admission or continuation as an informal or voluntary patient. R.S.O. 1990, c. M.7, s. 20 (5); 2000, c. 9, s. 7 (3, 4); 2015, c. 36, s. 1.

---

3) According to The Centre for Addiction and Mental Health Bill of Client Rights:

The Bill of Client Rights has been developed to assert and promote the dignity and worth of all of the people who use the services of the Centre for Addiction and Mental Health (CAMH). The Bill of Client Rights expresses the truth that clients are first and foremost human beings with the same rights as every Canadian.

Every client has the right to be provided with a written copy of, and assistance in understanding the Bill of Client Rights, and to have it posted at CAMH's main entrances and wherever clients receive services.

Right #1

Right to be Treated with Respect Every client:

1) is a person first, and has the right to be treated with respect.

2) has the right to be treated in a respectful manner, regardless of her/his race, culture, colour, religion, sex, age, mental or physical disability, class/economic position, sexual orientation, gender identity, diagnosis, inpatient status, or legal status.
3) has the right to have her/his privacy respected.

4) has the right to respect of her/his needs, wishes, values, beliefs and experience.

Right #2

Right to Freedom from Harm

Every client:
1) has the right not to be coerced or detained except where permitted by law.

2) has the right to be free from locked seclusion, environmental, chemical and mechanical restraint except where permitted by law. (i.e. when a client is a danger to self or others). Only the minimum necessary amount of restraint or locked seclusion is allowed and only after alternative methods of

resolution have been unsuccessful. Clients have the right to be informed of how they can be released from restraints or seclusion.

Right #3

Right to Dignity and Independence
Every client:

1) has the right to have services provided in a manner that respects the dignity, independence and self-determination of the individual.
2) has the right to confidentiality about personal information and records in accordance with the law.

Right #4

Right to Quality Services that Comply with Standards

Every client:

1) has the right to have services provided in a manner that complies with legal, professional, ethical, and other relevant standards.
2) has the right to a choice of services, and will not be denied other options if the client does not choose one treatment or service.
3) has a right to choose the least restrictive care.

4) has the right to have services provided in a manner that minimizes potential harm, and optimizes quality of life.

has the right to seek an additional medical opinion.

Right #6

Right to be Fully Informed

Every client:

1) has the right to be informed of her/his rights in this Bill of Client Rights

Right #7

Right to Make an Informed Choice, and Give Informed Consent to Treatment

1) No treatment shall be given without the client's informed consent, except in accordance with the law.

2) Consent must be for that particular treatment or plan of treatment.

3) Consent can be withdrawn at any time.

4) Every client is presumed to have decision-making capacity unless found to be incapable.

5) Consent must be voluntary and not obtained by coercion or misrepresentation.

Every client:

6) has the right to have her/his prior capable wishes respected to the fullest extent that the law allows.

7) has the right to be fully involved in treatment decisions (including location, duration and type of treatment).

Right #10

Right to Complain Every client:

1) has the right to make a complaint, access advocacy and to make suggestions and inquiries.

2) has the right to inform the Empowerment Council or Family Council of her/his complaint(s), in order to seek changes in the system.

Organizations:

1) The CAMH Empowerment Council:

The Empowerment Council is a voice for clients/survivors and ex-clients of mental health and addiction services, primarily of CAMH.

2) The Canadian Mental Health Association:

The Canadian Mental Health Association promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness.

3) The Mental Health Rights Coalition:

The Mental Health Rights Coalition of Hamilton is a non-profit organization funded by Ontario's Ministry of Health and Long Term Care as a Consumer/Survivor Initiative.

The Mental Health Rights Coalition advocates for its members through speaking up at various committees, attempting to create change through the system. This is different from individual advocacy in that we do not take on individual complaints; we use collective complaints as a catalyst for change.

(12) ONTARIO HEALTH CARE CONSENT ACT

Français

Health Care Consent Act, 1996

S.O. 1996, CHAPTER 2
Schedule A

Consolidation Period: From January 1, 2017 to the e-Laws currency date.

Last amendment: 2016, c. 23, s. 51.

Legislative History: 1998, c. 26, s. 104; 2000, c. 9, s. 31-48; 2002, c. 18, Sched. A, s. 10; 2004, c. 3, Sched. A, s. 84; 2006, c. 19, Sched. L, s. 2; 2006, c. 21, Sched. C, s. 111; 2006, c. 26, s. 14; 2006, c. 34, s. 34; 2006, c. 35, Sched. C, s. 52; 2007, c. 8, s. 207; 2007, c. 10, Sched. O, s. 13; 2007, c. 10, Sched. P, s. 15; 2007, c. 10, Sched. Q, s. 13; 2007, c. 10, Sched. R, s. 14; 2009, c. 26, s. 10; 2009, c. 33, Sched. 18, s. 10; 2010, c. 1, Sched. 9; 2015, c. 36, s. 17; 2016, c. 23, s. 51.

CONTENTS

PART I
GENERAL

Purposes

1. The purposes of this Act are,

(a) to provide rules with respect to consent to treatment that apply consistently in all settings;

(b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;

(c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,

(i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,

(ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and

(iii) requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;

(d) to promote communication and understanding between health practitioners and their patients or clients;

(e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service; and

(f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services. 1996, c. 2, Sched. A, s. 1.

Interpretation

2. (1) In this Act,

"attorney for personal care" means an attorney under a power of attorney for personal care given under the *Substitute Decisions Act, 1992*; ("procureur au soin de la personne")

"Board" means the Consent and Capacity Board; ("Commission")

"capable" means mentally capable, and "capacity" has a corresponding meaning; ("capable", "capacité")

"care facility" means,

(a) a long-term care home as defined in the *Long-Term Care Homes Act, 2007*, or

(b) a facility prescribed by the regulations as a care facility; ("établissement de soins")

"community treatment plan" has the same meaning as in the *Mental Health Act*; ("plan de traitement en milieu communautaire")

"course of treatment" means a series or sequence of similar treatments administered to a person over a period of time for a particular health problem; ("série de traitements")

"evaluator" means, in the circumstances prescribed by the regulations,

(a) a member of the College of Audiologists and Speech-Language Pathologists of Ontario,

(b) a member of the College of Dietitians of Ontario,

(c) a member of the College of Nurses of Ontario,

(d) a member of the College of Occupational Therapists of Ontario,

(e) a member of the College of Physicians and Surgeons of Ontario,

(f) a member of the College of Physiotherapists of Ontario,

(g) a member of the College of Psychologists of Ontario, or

(h) a member of a category of persons prescribed by the regulations as evaluators; ("appréciateur")

"guardian of the person" means a guardian of the person appointed under the *Substitute Decisions Act, 1992*; ("tuteur à la personne")

"health practitioner" means a member of a College under the *Regulated Health Professions Act, 1991* or a member of a category of persons prescribed by the regulations as health practitioners; ("praticien de la santé")

"hospital" means a private hospital as defined in the *Private Hospitals Act* or a hospital as defined in the *Public Hospitals Act*; ("hôpital")

"incapable" means mentally incapable, and "incapacity" has a corresponding meaning; ("incapable", "incapacité")

"mental disorder" has the same meaning as in the *Mental Health Act*; ("trouble mental")

"personal assistance service" means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person, but does not include anything prescribed by the regulations as not constituting a personal assistance service; ("service d'aide personnelle")

"plan of treatment" means a plan that,

(a) is developed by one or more health practitioners,

(b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and

(c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition; ("plan de traitement")

"psychiatric facility" has the same meaning as in the *Mental Health Act*; ("établissement psychiatrique")

"recipient" means a person who is to be provided with one or more personal assistance services,

(a) in a long-term care home as defined in the *Long-Term Care Homes Act, 2007*,

(b) in a place prescribed by the regulations in the circumstances prescribed by the regulations,

(c) under a program prescribed by the regulations in the circumstances prescribed by the regulations, or

(d) by a provider prescribed by the regulations in the circumstances prescribed by the regulations; ("bénéficiaire")

"regulations" means the regulations made under this Act; ("règlements")

"treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,

(a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,

(b) the assessment or examination of a person to determine the general nature of the person's condition,

(c) the taking of a person's health history,

(d) the communication of an assessment or diagnosis,

(e) the admission of a person to a hospital or other facility,

(f) a personal assistance service,

(g) a treatment that in the circumstances poses little or no risk of harm to the person,

(h) anything prescribed by the regulations as not constituting treatment. ("traitement") 1996, c. 2, Sched. A, s. 2 (1); 2000, c. 9, s. 31; 2007, c. 8, s. 207 (1); 2009, c. 26, ss. 10 (1, 2); 2009, c. 33, Sched. 18, s. 10 (1).

Refusal of consent

(2) A reference in this Act to refusal of consent includes withdrawal of consent. 1996, c. 2, Sched. A, s. 2 (2).

Section Amendments with date in force (d/m/y)

2000, c. 9, s. 31 - 1/12/2000

2007, c. 8, s. 207 (1) - 1/07/2010; 2007, c. 10, Sched. O, s. 13 - no effect - see 2009, c. 26, s. 10 (1) - 15/12/2009; 2007, c. 10, Sched. P, s. 15 - no effect - see 2009, c. 26, s. 10 (1) - 15/12/2009; 2007, c. 10, Sched. Q, s. 13 - no effect - see 2009, c. 26, s. 10 (1) - 15/12/2009; 2007, c. 10, Sched. R, s. 14 - no effect - see 2009, c. 26, s. 10 (1) - 15/12/2009

2009, c. 26, s. 10 (1) - 15/12/2009; 2009, c. 26, s. 10 (2) - 1/07/2015; 2009, c. 33, Sched. 18, s. 10 (1) - 15/12/2009

Meaning of "excluded act"

3. (1) In this section,

"excluded act" means,

(a) anything described in clause (b) or (g) of the definition of "treatment" in subsection 2 (1), or

(b) anything described in clause (h) of the definition of "treatment" in subsection 2 (1) and prescribed by the regulations as an excluded act. 1996, c. 2, Sched. A, s. 3 (1).

Excluded act considered treatment

(2) If a health practitioner decides to proceed as if an excluded act were a treatment for the purpose of this Act, this Act and the regulations apply as if the excluded act were a treatment within the meaning of this Act. 1996, c. 2, Sched. A, s. 3 (2).

Capacity

4. (1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1996, c. 2, Sched. A, s. 4 (1).

Presumption of capacity

(2) A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services. 1996, c. 2, Sched. A, s. 4 (2).

Exception

(3) A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be. 1996, c. 2, Sched. A, s. 4 (3).

Wishes

5. (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1).

Manner of expression

(2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner. 1996, c. 2, Sched. A, s. 5 (2).

Later wishes prevail

(3) Later wishes expressed while capable prevail over earlier wishes. 1996, c. 2, Sched. A, s. 5 (3).

Research, sterilization, transplants

6. This Act does not affect the law relating to giving or refusing consent on another person's behalf to any of the following procedures:

1. A procedure whose primary purpose is research.
2. Sterilization that is not medically necessary for the protection of the person's health.
3. The removal of regenerative or non-regenerative tissue for implantation in another person's body. 1996, c. 2, Sched. A, s. 6.

Restraint, confinement

7. This Act does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others. 1996, c. 2, Sched. A, s. 7.

PART II
TREATMENT

GENERAL

Application of Part

8. (1) Subject to section 3, this Part applies to treatment. 1996, c. 2, Sched. A, s. 8 (1).

Law not affected

(2) Subject to section 3, this Part does not affect the law relating to giving or refusing consent to anything not included in the definition of "treatment" in subsection 2 (1). 1996, c. 2, Sched. A, s. 8 (2).

Meaning of "substitute decision-maker"

9. In this Part,

"substitute decision-maker" means a person who is authorized under section 20 to give or refuse consent to a treatment on behalf of a person who is incapable with respect to the treatment. 1996, c. 2, Sched. A, s. 9.

CONSENT TO TREATMENT

No treatment without consent

10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent

on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

Opinion of Board or court governs

(2) If the health practitioner is of the opinion that the person is incapable with respect to the treatment, but the person is found to be capable with respect to the treatment by the Board on an application for review of the health practitioner's finding, or by a court on an appeal of the Board's decision, the health practitioner shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless the person has given consent. 1996, c. 2, Sched. A, s. 10 (2).

Elements of consent

11. (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.

2. The consent must be informed.

3. The consent must be given voluntarily.

4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

Informed consent

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) the person received responses to his or her requests for additional information about those matters. 1996, c. 2, Sched. A, s. 11 (2).

Same

(3) The matters referred to in subsection (2) are:

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment. 1996, c. 2, Sched. A, s. 11 (3).

Express or implied

(4) Consent to treatment may be express or implied. 1996, c. 2, Sched. A, s. 11 (4).

Included consent

12. Unless it is not reasonable to do so in the circumstances, a health practitioner is entitled to presume that consent to a treatment includes,

(a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and

(b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered. 1996, c. 2, Sched. A, s. 12.

Plan of treatment

13. If a plan of treatment is to be proposed for a person, one health practitioner may, on behalf of all the health practitioners involved in the plan of treatment,

(a) propose the plan of treatment;

(b) determine the person's capacity with respect to the treatments referred to in the plan of treatment; and

(c) obtain a consent or refusal of consent in accordance with this Act,

(i) from the person, concerning the treatments with respect to which the person is found to be capable, and

(ii) from the person's substitute decision-maker, concerning the treatments with respect to which the person is found to be incapable. 1996, c. 2, Sched. A, s. 13.

Withdrawal of consent

14. A consent that has been given by or on behalf of the person for whom the treatment was proposed may be withdrawn at any time,

(a) by the person, if the person is capable with respect to the treatment at the time of the withdrawal;

(b) by the person's substitute decision-maker, if the person is incapable with respect to the treatment at the time of the withdrawal. 1996, c. 2, Sched. A, s. 14.

CAPACITY

Capacity depends on treatment

15. (1) A person may be incapable with respect to some treatments and capable with respect to others. 1996, c. 2, Sched. A, s. 15 (1).

Capacity depends on time

(2) A person may be incapable with respect to a treatment at one time and capable at another. 1996, c. 2, Sched. A, s. 15 (2).

Return of capacity

16. If, after consent to a treatment is given or refused on a person's behalf in accordance with this Act, the person becomes capable with respect to the treatment in the opinion of the health practitioner, the person's own decision to give or refuse consent to the treatment governs. 1996, c. 2, Sched. A, s. 16.

Information

17. A health practitioner shall, in the circumstances and manner specified in guidelines established by the governing body of the health practitioner's profession, provide to persons found by the health practitioner to be incapable with respect to treatment such information about the consequences of the findings as is specified in the guidelines. 1996, c. 2, Sched. A, s. 17.

Treatment must not begin

18. (1) This section applies if,

(a) a health practitioner proposes a treatment for a person and finds that the person is incapable with respect to the treatment;

(b) before the treatment is begun, the health practitioner is informed that the person intends to apply, or has applied, to the Board for a review of the finding; and

(c) the application to the Board is not prohibited by subsection 32 (2). 1996, c. 2, Sched. A, s. 18 (1).

Same

(2) This section also applies if,

(a) a health practitioner proposes a treatment for a person and finds that the person is incapable with respect to the treatment;

(b) before the treatment is begun, the health practitioner is informed that,

(i) the incapable person intends to apply, or has applied, to the Board for appointment of a representative to give or refuse consent to the treatment on his or her behalf, or

(ii) another person intends to apply, or has applied, to the Board to be appointed as the representative of the incapable person to give or refuse consent to the treatment on his or her behalf; and

(c) the application to the Board is not prohibited by subsection 33 (3). 1996, c. 2, Sched. A, s. 18 (2).

Same

(3) In the circumstances described in subsections (1) and (2), the health practitioner shall not begin the treatment, and shall take reasonable steps to ensure that the treatment is not begun,

(a) until 48 hours have elapsed since the health practitioner was first informed of the intended application to the Board without an application being made;

(b) until the application to the Board has been withdrawn;

(c) until the Board has rendered a decision in the matter, if none of the parties to the application before the Board has informed the health practitioner that he or she intends to appeal the Board's decision; or

(d) if a party to the application before the Board has informed the health practitioner that he or she intends to appeal the Board's decision,

(i) until the period for commencing the appeal has elapsed without an appeal being commenced, or

(ii) until the appeal of the Board's decision has been finally disposed of. 1996, c. 2, Sched. A, s. 18 (3).

Emergency

(4) This section does not apply if the health practitioner is of the opinion that there is an emergency within the meaning of subsection 25 (1). 1996, c. 2, Sched. A, s. 18 (4).

Order authorizing treatment pending appeal

19. (1) If an appeal is taken from a Board or court decision that has the effect of authorizing a person to consent to a treatment, the treatment may be administered before the final disposition of the appeal, despite section 18, if the court to which the appeal is taken so orders and the consent is given. 1996, c. 2, Sched. A, s. 19 (1).

Criteria for order

(2) The court may make the order if it is satisfied,

(a) that,

(i) the treatment will or is likely to improve substantially the condition of the person to whom it is to be administered, and the person's condition will not or is not likely to improve without the treatment, or

(13) ONTARIO MENTAL HEALTH ACT

Français

Mental Health Act

R.S.O. 1990, CHAPTER M.7

Consolidation Period: From December 21, 2015 to the e-Laws currency date.

Last amendment: 2015, c. 36, s. 1-16.

CONTENTS

Definitions

1. (1) In this Act,

"attending physician" means a physician to whom responsibility for the observation, care and treatment of a patient has been assigned; ("médecin traitant")

"Board" means the Consent and Capacity Board continued under the *Health Care Consent Act, 1996*; ("Commission")

"community treatment plan" means a plan described in section 33.7 that is a required part of a community treatment order; ("plan de traitement en milieu communautaire")

"Deputy Minister" means the deputy minister of the Minister; ("sous-ministre")

"health practitioner" has the same meaning as in the *Health Care Consent Act, 1996*; ("praticien de la santé")

"informal patient" means a person who is a patient in a psychiatric facility, having been admitted with the consent of another person under section 24 of the *Health Care Consent Act, 1996*; ("malade en cure facultative")

"involuntary patient" means a person who is detained in a psychiatric facility under a certificate of involuntary admission, a certificate of renewal or a certificate of continuation; ("malade en cure obligatoire")

"local board of health" has the same meaning as board of health in the *Health Protection and Promotion Act*; ("conseil local de santé")

"medical officer of health" has the same meaning as in the *Health Protection and Promotion Act*; ("médecin-hygiéniste")

"mental disorder" means any disease or disability of the mind; ("trouble mental")

"Minister" means the Minister of Health and Long-Term Care or such other member of the Executive Council as the Lieutenant Governor in Council designates; ("ministre")

"Ministry" means the Ministry of the Minister; ("ministère")

"officer in charge" means the officer who is responsible for the administration and management of a psychiatric facility; ("dirigeant responsable")

"out-patient" means a person who is registered in a psychiatric facility for observation or treatment or both, but who is not admitted as a patient and is not the subject of an application for assessment; ("malade externe")

"patient" means a person who is under observation, care and treatment in a psychiatric facility; ("malade")

"personal health information" has the same meaning as in the *Personal Health Information Protection Act, 2004*; ("renseignements personnels sur la santé")

"physician" means a legally qualified medical practitioner and, when referring to a community treatment order, means a legally qualified medical practitioner who meets the qualifications prescribed in the regulations for the issuing or renewing of a community treatment order; ("médecin")

"plan of treatment" has the same meaning as in the *Health Care Consent Act, 1996*; ("plan de traitement")

"prescribed" means prescribed by the regulations; ("prescrit")

"psychiatric facility" means a facility for the observation, care and treatment of persons suffering from mental disorder, and designated as such by the Minister; ("établissement psychiatrique")

"psychiatrist" means a physician who holds a specialist's certificate in psychiatry issued by The Royal College of Physicians and Surgeons of Canada or equivalent qualification acceptable to the Minister; ("psychiatre")

"record of personal health information", in relation to a person, means a record of personal health information that is compiled in a psychiatric facility in respect of the person; ("dossier de renseignements personnels sur la santé")

"registered nurse in the extended class" means a registered nurse who holds an extended certificate of registration under the *Nursing Act, 1991*; ("infirmière autorisée ou infirmier autorisé de la catégorie supérieure")

"regulations" means the regulations made under this Act; ("règlements")

"restrain" means place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient; ("maîtriser")

"rights adviser" means a person, or a member of a category of persons, qualified to perform the functions of a rights adviser under this Act and designated by a psychiatric facility, the Minister or by the regulations to perform those functions, but does not include,

(a) a person involved in the direct clinical care of the person to whom the rights advice is to be given, or

(b) a person providing treatment or care and supervision under a community treatment plan; ("conseiller en matière de droits")

"senior physician" means the physician responsible for the clinical services in a psychiatric facility; ("médecin-chef")

"substitute decision-maker", in relation to a patient, means the person who would be authorized under the *Health Care Consent Act, 1996* to give or refuse consent to a treatment on behalf of the patient, if the patient were incapable with respect to the treatment under that Act, unless the context requires otherwise; ("mandataire spécial")

"treatment" has the same meaning as in the *Health Care Consent Act, 1996*. ("traitement") R.S.O. 1990, c. M.7, s. 1; 1992, c. 32, s. 20 (1-4); 1996, c. 2, s. 72 (1, 2, 4, 5); 2000, c. 9, s. 1; 2004, c. 3, Sched. A, s. 90 (1-3); 2015, c. 36, s. 2.

Meaning of "explain"

(2) A rights adviser or other person whom this Act requires to explain a matter satisfies that requirement by explaining the matter to the best of his or her ability and in a manner that addresses the special needs of the person receiving the explanation, whether that person understands it or not. 1992, c. 32, s. 20 (5).

2. REPEALED: 1992, c. 32, s. 20 (7).

3. REPEALED: 1992, c. 32, s. 20 (7).

4. REPEALED: 1992, c. 32, s. 20 (7).

5. REPEALED: 1992, c. 32, s. 20 (7).

Effect of Act on rights and privileges

6. Nothing in this Act shall be deemed to affect the rights or privileges of any person except as specifically set out in this Act. R.S.O. 1990, c. M.7, s. 6.

PART I
STANDARDS

Application of Act

7. This Act applies to every psychiatric facility. R.S.O. 1990, c. M.7, s. 7.

Conflict

8. Every psychiatric facility has power to carry on its undertaking as authorized by any Act, but, where the provisions of any Act conflict with the provisions of this Act or the regulations, the provisions of this Act and the regulations prevail. R.S.O. 1990, c. M.7, s. 8.

Advisory officers

9. (1) The Minister may designate officers of the Ministry or appoint persons who shall advise and assist medical officers of health, local boards of health, hospitals and other bodies and persons in all matters pertaining to mental health and who shall have such other duties as are assigned to them by this Act or the regulations.

Powers

(2) Any such officer or person may at any time, and shall be permitted so to do by the authorities thereat, visit and inspect any psychiatric facility, and in so doing may interview patients, examine books, records and other documents relating to patients, examine the condition of the psychiatric facility and its equipment, and inquire into the adequacy of its staff, the range of services provided and any other matter he or she considers relevant to the maintenance of standards of patient care. R.S.O. 1990, c. M.7, s. 9.

Provincial aid

10. The Minister may pay psychiatric facilities provincial aid in such manner, in such amounts and on such conditions as he or she considers appropriate. 1997, c. 15, s. 11 (1).

PART II
HOSPITALIZATION

Where admission may be refused

11. Despite this or any other Act, admission to a psychiatric facility may be refused where the immediate needs in the case of the proposed patient are such that hospitalization is not urgent or necessary. R.S.O. 1990, c. M.7, s. 11.

Admission of informal or voluntary patients

12. Any person who is believed to be in need of the observation, care and treatment provided in a psychiatric facility may be admitted thereto as an informal or voluntary patient upon the recommendation of a physician. R.S.O. 1990, c. M.7, s. 12.

Child as informal patient

13. (1) A child who is twelve years of age or older but less than sixteen years of age, who is an informal patient in a psychiatric facility and who has not so applied within the preceding three months may apply in the approved form to the Board to inquire into whether the child needs observation, care and treatment in the psychiatric facility. R.S.O. 1990, c. M.7, s. 13 (1); 1992, c. 32, s. 20 (6); 2000, c. 9, s. 2 (1).

Application deemed made

(2) Upon the completion of six months after the later of the child's admission to the psychiatric facility as an informal patient or the child's last application under subsection (1), the child shall be deemed to have applied to the Board in the approved form under subsection (1). R.S.O. 1990, c. M.7, s. 13 (2); 1992, c. 32, s. 20 (6); 2000, c. 9, s. 2 (2).

Considerations

(3) In determining whether the child needs observation, care and treatment in the psychiatric facility, the Board shall consider,

(a) whether the child needs observation, care and treatment of a kind that the psychiatric facility can provide;

(b) whether the child's needs can be adequately met if the child is not an informal patient in the psychiatric facility;

(c) whether there is an available alternative to the psychiatric facility in which the child's needs could be more appropriately met;

(d) the child's views and wishes, where they can be reasonably ascertained; and

(e) any other matter that the Board considers relevant. R.S.O. 1990, c. M.7, s. 13 (3); 1992, c. 32, s. 20 (6).

Powers of Board

(4) The Board by an order in writing may,

(a) direct that the child be discharged from the psychiatric facility; or

(b) confirm that the child may be continued as an informal patient in the psychiatric facility. R.S.O. 1990, c. M.7, s. 13 (4); 1992, c. 32, s. 20 (6).

No limitation

(5) Nothing in this section prevents a physician from completing a certificate of involuntary admission in respect of the child. R.S.O. 1990, c. M.7, s. 13 (5).

Panels of three or five members

(6) Despite subsection 73 (1) of the *Health Care Consent Act, 1996*, the chair shall assign the members of the Board to sit in panels of three or five members to deal with applications under this section. 1996, c. 2, s. 72 (6).

Procedure

(7) Subsection 39 (14) and section 42 of this Act and clause 73 (3) (a), subsection 73 (4) and sections 74 to 80 of the *Health Care Consent Act, 1996* apply to an application under this section, with necessary modifications. 1996, c. 2, s. 72 (6); 2015, c. 36, s. 3.

Informal or voluntary patient

14. Nothing in this Act authorizes a psychiatric facility to detain or to restrain an informal or voluntary patient. R.S.O. 1990, c. M.7, s. 14.

Application for psychiatric assessment

15. (1) Where a physician examines a person and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

the physician may make application in the prescribed form for a psychiatric assessment of the person. R.S.O. 1990, c. M.7, s. 15 (1); 2000, c. 9, s. 3 (1).

Same

(1.1) Where a physician examines a person and has reasonable cause to believe that the person,

(a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person; and

(b) has shown clinical improvement as a result of the treatment,

and if in addition the physician is of the opinion that the person,

(c) is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment; and

(e) is incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained,

the physician may make application in the prescribed form for a psychiatric assessment of the person. 2000, c. 9, s. 3 (2).

Contents of application

(2) An application under subsection (1) or (1.1) shall set out clearly that the physician who signs the application personally examined the person who is the subject of the application and made careful inquiry into all of the facts necessary for him or her to form his or her opinion as to the nature and quality of the mental disorder of the person. R.S.O. 1990, c. M.7, s. 15 (2); 2000, c. 9, s. 3 (3).

Idem

(3) A physician who signs an application under subsection (1) or (1.1),

(a) shall set out in the application the facts upon which he or she formed his or her opinion as to the nature and quality of the mental disorder;

(b) shall distinguish in the application between the facts observed by him or her and the facts communicated to him or her by others; and

(c) shall note in the application the date on which he or she examined the person who is the subject of the application. R.S.O. 1990, c. M.7, s. 15 (3); 2000, c. 9, s. 3 (4).

Signing of application

(4) An application under subsection (1) or (1.1) is not effective unless it is signed by the physician within seven days after he or she examined the person who is the subject of the examination. R.S.O. 1990, c. M.7, s. 15 (4); 2000, c. 9, s. 3 (5).

Authority of application

(5) An application under subsection (1) or (1.1) is sufficient authority for seven days from and including the day on which it is signed by the physician,

(a) to any person to take the person who is the subject of the application in custody to a psychiatric facility forthwith; and

(b) to detain the person who is the subject of the application in a psychiatric facility and to restrain, observe and examine him or her in the facility for not more than 72 hours. R.S.O. 1990, c. M.7, s. 15 (5); 2000, c. 9, s. 3 (6).

Justice of the peace's order for psychiatric examination

16. (1) Where information upon oath is brought before a justice of the peace that a person within the limits of the jurisdiction of the justice,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition based upon the information before him or her the justice of the peace has reasonable cause to believe that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

the justice of the peace may issue an order in the prescribed form for the examination of the person by a physician. R.S.O. 1990, c. M.7, s. 16 (1); 2000, c. 9, s. 4 (1).

Same

(1.1) Where information upon oath is brought before a justice of the peace that a person within the limits of the jurisdiction of the justice,

(a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person; and

(b) has shown clinical improvement as a result of the treatment,

and in addition based upon the information before him or her the justice of the peace has reasonable cause to believe that the person,

(c) is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment; and

(e) is apparently incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained,

the justice of the peace may issue an order in the prescribed form for the examination of the person by a physician. 2000, c. 9, s. 4 (2).

Idem

(2) An order under this section may be directed to all or any police officers of the locality within which the justice has jurisdiction and shall name or otherwise describe the person with respect to whom the order has been made. R.S.O. 1990, c. M.7, s. 16 (2); 2000, c. 9, s. 4 (3).

Authority of order

(3) An order under this section shall direct, and, for a period not to exceed seven days from and including the day that it is made, is sufficient authority for any police officer to whom it is addressed to take the person named or described therein in custody forthwith to an appropriate place where he or she may be detained for examination by a physician. R.S.O. 1990, c. M.7, s. 16 (3); 2000, c. 9, s. 4 (4).

Manner of bringing information before justice

(4) For the purposes of this section, information shall be brought before a justice of the peace in the prescribed manner. 2000, c. 9, s. 4 (5).

Action by police officer

17. Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

and that it would be dangerous to proceed under section 16, the police officer may take the person in custody to an appropriate place for examination by a physician. 2000, c. 9, s. 5.

Place of psychiatric examination

18. An examination under section 16 or 17 shall be conducted by a physician forthwith after receipt of the person at the place of examination and where practicable the place shall be a psychiatric facility or other health facility. R.S.O. 1990, c. M.7, s. 18.

Change from informal or voluntary patient to involuntary patient

19. Subject to subsections 20 (1.1) and (5), the attending physician may change the status of an informal or voluntary patient to that of an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission. R.S.O. 1990, c. M.7, s. 19; 2000, c. 9, s. 6.

Duty of attending physician

20. (1) The attending physician, after observing and examining a person who is the subject of an application for assessment under section 15 or who is the subject of an order under section 32,

(a) shall release the person from the psychiatric facility if the attending physician is of the opinion that the person is not in need of the treatment provided in a psychiatric facility;

(b) shall admit the person as an informal or voluntary patient if the attending physician is of the opinion that the person is suffering from mental disorder of such a nature or quality that the person is in need of the treatment provided in a psychiatric facility and is suitable for admission as an informal or voluntary patient; or

(c) shall admit the person as an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission if the attending physician is of the opinion that the conditions set out in subsection (1.1) or (5) are met. R.S.O. 1990, c. M.7, s. 20 (1); 2000, c. 9, s. 7 (1).

Conditions for involuntary admission

(1.1) The attending physician shall complete a certificate of involuntary admission, a certificate of renewal or a certificate of continuation if, after examining the patient, he or she is of the opinion that the patient,

(a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person;

(b) has shown clinical improvement as a result of the treatment;

(c) is suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment;

(e) has been found incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained; and

(f) is not suitable for admission or continuation as an informal or voluntary patient. 2000, c. 9, s. 7 (2); 2015, c. 36, s. 1.

Physician who completes certificate of involuntary admission

(2) The physician who completes a certificate of involuntary admission pursuant to clause (1) (c) shall not be the same physician who completed the application for psychiatric assessment under section 15. R.S.O. 1990, c. M.7, s. 20 (2).

Release of person by officer in charge

(3) The officer in charge shall release a person who is the subject of an application for assessment under section 15 or who is the subject of an order under section 32 upon the completion of 72 hours of detention in the psychiatric facility unless the attending physician has released the person, has admitted the person as an informal or voluntary patient or has admitted the person as an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission. R.S.O. 1990, c. M.7, s. 20 (3).

Authority of certificate

(4) An involuntary patient may be detained, restrained, observed and examined in a psychiatric facility,

(a) for not more than two weeks under a certificate of involuntary admission; and

(b) for not more than,

(i) one additional month under a first certificate of renewal,

(ii) two additional months under a second certificate of renewal,

(iii) three additional months under a third certificate of renewal, and

(iv) three additional months under a first or subsequent certificate of continuation,

that is completed and filed with the officer in charge by the attending physician. R.S.O. 1990, c. M.7, s. 20 (4); 2015, c. 36, s. 4 (1).

Conditions for involuntary admission

(5) The attending physician shall complete a certificate of involuntary admission, a certificate of renewal or a certificate of continuation if, after examining the patient, he or she is of the opinion both,

(a) that the patient is suffering from mental disorder of a nature or quality that likely will result in,

(i) serious bodily harm to the patient,

(ii) serious bodily harm to another person, or

(iii) serious physical impairment of the patient,

unless the patient remains in the custody of a psychiatric facility; and

(b) that the patient is not suitable for admission or continuation as an informal or voluntary patient. R.S.O. 1990, c. M.7, s. 20 (5); 2000, c. 9, s. 7 (3, 4); 2015, c. 36, s. 1.

Change of status, where period of detention has expired

(6) An involuntary patient whose authorized period of detention has expired shall be deemed to be an informal or voluntary patient. R.S.O. 1990, c. M.7, s. 20 (6).

Idem, where period of detention has not expired

(7) An involuntary patient whose authorized period of detention has not expired may be continued as an informal or voluntary patient upon completion of the approved form by the attending physician. R.S.O. 1990, c. M.7, s. 20 (7); 2000, c. 9, s. 7 (5).

Examination of certificate by officer in charge

(15) THE CENTRE FOR ADDICTION AND MENTAL HEALTH BILL OF RIGHTS

The Centre for Addiction and Mental Health
Bill of Client Rights

Preamble

The Bill of Client Rights has been developed to assert and promote the dignity and worth of all of the people who use the services of the Centre for Addiction and Mental Health (CAMH). The Bill of Client Rights expresses the truth that clients are first and foremost human beings with the same rights as every Canadian. The clients, families and staff of CAMH who have worked together to develop the Bill of Client Rights want it to be a living document that will grow and change as it helps to create an organizational culture of mutual respect. The Bill of Client Rights is intended to emphasize the rights of clients rather than organizational convenience. Policies at CAMH should be consistent with the Bill of Client Rights.

CAMH is committed to upholding all the rights of people under the law. The rights outlined in the Bill of Client Rights may be restricted by law or by order of a court or Review Board; or, they may be restricted reasonably to ensure the protection of the rights and safety of the individual and/or others. The restriction of some rights leaves other rights intact.

The Board of Trustees of the Centre for Addiction and Mental Health endorses the Bill of

Client Rights and, in so doing, creates a number of expectations: that the Centre for Addiction and Mental Health and every one working at CAMH – including volunteers and students – will respect and uphold the Bill of Client Rights; will promote awareness and understanding of the Bill of Client Rights; and will interpret the Bill of Client Rights as broadly and generously as is consistent with its responsibility to clients collectively. **Every client has the right to be provided with a written copy of, and assistance in understanding the Bill of Client Rights, and to have it posted at CAMH's main entrances and wherever clients receive services.**

Right #1

Right to be Treated with Respect Every client:

5) **is a person first, and has the right to be treated with respect.**

6) **has the right to be treated in a respectful manner, regardless of her/his race, culture, colour, religion, sex, age, mental or physical disability, class/economic position, sexual orientation, gender identity, diagnosis, inpatient status, or legal status.**
7) **has the right to have her/his privacy respected.**

8) **has the right to respect of her/his needs, wishes, values, beliefs and experience.**

Right #2

Right to Freedom from Harm

Every client:

3) has the right to a safe environment while a client at CAMH.

4) has the right to be free from physical, sexual, verbal, emotional and financial abuse. CAMH will use its best efforts to protect clients from harm. CAMH will assist clients who experience abuse.

5) has the right to be free from discrimination, harassment, retribution, punishment and exploitation.

6) **has the right not to be coerced or detained except where permitted by law.**

7) **has the right to be free from locked seclusion, environmental, chemical and mechanical restraint except where permitted by law. (i.e. when a client is a danger to self or others). Only the minimum necessary amount of restraint or locked seclusion is allowed and only after alternative methods of resolution have been unsuccessful. Clients have the right to be informed of how they can be released from restraints or seclusion.**

8) has the right to care based on support and healing.

Right #3

Right to Dignity and Independence Every client:

3) has the right to be informed promptly that she/he is no longer an involuntary patient when the client successfully appeals a form of involuntary admission. She/he must be informed that she/he may leave the hospital and be allowed to leave.

4) **has the right to have services provided in a manner that respects the dignity, independence and self-determination of the individual.**

5) has the right to private communication with others in accordance with the law.

6) **has the right to confidentiality about personal information and records in accordance with the law.**

7) has the right to contact with clergy or other spiritual advisors of her/his choice, and to exercise religious and spiritual observances, rituals, customs, and dress.

8) has the right to retain and use personal possessions, with access to secure storage, in keeping with safety requirements and other clients' rights.

9) has the right to wear their own clothing.

10) has the right to manage her/his own financial resources unless found to be financially incapable. This right includes access to her/his money and to accurate information about her/his hospital account.

11) has the right to be recognized as having needs for privacy and intimacy, including sexual expression between consenting adults. This includes access to privacy, information and education regarding safer sex, and forms of contraception and protection from sexually transmitted diseases.

12) has the right, if eligible, to vote in any election, and to receive the necessary information to be enumerated and to vote, as well as assistance in getting to the polling station, if on hospital premises.

13) has the right to all freedoms in accordance with the law.

Right #4

Right to Quality Services that Comply with Standards Every client:

5) **has the right to have services provided in a manner that complies with legal, professional, ethical, and other relevant standards.**

6) has the right to identify their own needs, to have those needs form the basis of the development of a plan for services, and to have services provided in accordance with that plan.

7) has the right to fair and equitable access to a range of services.

8) **has the right to a choice of services, and will not be denied other options if the client does not choose one treatment or service.**

9) has the right to have their record identify sources of data, record only relevant and useful facts, and avoid unfounded conclusions, prejudice, value judgements and labelling.

10) has the right to access care without undue difficulty to meet basic needs.
Every client has the right to reasonable accommodations required to access services.

11) **has a right to choose the least restrictive care.**

12) **has the right to have services provided in a manner that minimizes potential harm, and optimizes quality of life.**

13) has the right to co-operation and collaboration among providers to ensure quality and continuity of client centred care (including integration with other healing practices), in support of wellness and recovery.

14) has the right to be informed of the name and staff title of those providing services to her/him, to express a preference and to have that preference considered.

15) has the right to sufficient, nutritious and palatable food, in accordance with medical and religious requirements, and with consideration of personal and cultural choices.

16) has the right to daily access to the outdoors.

17) has the right to regular, consistent access to educational and recreational activities. 14) has the right to a quiet, safe and secure sleeping environment.

15) has the right to: participate in creating an individualized, written plan of care and service; consent to it; and receive a copy of it.

16) **has the right to seek an additional medical opinion**.

17) has the right to assistance with meeting their basic needs, accessing education and vocational training, income, getting identification, housing, employment, social supports and health care.

18) has the right to be involved in their discharge planning, and to have access to information about various support options available in the community, including self-help organizations.

19) has the right to access toilet facilities with all possible privacy.

Right #5

Right to Effective Communication Every client:

1) has the right to effective communication in a form, language, and manner that assists the client to understand the information provided. Where necessary, this includes the right to a competent interpreter.

2) has the right to an environment that enables both client and provider to communicate openly, honestly and effectively.

Right #6

Right to be Fully Informed Every client:

2) **has the right to be informed of her/his rights in this Bill of Client Rights**

3) and substitute decision maker or appointed representative has the right to information, including written information on request, of:

   a. The perceived problem, diagnosis or condition.

   b. The treatment that is proposed.

   c. An explanation of the alternative options/treatments including no treatment.

   d. An assessment of the benefits, risks (short term and long term), side effects, and costs of these options.

   e. Additional medication related information such as drug interactions, dosages, and withdrawal effects.

   f. The results of tests and procedures.

4) has the right to honest and accurate answers to questions relating to services, including questions about:

   a. The name and qualifications of the provider.

   b. The recommendations for treatments or services.

   c. How to obtain an opinion from another provider.

   d. Where to access additional information if wanted.

e. Notification of developments in the area of treatment affecting the client.

5) has the right to view her/his clinical record without undue difficulty.

6) has the right to have her/his clinical record corrected or to add a statement of disagreement to it in accordance with the law.

7) has the right to information requested about services and procedures relevant to being a CAMH client, such as rules, policies and rights that apply to her/him at the CAMH, and have access to them in writing.

Right #7

Right to Make an Informed Choice, and Give Informed Consent to Treatment

8) **No treatment shall be given without the client's informed consent, except in accordance with the law.**

9) **Consent must be for that particular treatment or plan of treatment.**

10) **Consent can be withdrawn at any time.**

11) Information about the treatment must be provided in writing on request.
Every effort must be made to promote understanding and access to information about proposed treatments.

12) **Every client is presumed to have decision-making capacity unless found to be incapable.**

13) **Consent must be voluntary and not obtained by coercion or misrepresentation.**

14) If a client is legally found to be incapable of making decisions, her/his substitute decision-maker has the same rights as the client to informed consent.

Every client:

15) **has the right to have her/his prior capable wishes respected to the fullest extent that the law allows.**

16) **has the right to be fully involved in treatment decisions (including location, duration and type of treatment).**

17) including those considered incapable of making treatment decisions, has the right to be involved in the development of her/his treatment goals, plan of care and discharge planning.

Right #8

The Right to Support Every client:

1) has the right to visits from one or more support persons (e.g. family, friends, partner - including same sex partner, community support) of her/his choice, and assistance in contacting them.

2) has the right to request the presence of a third party during a physical examination.

3) has the right to access confidential support when needed: counselling, rights advice, advocacy, legal counsel, other supports of his or her choice.

4) has the right to assistance in obtaining: financial support, housing, recreation, employment supports, social support, and community supports in keeping with her/his needs and wishes.

Right #9

Rights in Respect of Research or Teaching Every client:

1) has the right to decline involvement in research at any time and to know that declining participation will not affect her/his access to care, treatment or future service provision.

2) who is not eligible for research has the right to be informed of treatment options available to her/him.

3) has the right to give informed consent to participate in research, including risks, and whether this treatment is new (or new for this purpose).

4) has the right to be advised when students are involved and to decline student involvement in any part of her/his treatment, except in the case of psychiatric residents.

5) research participant has the right to be informed of what the research study is about, and the results of the research in summary form.

Right #10

Right to Complain Every client:

3) **has the right to make a complaint, access advocacy and to make suggestions and inquiries.**

4) has the right to make a complaint without retribution.

5) can make a complaint to: the individual(s) who provided the service, the Client Relations Coordinator, the Psychiatric Patient Advocate Office, or any other person(s).

6) **has the right to inform the Empowerment Council or Family Council of her/his complaint(s), in order to seek changes in the system.**

7) The client will be informed of any relevant internal or external complaints procedures.

8) In the case of complaints made through the Centre's complaint process:

- Every client has the right to have a person of her/his choice to support him or her through the complaint process.
- Staff must facilitate the fair, simple, speedy and efficient resolution of

complaints.

- The complaint will be acknowledged and documented. The client will be

informed of the progress of the client's complaint, in writing if requested.

- All complaints resolutions will be consistent with this Bill of Client Rights.

The complaints process described above applies to the CAMH Client Relations Office.

This is the internal CAMH mechanism for complaints. The Psychiatric Patient Advocate Office offers independent, individual advocacy for clients. The Empowerment Council offers independent systemic advocacy for clients.

(15) THE CAMH EMPOWERMENT COUNCIL

Empowerment Council

A Voice for the Clients of the Centre for Addiction and Mental Health

Mission Statement:

The Empowerment Council is a voice for clients/survivors and ex-clients of mental health and addiction services, primarily of CAMH.

Statement of Purpose:

To conduct system wide advocacy on behalf of clients and ex-clients.

From the CAMH/EC Memorandum of Understanding: "CAMH and the Empowerment Council acknowledge the key role played by clients in the ability of CAMH to deliver client centred care."

Terms of Reference

The Organization

The Empowerment Council takes its direction from clients and is funded by CAMH. The EC is an independent incorporated organization consisting entirely of people who have received mental health or/and addiction services. The EC client membership elects a Board of 10 people, two from each of the four CAMH sites, and two from the community. The EC staff consists of a full-time Coordinator and two half time Outreach workers. At this time there is also an additional half time position dedicated to teaching the CAMH Bill of Client Rights.

The Empowerment Council Agenda:

Within the limits of the resources of the organization.

Advocacy

The Empowerment Council will:

- Advocate on a systemic level (e.g. to C.A.M.H., various levels of government, in the judicial system) on behalf of addiction and mental health clients. The EC will place clients self identified needs first, and communicate through various means for greatest effectiveness.

- Consolidate the client voice through consultations, surveys, election of representatives

Please note that while it is helpful to know of individual advocacy issues to inform the EC voice on clients' behalf, the Empowerment Council does not conduct individual advocacy - for this we refer people to the Patient Advocate Office or the Client Relations Coordinator

Representation

The Empowerment Council will:

- Ensure the representation of the client perspective at CAMH through significant participation on relevant committees, work groups, and other decision-making and accountability structures.

- Communicate with clients on committees, and evaluate the influence of client involvement on CAMH policies and practices

Outreach and Community Development

The Empowerment Council will:

- Conduct outreach and community development with mental health and addiction clients of CAMH through site visits, meetings, consultations, events, etc.

Education and Information Sharing

The Empowerment Council will:

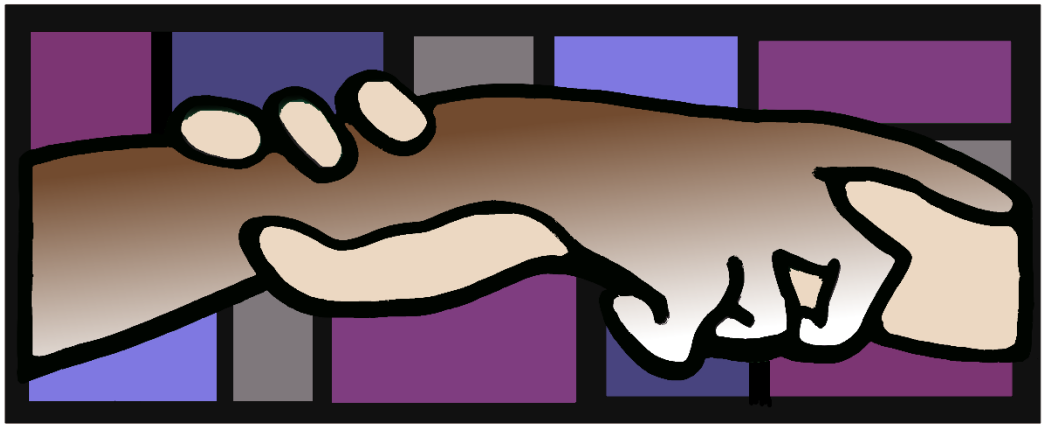
- Ensure client access to information, and educate clients in regard to choices, rights, self-advocacy, critical thinking, and other critical aspects of self-empowerment.

- Educate, sensitize, and provide training to mental health professionals, addiction workers, and other members of the community.

http://www.empowermentcouncil.ca/

(16) THE MENTAL HEALTH RIGHTS COALITION

MENTAL HEALTH RIGHTS COALITION



Our Organization

The Mental Health Rights Coalition of Hamilton is a non-profit organization funded by Ontario's Ministry of Health and Long Term Care as a Consumer/Survivor Initiative.

In this context, ***a consumer*** is a person who has a mental health issue.
A ***Consumer Survivor*** is a person who has been afflicted with a mental health issue and has learned to cope with that issue.
Consumer/Survivor Initiatives (CSIs) are consumer-driven agencies, which allow survivors to use their coping skills to help other consumers become survivors. Learn more about CSIs with the the "CSI Builder Report" or Consumer Survivor Initiatives in Ontario: Building for an Equitable Future

History

The Mental Health Rights Coalition (MHRC) was formed in 1991 by a group of Consumer/Survivors who were concerned about the province's move toward de-institutionalization in the absence of adequate and appropriate community supports and services. MHRC later became one of dozens of organizations that were funded in a provincial initiative to create CSIs. Find out more about our local CSIs at www.csilhin4.org MHRC was incorporated as a non-profit in 1995, and is governed by a volunteer Board of Directors and supported by paid staff.

Membership is free of charge to mental health consumers over the age of 18, and almost all of our programs and services are free of charge to consumer members. Family members and service providers are also free to join, but only those who have self-identified as consumer/survivors have voting privileges, can stand for election to the Board of Directors, or can be hired to work at MHRC. To sign up, please see our membership form on our contact page.

Our Services

Peer support

Peer support is the support provided by a person who has a similar lived experience, experienced recovery and is trained to provide listening and support.

Peer support is available in-person and on the telephone during drop-in hours.

We also provide training to those wishing to become peer support workers.

Find out more on our peer support page.

Drop-in centre

Mental Health Rights Coalition prides itself in having a safe and cozy place for consumers to visit during the day. As a member-driven organization, members are encouraged to take part in the planning of programs. During our monthly members' meeting, members provide feedback on drop in structure and calendar activities. The daily programming can be found on our calendar and newsletter.

Members are welcome to drop in for daily activities, socialize and partake in individual and self-led group activities and partake in peer support. Coffee is available for 25 cents. There is also available to members computers with internet, telephones and a resource library including books to read in the drop-in and community resource cards and brochures for the taking.

Systemic Advocacy

The Mental Health Rights Coalition advocates for its members through speaking up at various committees, attempting to create change through the system. This is different from individual advocacy in that we do not take on individual complaints; we use collective complaints as a catalyst for change.

(17) SUPPORTING STATEMENTS AND AFFIDAVITS

Affidavit

Tarik Leighton Carey

106 New Haven Court, Garner, North Carolina 27529, United States
Email: renewed@gmail.com, Mobile: 754-273-6534

I, Tarik Leighton Carey of 106 New Haven Court, Garner, North Carolina 27529, United States, have known Roxanne Stewart since childhood. I was diagnosed with bipolar disorder in 1995 and have been living with the condition for approximately 22 years. In my experience in Jamaica my right to consent to medical interventions and forced drug treatments have been ignored and violated both by my family members and by medical practitioners I have interfaced with.

Because of severe side effects I experienced on many of the psychotropic drugs I was put on, after 3 years I let my mother know I wanted to choose a more holistic approach to my mental health, such as through diet, exercise and meditation exercises. However this was not respected as my mother and sister continued to secretly put these drugs in my food and drink. Some of the severe side effects I experienced on these medications were symptoms of Tardive Dyskinesia such as tremors, being almost catatonic or stupefied, along with extreme somnolence.

However during periods when I would chose to come off these heavy medications, I would be able to maintain a job and go to school.

In approximately 2001, when I had been off these medications for a number of years and able to have some semblance of independence, my mother asked me to "say goodbye" to my psychiatrist who I had been seeing over the years. Once at his office, the doors were locked and I was locked in the building for an hour while an ambulance was called and I was forcibly taken to the University Hospital of the West Indies. I informed the doctors present that I did not consent to this treatment and when I attempted to leave the hospital I was held down and injected with Modecate, a very powerful antipsychotic.

Now living in the United States I have been better able to exercise my autonomy in managing my mental health and have better options available to me. I am able to have independence and currently work as a production technician at Konica Minolta and am also involved with my local church.

I believe persons with bipolar disorder or any psychiatric diagnosis should have the freedom to choose how to manage their condition and their rights to consent should be respected. Options and risks of different treatments should be evaluated and explained to them and persons shouldn't have to live in the constant fear of being involuntarily hospitalized especially if they pose no danger to themselves or others.

I, Tarik Leighton Carey, hereby state that all events and details aforementioned are true to the best of my knowledge and consent to this statement being used in the IRB hearing of Roxanne Stewart.

Sincerely,

Tarik Carey

Tarik Leighton Carey

Witnessed by,

JOSEPH C. IADONISI
Notary Public
Wake County
My Commission Expires
September 19, 2021
NORTH CAROLINA

_____, dated June 22, 2017

(Name of Notary Public)

Cameron Daniel Fray

175 Malvern Street, Scarborough Ontario M1B 1S7

Email: cjfray30@hotmail.com, Mobile: 416-906-0748

I, Cameron Daniel Fray, of 175 Malvern Street, Scarborough, Ontario, M1B 1S7, met the claimant, Roxanne Melissa Stewart in May of this year, 2017 through our church Toronto East Seventh Day Adventist church. I was diagnosed with bipolar disorder in 1998.

I am a husband and father and very active in my church. I am a truck driver for Rocket Ready Mix Incorporated and a musician as well as run the charity organization Daddy's House, mentoring men to be better father's for their children.

I can say even with the challenges of my condition I have been able to contribute to society through my church and through my charity while also being an attentive husband and father and believe that persons with psychiatric diagnoses ought to be given the right to live full productive lives contributing to their communities and families with their skills and talents.

I Cameron Daniel Fray do state that all the aforementioned is true to the best of my knowledge.

Sincerely,

X _____

Mr. Cameron Daniel Fray

Witnessed by:

_____

Willie James

André Anderson

A. Anderson (PASTOR)

(18) MEDICAL DIAGNOSIS/RECORDS: BUTLER HOSPITAL, MEDICAL ASSOCIATES HOSPITAL

TRANSFER/DISCHARGE SUMMARY PART I

BUTLER HOSPITAL, Providence, Rhode Island

Date Admitted: 4-22-05

Date ☐ Transferred ☒ Discharged 4-28-05

107780
STEWART, ROXEANNE
226 PLEASANT STREET
PROVIDENCE, RI 08/08/1981
DR L. SHEA HCVM

Name 04/22/2005 ~~DAY/OHP~~

MR# 2

FROM: AMA/Unplanned? ☐ yes ☒ no

Level of Care:
☐ acute inpatient ☐ residential inpatient
☐ observation bed ☒ partial hospital ☐ outpatient
☐ other

Program:
Unit/Site: PHP
Clinician: Shea

TO: ☐ No Further Treatment

Level of Care:
☐ acute inpatient ☐ residential inpatient
☐ observation bed ☐ partial hospital ☒ outpatient
☐ other

Program:
Unit/Site:
Clinician: Dr. Allen (Jamaica)

DIAGNOSES PRINCIPAL: ~~Bipo~~ ~~Psychotic Disorder NOS~~ bipolar I Disorder, manic, with psychotic features 296.44

Axis I: h/o Early Disorder NOS

Axis II: Deferred 799.9

Axis III: Obesity
Constipation 564.00

Axis IV: School

Axis V current 60-65 highest past year

IDENTIFYING INFORMATION AND REASON FOR TREATMENT

23yo Jamaican HISD graduate student transferred to PHP for further stabilization s/p inpt admit for acute psychosis.

SUMMARY OF CURRENT ASSESSMENT/TREATMENT Summarize response to medications, therapy, results of labs, consults, progress towards treatment goals.

attended PHP x 5 days. Individual / group treatment. Educated re: coping behavioral strategies to manage sx. Risperdal + valproic acid continued. Family very supportive + involved. Education re: illness + treatment. Neurology cons → labs + MRI ordered.

Last serum medication level: 4/27 90.5

CURRENT CONDITION/REASON FOR CHANGE IN LEVEL OF CARE Identify goals for further treatment or reason for ending treatment.

Improved & acute psychotic symptoms
She will be returning to Jamaica for follow up

discharged 4/28/05 ID 3303

CURRENT RISKS Active problems which may affect clinical course. Describe all positives.

☐ yes ☒ no Active Medical Problems:
☐ yes ☒ no Medication Allergies:
☐ yes ☒ no Suicidal:
☐ yes ☒ no Dangerous:
☐ yes ☒ no Substance Abuse:
☐ yes ☒ no Other: (compliance/abuse/legal/social/cultural):

4-28-05 (Date) | Dr. Rey MD (Signatures (s)) | Shea (Print Names(s))

MR 12 (Rev. 6-98 Kent) **DISTRIBUTION:** WHITE - Chart Copy, CANARY - CIS Copy

TRANSFER / DISCHARGE SUMMARY
PART II
PATIENT INSTRUCTIONS

BUTLER HOSPITAL
345 Blackstone Blvd.
Providence, Rhode Island

107780
STEWART, ROXEANNE
226 PLEASANT STREET
PROVIDENCE, RI 08/08/1981
DR L. SHEA HCVM

Name: 04/22/2005 DAY/DHP
MR #: 2

MEDICATIONS To be completed by physician or designee, not valid unless signed below by physician.

Name of Medication	❑ No Medication	Dose	Times to be taken
Valproic acid		250 mg	1 pill every morning and 2 pills at bedtime # 90 unf
Risperdal		1 mg	1 pill every morning and 2 pills at bedtime # 90 unf
Celexa		10 mg	1 pill twice daily

SOMA 724.4 296.44

799.9 564.00

Risks, benefits, and alternatives discussed? ☑ Yes ❑ No Explain: _____

OTHER RECOMMENDATIONS / INSTRUCTIONS

MRI 4/29/05

FOLLOW-UP APPOINTMENTS Include medical and non-medical appointments.
Patient or guardian has signed release of information for follow-up outside the Butler system? ❑ Yes ❑ No

MEDICAL	NON-MEDICAL
Name: Tony Allen, MD	Name:
Address: Shedai medical center	Address:
Tel#: bryan s samaria	Tel#:
Time & Date of Appt: May 16, 2005	Time & Date of Appt:
❑ Psychiatrist ❑ PCP ❑ other	❑ Psychotherapy ❑ other

Until you are seen by Dr. Allen (print name or program)

If you have any problems or questions about your condition or these medications, instructions or plans, please contact

Lisa Shea, MD (print name) at 5194614355-6206 (telephone)

These instructions have been reviewed with me* _____ (signature)

* ☑ patient ❑ parent ❑ guardian ❑ other _____

Comment if no signature: _____

4-18-05 (Date) _____ (Signature (s) (must be signed by physician if meds listed)) _____ (Print Name (s))

MR-13 (11-2002) **DISTRIBUTION: WHITE** - Chart **WHITE** - Customer Copy

TRANSFER/DISCHARGE SUMMARY
PART I

107780
STEWART, ROXEANNE
226 PLEASANT STREET
PROVIDENCE, RI 08/08/1981
DR G. SURTI OUTSIDE BC

BUTLER HOSPITAL, Providence, Rhode Island

Date Admitted: 4/11/05
Date ☐ Transferred ☑ Discharged 4/22/05

Name
MR#

FROM: AMA/Unplanned? ☐ yes ☐ no

Level of Care:
☑ acute inpatient ☐ residential inpatient
☐ observation bed ☐ partial hospital ☐ outpatient
☐ other
Program: ITU
Unit/Site:
Clinician: Surti

TO: 04/11/2005 ☐ No Further Treatment ITU/ITP 3

Level of Care:
☐ acute inpatient ☐ residential inpatient
☐ observation bed ☑ partial hospital ☐ outpatient
☐ other
Program:
Unit/Site: Dr Surti
Clinician:

DIAGNOSES **PRINCIPAL:** Psychosis NOS - 298.9

Axis I R/o Bipolar disorder 296.80
R/o Eating disorder NOS. 307.50

Axis II deferred 799.9

Axis III None active

Axis IV Deferred.

Axis V current 55-60 highest past year

IDENTIFYING INFORMATION AND REASON FOR TREATMENT

23 year old female, single, from Jamaica, RISD student admitted for disorganized and psychotic behavior.

SUMMARY OF CURRENT ASSESSMENT/TREATMENT Summarize response to medications, therapy, results of labs, consults, progress towards treatment goals.

Patient was religiously preoccupied, paranoid, inappropriate smiles, preoccupied, ↓ intake, poor response to Zyprexa, started on Risperdal then Depakote added, fair response: more organized, not delusional, improved care & attention, more social. Multiple Meeting held with mother

Last serum medication level:

CURRENT CONDITION/REASON FOR CHANGE IN LEVEL OF CARE Identify goals for further treatment or reason for ending treatment.

Affect Calm Thought Organized ∅ A/V Hallucination
∅ delusions. ∅ SI ∅ HI A×O×3

CURRENT RISKS Active problems which may affect clinical course. Describe all positives.

☐ yes ☑ no Active Medical Problems: None active
☐ yes ☑ no Medication Allergies: NKDA
☐ yes ☑ no Suicidal: ∅ SI ∅ HI
☐ yes ☑ no Dangerous:
☐ yes ☑ no Substance Abuse:
☐ yes ☑ no Other: (compliance/abuse/legal/social/cultural):

4/22/05 — [signature] — Surti
Date Signatures (s) Print Names(s)

MR 12 (Rev. 6-98 Kent) **DISTRIBUTION:** WHITE - Chart Copy, CANARY - CIS Copy

TRANSFER / DISCHARGE SUMMARY
PART II
PATIENT INSTRUCTIONS

BUTLER HOSPITAL
345 Blackstone Blvd.
Providence, Rhode Island

107780
STEWART, ROXEANNE
226 PLEASANT STREET
PROVIDENCE, RI 08/08/1981
DR G. SURTI OUTSIDE BC

Name: 04/11/2005 ITU/ITP
MR #: 3

MEDICATIONS To be completed by physician or designee, not valid unless signed below by physician.

Name of Medication ❑ No Medication Dose Times to be taken

Depakote 250mg PO 8AM & 500mg PO 8PM

~~Zyprexa~~ Error

Risperidal 1mg PO 8AM & 2mg PO QHS.

Attend Partial Hospital daily MONDAY — Friday 8:45AM - 3PM AT BUTLER HOSPITAL.

Risks, benefits, and alternatives discussed? ☑ Yes ❑ No Explain:

OTHER RECOMMENDATIONS / INSTRUCTIONS

If feel unsafe or Suicidal Call MD or return to hospital

FOLLOW-UP APPOINTMENTS Include medical and non-medical appointments.
Patient or guardian has signed release of information for follow-up outside the Butler system? ❑ Yes ❑ No

MEDICAL

Name:
Address:
Tel#:
Time & Date of Appt:
❑ Psychiatrist ❑ PCP ❑ other

NON-MEDICAL

Name:
Address:
Tel#:
Time & Date of Appt:
❑ Psychotherapy ❑ other

Until you are seen by
print name or program

If you have any problems or questions about your condition or these medications, instructions or plans, please contact

Dr Surti at 455-6365
print name telephone

These instructions have been reviewed with me*
signature

* ❑ patient ❑ parent ❑ guardian ❑ other

Comment if no signature:

4/22/05 Surti Surti
Date Signature (s) (must be signed by physician if meds listed) Print Name (s)

MR-13 (11-2002) **DISTRIBUTION: WHITE** - Chart **WHITE** - Customer Copy

Gmail **RoxStew5 . <rstewart.micopr@gmail.com>**

Release of Hospital Medical Records Copies

3 messages

RoxStew5 . <rstewart.micopr@gmail.com> Sat, May 20, 2017 at 10:10 AM
To: frank.knight@cwjamaica.com

Hello Dr. Knight, I hope you are doing well. There seems to have been a misunderstanding when my mother, Dr. Marcia Stewart, met with you to make known my request for copies of my medical records at Medical Associates Hospital. I am not asking for a report or a summary of my April 2015 hospitalization.

I, Roxanne Stewart (married name now Johnson), am asking you to give Medical Associates Hospital permission to release copies of the **existing medical records on file during my April 2015 hospitalization.**

When speaking to the hospital directly to have copies of these records released to me, they informed me that they needed your permission to release copies of the records before they could do so. I am simply asking for **copies of the medical records on file** during my April 2015 hospitalization. A report or summary will not be needed.

I appreciate your assistance,
Thank you

--
Roxanne Johnson,
Presenter / Voice Talent / Writer / Producer,
322-1182
www.facebook.com/roxannejohnsonmedia

Frank Knight <frank.knight@cwjamaica.com> Mon, Jun 12, 2017 at 8:55 PM
To: "RoxStew5 ." <rstewart.micopr@gmail.com>

Thank you for your email.

It seems Medical Associates does not have a record of the 2015 admission that they can find. But I have located my own notes and will provide your mother with a report based on them.

I hope all goes well with you

Regards,

Frank Knight.
[Quoted text hidden]

RoxStew5 . <rstewart.micopr@gmail.com> Tue, Jun 13, 2017 at 1:23 AM
To: Frank Knight <frank.knight@cwjamaica.com>

Thank you Dr. Knight, but that won't be necessary.

Thanks again,
[Quoted text hidden]

MEDICAL ASSOCIATES HOSPITAL
NURSING RECORD

DATE AND TIME	REMARKS
3/6/15 Cont'd	boyfriend's house as she did not feel safe. This am, while walking, she decided that she can no longer manage on her own so she was taken to AAE. Medicated & hospitalized for observation and Haldol 10mg. Admitted for management PMH - Nil PSH - Nil Drug Hx - Depacote, Seroquel Allergies - Social Hx - Smoke Drink O/A Young looking female. Very tearful and appears depressed. MSE Patient not boisterous in appropriately dressed for climate. Signs of paranoia noted as patient believes Nurse is trying to accuse her of lying about her condition. Patient shows signs of visual hallucinations. Insight fair as patient knows she needs help. No suicidal or homicidal ideations noted. O/A Drowsy female breathing freely on room air chest expansions equal and adequate. MM pink and moist. Perfusion adequate centrally and peripherally. Abdomen soft and non-tender. Voids spontaneously. Full movement and sensation present. Skin

NAME: Roxane Stewart DOCTOR: Knight ROOM: 109

W - Witheld as Ordered, R - Refused
U - Patient unable to take Medication, S - Stock

MEDICAL ASSOCIATES HOSPITAL
PROGRESS NOTES

STATE

Sat Apr 04 Seen 8:15 a.m.

Doing: But can rouse enough to make full contact

Nurses report she declined Seroquel yesterday as she said it [redacted] has caused her in the past to have hallucinations. So it has b

She speaks clearly + has reasonable insight. Recalls the yesterday her friend seemed to be acting strangely. Reports she has no hallucinations since (A?), but only "illusions" (she has the concept correct! eg. cell phones + g/c seemed to be louder. But also she did at one point hear a baby's crying). Inquires what her IM inj yesterday was.

HR BP has been low (90/60 at 6 am)

Assess: Improved.

Plan: 11/4 Switch to CPZ 100 + bid (from Seroquel)

7KNIGHT

DOCTOR: Knight ROOM: 109

STEWART

MEDICAL ASSOCIATES HOSPITAL
PROGRESS NOTES

DATE AND TIME	
2015 Sun Apr 05 Mon Apr 06	Seen 7:15 am (Had just come back from an outside stroll with her Niece) Fully clothed. Fully in touch. Reluctant to agree to home Secroquel Plan: 1 Risperidal 4 mg tds 7KNIGHT
Tue Apr 07	Seen 6:45 pm Clinically she is ready ready to leave hospital. I have left a message for Dr Earl Wright who will be taking over Ms Stewart's care and arranging for her discharge. I will inform the Hospital when the transfer takes place. Plan Keep on regime 7KNIGHT

NAME: Ms Roxanne STEWART
DOCTOR: F Knight
ROOM: 109.

W - Withheld as Ordered, R - Refused, PNTD - Patient not in [illegible]
U - Patient unable to take Medication, S - Stock

MEDICAL ASSOCIATES HOSPITAL

NURSING RECORD

DATE AND TIME	REMARKS
6/4/15	if she doesn't have a problem with the [illegible]
	[illegible] and if she doesn't have a problem
	with not being informed of the [illegible]
	She said "yes" but she [illegible] the
	discussion beyond the "yes", the [illegible]
	[illegible]
2-3:30 pm	Patient ambulating along corridor and down
	staircase with nurse and [illegible] — [illegible]
4:00 pm	[illegible] in room with [illegible] — [illegible]
5:30 pm	Tolerated [illegible] of diet
06.04.2015 8:00 pm	Received patient in bed. Nil distress observed. Voiced no
	complaints. MAE. Alert and oriented. Calm. Affect congruent
	c̄ mood. Appropriately attired. Denies hallucinations,
	suicidal or homicidal ideations. Nil paranoia observed
	at this time. Judgment good. Thought process good. Insight
	to illness fair. Long and short term memory intact. Physical
	assessment unremarkable. — [illegible]
	Plan: Monitor v/s. Medicate as ordered. Give and comfort [illegible]
	[illegible] MAE when awake. Ensure safety. [illegible]
	Private nurse present. — [illegible]
09.04.2015 2:00 pm	Tolerated water — [illegible]
9:00 pm	v/s T 97 P 96 R 20 BP 100/70 — [illegible]
10.04.2015 9:30 pm	Patient asleep in bed. Nil distress observed. [illegible]
11 pm	Patient was asleep in bed. — [illegible]
[illegible].04.2015 12 MN	Patient remained asleep in bed. Private nurse present. [illegible]
12-2 am	Patient was still asleep. Nil distress noted — [illegible]

NAME: Roxanne Stewart DOCTOR: Knight ROOM: 109

W - Witheld as Ordered, R - Refused, [illegible]
U - Patient unable to take Medication, S - Stock

MEDICAL ASSOCIATES HOSPITAL
PROGRESS NOTES

DATE AND TIME	
2015 Sun Apr 05 Mon Apr 06	Seen 7:15 am (Had just come back from an outside stroll with her Niece) Fully clothed. Fully in touch. Reluctant to agree to home Secroquel Plan: 1 Risperidal 4 mg tds 7KNIGHT
Tue Apr 07	Seen 6:45 pm Clinically she is ready ready to leave hospital. I have left a message for Dr Earl Wright who will be taking over Ms Stewart's care and arranging for her discharge. I will inform the Hospital when the transfer takes place. Plan Keep on regime 7KNIGHT

NAME: Ms Roxanne STEWART
DOCTOR: F Knight
ROOM: 109.

W - Withheld as Ordered, R - Refused, PNTD - Patient not in [illegible]
U - Patient unable to take Medication, S - Stock

MEDICAL ASSOCIATES HOSPITAL

NURSING RECORD

DATE AND TIME	REMARKS
7.4.15	Cnt'd That he is not informing her re changes in medication and that she is on antipsychotic Risperidone and in makes her hallucinate [illegible] She stated she [illegible] an empty box that appear like earphone [illegible]
5pm	Tolerated supper remains calm — [illegible]
6pm	Medicated ̄c Risperidone 3mg, Lithium [illegible], [illegible] 8mg — [illegible]
7pm	Reviewed by Dr Knight no changes in mx Stable care continues — [illegible]
8pm	Patient received awake and alert, nil immediate Dishes Patient verbalized
7th/April/2015	Visual Hallucination MSE: Affect flat mood incongruent with expressed [illegible], Affect appropriate nil homicidal or suicidal ideations patient cooperative and pleasant. O/E Afebrile [illegible] Anicteric, chest expansion equal adequate. Abdomen soft non-tender, bowel sounds active, movement and sensation to all limbs. Plan [illegible] ① Meds as prescribed ② Ensure safety ③ [illegible] ④ Provide psychological support — [illegible]
SpO2 96% 10pm	V/S T 97.2 P [illegible] [illegible] BP [illegible]
7th/April/2015 10pm	Medicated as prescribed by physician [illegible]
10pm–12MN	Patient Asleep nil distress — [illegible]
12MN–2Am	Patient Asleep nil change — [illegible]
2Am–4Am	Patient Asleep nil change — [illegible]
6Am	Medicated as prescribed — [illegible]

NAME: Roxanne Stewart DOCTOR: Knight ROOM: 19

W - Witheld as Ordered, R - Refused, PNTD - [illegible]
U - Patient unable to take Medication, S - Stock

MEDICAL ASSOCIATES HOSPITAL

NURSING RECORD

DATE AND TIME	REMARKS
09.04.2015 Cont'd	Thought process good. Judgement good. Long and short term memory intact. Fair insight to illness. Denies any hallucinations, homicidal or suicidal ideations. NAD to physical assessment. Plan: Medicate as ordered. Monitor v/s. Monitor MSE. Ensure safety. Psychological support. ——— RMiller RN
09.04.2015 9pm	Patient settled to sleep. v/s T 96.4 P 58 R [illegible] BP 100/60 Private nurse present. ——— RMiller RN
09.04.2015 10pm	Patient was seen asleep in bed. Rails up for safety. RMiller
10-12md	Patient was asleep in bed. Nil distress was observed. RMiller RN
10.04.2015 12-2am	Remained asleep throughout. ——— RMiller RN
8:30am	Patient is now awake. Stated it was too early. Requested water. Same given. ——— RMiller RN
10.04.2015	Returned to bed ——— RMiller RN
5:30am	Had hygienic needs met. ——— RMiller RN
10.04.2015 6:00am	v/s T 96 P 88 R 24 BP 160/100 SpO_2 98% RMiller RN
	Medicated as ordered c̄ lithium 50mg po, cogentin 2mg po and risperidone 3mg po. ——— RMiller RN
10.04.2015 7:00am	Left patient sitting out of bed. Fair shift spent. For home today. Dr. will not come to review. Care continues. ——— RMiller RN
10.04.15 8:00	Received patient lying in bed breathing freely on roomair. Pale pink peripherally and centrally. Chest expansion equal and adequate. Chest clear. Abdomen obese. NAD to extremities. Affect flat,

NAME: Roxanne Stewart DOCTOR: Knight ROOM: 109

Witheld as Ordered, R - Refused, PNID - Patient Not in Department,
Patient unable to take Medication, S - Stock