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Manitoba Ombudsman

November 19, 2014

The Honourable Ken Champagne
Chief Judge
Provincial Court of Manitoba
5th Floor - 408 York Avenue
Winnipeg MB R3C 0P9

Dear Chief Judge Champagne:

INQUEST INTO THE DEATH OF AHMAD SALEH-AZAD
AT WINNIPEG, MANITOBA
OUR FILE: 2011-0495

As you are aware, it is the practice of my office to follow up on inquest recommendations when they relate to a provincial department, agency or municipality.

I am writing to advise you of the results of the inquiries made by my office concerning the inquest report recommendation into the death of Mr. Ahmad Saleh-Azad. The inquest report, dated September 30, 2011, was issued by the Honourable Judge Lee Ann Martin.

Mr. Saleh-Azad came to his death on March 27, 2007; the cause of death was a gunshot wound fired by a member of the Winnipeg Police Service in the course of his duties.

The Chief Medical Examiner called an Inquest pursuant to subsection 19(3) of *The Fatality Inquiries Act*. The Inquest Report was released on October 5, 2011.

In this case, Judge Martin made a multifaceted recommendation that was directed to the Government of Manitoba.

The following are the responses we received to the recommendation and conclusions of Judge Martin:

CONCLUSIONS and RECOMMENDATION

Judge Martin reached the following conclusions after hearing all of the evidence presented during the inquest:

[32] Mr. Saleh-Azad, a man with a prior history of violence and a diagnosis of paranoid schizophrenia was living in the community under the care and supervision of a psychiatrist and community support workers under the umbrella of the Winnipeg Regional Health Authority. This support structure was designed to monitor Mr. Saleh-Azad's mental health status to ensure that he did not pose a risk to the public. In February 2007 when there was some evidence that Mr. Saleh-Azad was becoming psychotic and displaying assaultive behavior, such signs and symptoms seemingly did not fall within the scope of the provisions of The Mental Health Act that mandate a test of likelihood to case "serious harm" for an involuntary admission. And, as a result of Home Care's decision to suspend services to Mr. Saleh-Azad for staff safety reasons, he was living in the community with sporadic monitoring.

[33] It was within this context that Mr. Saleh-Azad took Mr. Kolesnyk's life in a horrific and violent attack, and injured others, both physically and psychologically. At the time of the attack, the medication prescribed to Mr. Saleh-Azad was no longer in his system, meaning that he had stopped taking his medication.

[34] The evidence at the inquest is that the members of the Winnipeg Police Service who attended at the Madison Memorial Lodge on March 27, 2007 acted, not only in accordance with standard police practice, but in my view, appropriately given the situation that was presented to them on that morning.

In the circumstances, I find that the Winnipeg Police Service members had no other alternative on that day than to fire their service pistols at Mr. Saleh-Azad. There are no recommendations with respect to the Winnipeg Police Service programs, policies or practices.

[35] That said, the circumstances that led to the police shooting of Mr. Saleh-Azad cry out for government action so that similar deaths can be prevented from occurring in the future.

[36] The appropriateness of housing and support services in place for Mr. Saleh-Azad and the availability of other such services in the Province of Manitoba are not within the mandate of this inquest. That said, it is apparent from the evidence at the inquest that Mr. Saleh-Azad fell through the cracks at a great cost: two lives were lost on March 27, 2007 and many others lives irreparable affected. The families of the deceased, the witnesses to the deaths and the police officers who were involved will forever be haunted by this day. Mr. Saleh-Azad's family had counted on the system to ensure that his mental disorder was being managed and that he was receiving adequate support and supervision. I cannot blame Home Care for wanting to ensure the safety of their staff from Mr. Saleh-Azad when he was becoming violent, especially given his past history for assaultive behavior. The problem here is that it appears though the only solutions available were those under The Mental Health Act or the criminal justice system.

Yet no one called the police when Mr. Saleh-Azad assaulted two Home Care staff and the provisions of The Mental Health Act are such that the psychiatrist did not feel that he had grounds to involuntarily admit Mr. Saleh-Azad for an assessment. Mr. Saleh-Azad was therefore living in a housing complex that, although welcoming of individuals with mental health and physical disabilities given the difficulty they face trying to find accommodations, was not designed nor equipped to provide any supportive or supervisory services.

Judge Martin subsequently made one recommendation:

RECOMMENDATION

I therefore recommend that the Government of Manitoba undertake a review of The Mental Health Act, and in particular, sections 8(1) and 17(1), as well as its policies regarding support services and the availability of appropriate housing for those individuals with a mental disorder as defined under The Mental Health Act to determine whether public safety issues are adequately addressed.

In an inquiry letter to Manitoba Health (the department), dated November 18, 2011, we asked for information on the actions taken or proposed with respect to the recommendation. Additionally, the former Manitoba Ombudsman informed the department that absent an inquest recommendation, section 15 of *The Ombudsman Act* authorizes the Ombudsman to investigate matters of administration. As such, consideration was given to the conclusions reached by Judge Martin and the department was also asked to clarify what internal reviews had been conducted in relation to the following:

- The policies and procedures related to the delivery of support services to clients of Manitoba Health and regional health authorities, who are living in the community with mental illness, and require a support structure to adequately monitor their mental health status.

- The policies and procedures related to the establishment of appropriate and sufficient housing options for clients of Manitoba Health and regional health authorities, who are living in the community with mental illness.

- The policies and procedures related to ensuring necessary support and supervisory services are available and clearly understood by all stakeholders when clients of Manitoba Health and regional health authorities are living in the community.

RESPONSE FROM DEPARTMENT

My office received the following response from the department on December 20, 2011.

Re: The Mental Health Act

The Department has undertaken an inter-jurisdictional scan of other provincial Mental Health Acts, as well as other literature to determine how Manitoba's Act

compares in regards to the management of involuntary assessment and admission with a view to public safety.

It is the fundamental goal of such legislation to strike an appropriate balance between the protection of individual human rights and the protection of public safety. It is the Department's opinion that Manitoba's Act is consistent with other Acts across Canada in this regard, and that it strikes the appropriate balance. When a physician is of the opinion that an individual, because of a mental disorder, is at risk of harming himself or others or will experience substantial mental or physical deterioration Manitoba's Act allows for involuntary assessment and admission. It should be noted that decisions regarding patient risk (in applying the provisions of the Act) are made on the basis of clinical judgment.

In Manitoba, The Mental Health Act also provides for a Certificate of Leave, which permits a physician to discharge a patient from hospital into the community with a prescribed treatment plan if the physician believes that continuing care and supervision is necessary and possible. If the individual fails to comply with the specifications of the Leave Certificate, the patient can be taken into custody and returned to a psychiatric facility for assessment.

It should also be noted that The United Nations Convention on the Rights of Persons with Disabilities (ratified by Canada in 2010) provides a new touchstone for legislation, policies and regulations that affect people living with mental health problems and illnesses. A key principle of the Convention is to employ the least restrictive intervention possible. For example, the Convention recognizes involuntary admission and treatment may at times be necessary, but calls for the strongest possible safeguards to make it truly a last resort.

<u>Re: Matters of Administration</u>

The matter of housing and supports for individuals living in the community with mental illness is a complex issue and one that is not solely under the domain of Manitoba Health. The issue is being looked at by many departments.

The province overall has made significant efforts in enhancing access to housing for individuals living in the community with mental illness. In 2008, a provincial advisory group developed a position paper: "Housing and Supports for People with Mental Illness" which was a review of housing options and provided background for provincial planning.

In 2009, a provincial homeless strategy was launched with a focus on mental health housing. Efforts have also been seen through Manitoba Housing's Long-Term Housing Strategy, HOMEWorks, and through the development of the Cross-Department Coordination Initiative (CDCI).

Government has developed the CDCI to build capacity through coordination of

Health, Housing and Social Service systems to improve access to coordinated health, housing and social supports for vulnerable populations, including seniors and individuals with mental health issues. Specific initiatives related to mental health have included:

- *the redevelopment of the Bell hotel into 42 units of permanent housing with on-site mental health and addictions support available 24 hours a day to support stable tenancies for tenants who have experienced chronic homelessness and are high users of health and social service resources;*
- *a Community Wellness Initiative operated in Manitoba Housing as a partnership between Manitoba Health and the RHAs to increase the success of individual tenancies;*
- *the development of the Community Housing with Support Project - a community support team funded by Manitoba Health to provide support services to 50 individuals with a history of homelessness and mental health needs to secure and maintain housing in a scattered site housing model;*
- *support for capital improvements and the transition of the Madison Memorial Lodge to the Siloam Mission with an emphasis on enhanced access to community-based health and social support services for individuals residing in the facility; and*
- *the development of the Portable Housing Benefit, a financial enhancement for individuals living in the community with a mental health disability.*

Winnipeg is also a site for the Mental Health Commission of Canada's homelessness project. This project is a five-year research/demonstration project that addresses the housing and support need of homeless individuals, many of whom suffer from mental health issues. The project will be transitioning into the local jurisdiction in 2013.

Lastly, with the recent launch of "Rising to the Challenge", Manitoba's five-year Mental Health Strategic Plan, there is another opportunity to identify activities related to housing and support needs for individuals living in the community with mental illness who require support. As we continue with this work, we will continue to consider policy and procedures related to housing and supports.

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Additional correspondence was sent from my office to the department on January 3, 2012 in an effort to further clarify the department's policies and procedures. The department was requested to provide the following information:

- The steps taken by community mental health workers to secure suitable accommodations for clients and the criteria considered to ensure the accommodations are designed and equipped to provide the necessary supportive and supervisory services.

- The number of monthly contacts community mental health workers should have with clients including home visits.

- The purpose of the home visits and what should be included as part of the home visit.

- The notification requirements (i.e. psychiatry, police) when a community mental health worker believes a client is becoming a danger to themselves or others and/or the client is beginning to decompensate.

- The criteria followed by community mental health workers when determining the need to attend appointments with clients to ensure current and accurate information is considered by clinicians and to assist in evaluating the adequacy of supports and supervision available to the client in the community.

- The steps taken when service providers withdraw service (i.e. home care, meals on wheels, community programs) and how this information is communicated to collaterals such as psychiatry and staff with regional health authorities who provide care to the client.

- The number and frequency of case consults community mental health workers should have with collaterals for the purpose of updating care plans and to determine if supports and supervision are adequate.

- The notification requirements when clients refuse service (i.e. home care, meals on wheels, community programs) and how this information is communicated to collaterals such as psychiatry and staff with regional health authorities who provide care to the client.

RESPONSE FROM DEPARTMENT

On January 30, 2012, we received the following response from the department:

> *Thank-you for your letter dated January 3, 2012 in which you requested further information regarding the policies and procedures that are in place to ensure the appropriate level of supports and supervision available to individuals living with major mental illnesses. As you know, these practices, policies and procedures will vary across the 11 regional health authorities (RHAs) in Manitoba that are responsible for service provision. Staff in the Department will discuss your request at the next meeting of the Mental Health Management Network of the RHAs which will take place on March 6, 2012, and a response will be provided to you subsequent to that meeting.*

Following the meeting of the Mental Health Management Network in March, the department provided a further response:

Thank you for your letter dated January 3, 2012 in which you request further information regarding the policies and procedures that are in place to ensure the appropriate level of supports and supervision available to individuals living with major mental illnesses in the community.

As you know, these practices, policies and procedures vary across the 11 regional health authorities (RHAs) in Manitoba that are responsible for service provision. Staff in the department presented your questions at the meeting of the Mental Health Management Network of the RHAs which took place on March 6, 2012 where there was an opportunity for discussion.

In general, service providers emphasized that these questions for the most part relate to the provision of support and supervision to an adult, voluntary, community-based population. Best practice in mental health programs and services, as well as mental health legislation, dictates that client choice is a primary consideration when offering support to this voluntary population, therefore the specific services and level of supervision will vary depending on client choice as well as client need, and the availability of services in a particular region.

The following summarizes the discussion with respect to each question.

1. The steps taken by community mental health workers to secure suitable accommodations for clients and the criteria considered to ensure the accommodations are designed and equipped to provide the necessary supportive and supervisory services.

The steps taken by community mental health workers in regards to housing and the criteria considered regarding ensuring adequate support and supervision will vary depending on the availability of housing and supports within the region, as well as client need and client choice. If the client is assessed as requiring a good deal of support and supervision, workers will focus significant efforts to obtain this type of support in the community. All regions have a continuum of housing options and supports for individuals with mental health problems and illnesses and the decision of the appropriate housing and supports for any particular client will be a joint decision between the client and the treatment team.

2. The number of monthly contacts community mental health workers should have with clients including home visits.

The number of monthly contacts community mental health workers should have with clients including home visits will vary depending on the assessed client need and client choice. Individual service plans are developed by the client and the worker, which may outline the frequency of contact.

3. The purpose of the home visits and what should be included as part of the home visit.

The purpose of the home visits and what should be included as part of the home visit will vary depending on the assessed client need and client choice. If there is a history that indicates the client requires support and supervision in order to maintain safety in the community, the individual treatment plan (as developed between the clinicians and the client) will include a comprehensive safety plan which will include items such as checks and balances for taking medication, knowing what to do if feeling unsafe, self-soothing practices, knowing triggers for behaviours that might result in lack of safety, knowing who to call or where to go if needing assistance after hours.

4. The notification requirements (i.e., psychiatry, police) when a community mental health worker believes a client is becoming a danger to themselves or others and/or the client is beginning to decompensate.

Community mental health workers are trained to be aware of the requirements under The Mental Health Act related to individuals who they assess as being a danger to themselves or others or who are assessed as experiencing substantial mental or physical deterioration. Depending on the situation the worker may escort a client for a psychiatric assessment, or may call upon a mobile crisis service or police to assist in escorting the client either directly to a psychiatrist or to an emergency department for assessment.

5. The criteria followed by community mental health workers when determining the need to attend appointments with clients to ensure current and accurate information is considered by clinicians and to assist in evaluating the adequacy of supports and supervision available to the client in the community.

Community mental health workers will at times attend appointments with clients, if it is considered necessary, and if the client consents. If there is a history that indicates there is a need for this type of support and supervision in order to maintain safety in the community, the worker may attend appointments with clients.

6. The steps taken when service providers withdraw service (i.e., home care, meals on wheels, community programs) and how this information is communicated to collaterals such as psychiatry and staff with regional health authorities who provide care to the client.

If considered relevant to the treatment and safety of the individual, information is communicated to collaterals verbally and/or by written communication.

7. The number and frequency of case consults community mental health workers should have with collaterals for the purpose of updating care plans and to determine if supports and supervision are adequate.

The number and frequency of case consults community mental health workers should have with collaterals for the purpose of updating care plans and to determine if supports and supervision are adequate would depend on clinical judgment as a result of ongoing assessment of the individual and his or her particular needs. These types of decisions would be considered when developing the treatment plan and corresponding safety plan for the client and their particular circumstances. Some of this decision would be the judgment of the clinician, or the community mental health worker, and again, in collaboration with the voluntary adult client. Risk assessment is an ongoing aspect of the treatment plan.

8. The notification requirements when clients refuse service (i.e., home care, meals on wheels, community programs) and how this information is communicated to collaterals such as psychiatry and staff with regional health authorities who provide care to the client.

For the majority of adult voluntary clients receiving mental health programs in the regional health authorities there are no notification requirements when clients refuse service. If it is the clinical judgment of the worker that a refusal of service might impact safety, then the information will be communicated, either verbally or by written communication.

In cases where the involvement in mental health services is mandated, e.g. under an Order with the Office of the Public Trustee, or if the individual meets the requirements for involuntary treatment under The Mental Health Act or is under a Certificate of Leave, there is a legislated requirement to notify and processes are in place for that. Also, in most cases, if clients have refused a referral the referral source would be notified.

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From the information that has been provided to my office, it would appear that the department did undertake a review of *The Mental Health Act*, specifically sections 8(1) and 17(1), as recommended by Judge Martin. It is the department's view that the legislation in Manitoba is consistent with legislation that exists elsewhere in Canada.

However, while the department is of the view the legislation in Manitoba is consistent with other jurisdictions, the Canadian Mental Health Association (CMHA - Winnipeg Region) is participating in a national project regarding mental illness and human rights that has been funded through the Mental Health Commission of Canada. We are advised that this project includes research and "the development of a tool to review mental health legislation through a human rights lens using the Convention on the Rights for Persons with Disabilities. Under this pilot project, teams investigated the mental health legislation of three jurisdictions including Manitoba, British Columbia and Nova Scotia. It is our understanding that work is continuing in this area."

Respecting the second part of the inquest recommendation, regarding a review of the policies related to support services and the availability of appropriate housing for individuals with a mental disorder as defined in *The Mental Health Act*, the department has reported on a number of initiatives and strategies undertaken to address this matter. Some of these initiatives and strategies include the Cross-Department Coordination Initiative (CDCI); HOMEWorks long-term housing strategy; and the five year research project being led by the Mental Health Commission of Canada concerning the housing and support needs of homeless individuals, many of whom suffer from mental health issues. The department noted that Winnipeg is one of the sites that the Mental Health Commission of Canada will be considering.

Further, my office acknowledges that department's position regarding the complexity of the issues involving homelessness and the supports necessary for individuals living in the community with mental illness. Many of the issues cross departmental boundaries and require a holistic approach which looks to break down barriers and seeks to achieve improved continuity of care for individuals with mental illness who are reliant on the various systems.

The government has communicated its commitment to continue reviewing this matter, including policy and procedures related to housing and supports. On June 29, 2011, "Rising to the Challenge", a five year mental health provincial strategy, was launched. It reads in part:

> *The strategic plan is the result of consultation and discussion with a cross-section of groups, including individuals with lived experience of mental health problems and illnesses, families and natural supports, mental health clinicians, policy makers, other government departments and community partners. The intent during development of the plan was to make it reflective of the shared knowledge, experience and hopes of Manitobans.*

The plan sets out a number of objectives to be addressed during the five year period and includes a reporting model whereby stakeholders will be notified annually of the completion of key achievements. The strategy reads:

> *A work plan for each of the six goals will be created by "expert" working groups made up of researchers, service providers, policy analysts, individuals with lived experience of mental health problems and illnesses, and their families and natural supports. The working group plans will be organized through a coordinating committee, which will be accountable to a departmental steering committee. The plans will be accumulated into a five year work plan, which will identify expected outputs and outcomes, and will guide the implementation of the overall strategic plan.*
>
> *While several high level outcomes are referenced within this strategic planning document, such as reducing mental health problems and illnesses and increasing access to mental health supports and services, part of the role of the working groups will be to set specific, valid, and measurable outputs and outcomes, based on the strategic actions set out in each goal area. Monitoring and evaluating the plan will be crucial and will assist in following the established directions. To this*

end, a corresponding evaluation plan will measure the strategic plan's successes on many levels including practice, program, organizational, and policy levels. The evaluation plan will help translate the strategic plan into measurable actions and will demonstrate accountability and value for the actions undertaken.

An online copy of "Rising to the Challenge" can be accessed at http://www.gov.mb.ca/healthyliving/mh/challenge.html

Prior to finalizing our file on this inquest, on August 11, 2014, I wrote to the department. I enclosed a draft report on the inquest, containing the responses they had provided to the recommendation to date, and I requested updated information prior to completing this report and posting it on our website, as per our established practice for inquest reporting.

On October 1, 2014, the department responded with the following information:

In the draft closing report, you highlight work being done through the Mental Health Commission of Canada (MHCC) regarding research and tool development to review mental health legislation through a human rights lens. We are looking forward to the outcomes of this work and its potential application to our ongoing work.

We would like to provide you with an update on the status of the research project led by the MHCC At-Home/Chez Soi, a project focused on a housing-first model for persons with mental illness and homelessness. According to the final report on the Winnipeg study, the project was successful in its goals to reduce homelessness, create a cost-benefit to providing housing with appropriate supports, and to increase quality of life for persons with mental illness.

The report can be found at: http://www.mentalhealthcommission.ca/English/document/32946/winnipeg-final-report-homechezsoi-project.

We are pleased to inform you that the At Home/Chez Soi project is now receiving support through the departments of Manitoba Health, Healthy Living and Seniors (MHHLS) and Manitoba Housing and Community Development to continue.

We are also pleased to inform you that MHHLS is providing $400,000 to each of two new, affordable, integrated housing projects with mental health support services:

- *Concordia Village IV, a new 45-unit, safe, affordable and integrated housing project, will support up to 16 people with lived experience of mental health problems or illnesses, with supports provided by Eden Health Care Services.*

- *Partnering with Winnipeg's Sara Riel Inc. to build Place Bernadette Poirier, an integrated 28-unit complex that will provide on-site 24-hour, recovery-based services to support tenants in achieving and maintaining permanent housing; 14 of the units are designated for people with lived experience of mental health problems or illnesses.*

Lastly, since the 2011 launch of "Rising to the Challenge", Manitoba's five-year Mental Health Strategic Plan, there have been a number of initiatives stemming from the plan that have been accomplished or are in process of completion.

The Year One Report of Achievements can be found at: httb://www.gov.mb.ca/healthyliving/mh/doc/challenge report of_ achievements.pdf.

The Year Two Report is expected to be posted on the government website in the next few months.

Thank you for sharing the draft closing report with our department and providing the opportunity to update you on work to date. As we continue to implement the mental health strategic plan, housing and supports for persons with mental health problems and illnesses will remain a focus.

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It appears these matters remain a work in progress that the department has communicated its commitment to advance. Nevertheless, based on our review of this file, it would appear that the Department of Health has given reasonable consideration to the recommendation contained in the inquest report dated September 30, 2011. Accordingly, we have concluded our monitoring of the implementation of the recommendation given the information provided and our file concerning the inquest has been closed. This report will be posted on our website at: www.ombudsman.mb.ca

Yours truly,

Original Signed By

Mel Holley
A/Ombudsman

cc: Ms Karen Herd, Deputy Minister of Health
Dr. Thambirajah Balachandra, Chief Medical Examiner