HUMAN RIGHTS AND THE SITUATION OF THIRD SECTOR MENTAL HEALTH NGOs IN SASKATCHEWAN

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The Social Policy Research Unit (SPR)

The Social Policy Research Unit (SPR) was established in 1980 as the research arm of the Faculty of Social Work, University of Regina. The unit coordinates the research endeavours of all faculty members and provides assistance to students and others investigating social welfare and social policy issues. SPR's primary goal is to conduct critical analytical research that enhances the quality of life for individuals, families and communities.

The unit maintains close working relations with community-based organizations, government departments and other research and policy institutes in order to contribute to informed social policy and human service developments in Saskatchewan and elsewhere. In addition, the unit is involved in disseminating social policy analysis and research findings through conferences, workshops, seminars, the media and various publications, including working and occasional papers and project publications.

SPR's Working Paper Series is designed to initiate discussion on emerging issues in social policy and human service practices and to identify research priorities. The Occasional Paper Series and SPR Project Publications provide access to the findings of substantive research in social policy and human services. All publications are intended as resources for policy development, teaching and educational work in the university and the community at large. A list of SPR’s most recent publications is found on the back cover of this paper and on SPR's web site at www.uregina.ca/spru_publications.htm

Fiona Douglas
Managing Editor
Social Policy Research Unit
Abstract

This paper surveys the situation of the third sector mental health NGOs in Saskatchewan and highlights how human rights implementation may serve to empower these NGOs. It suggests how a resolution of their major difficulties – which are primarily funding concerns – relates to the great geo-cultural diversity of the province and to orienting social policy towards the implementation of government's human rights obligations. During the spring of 2000, the Social Policy Research Unit (SPR) of the Faculty of Social Work at the University of Regina identified, mapped and surveyed the third sector mental health NGOs in Saskatchewan. The purpose was to discover their role in providing for essential mental health services, the major difficulties they face in attempting to provide such services, the nature of their funding sources, and their attitudes toward funding sources. Analysis of the survey suggests that third sector mental health NGOs are essential to the delivery of the highest attainable standard of mental health in Saskatchewan; that the major problem was finding sufficient funding from sources which do not cripple the NGO's ability to animate and deliver culturally specific and other essential services; and that there is a complementary linkage between the empowerment of the NGOs and human rights implementation.
Acknowledgements

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Introduction

Saskatchewan is a sparsely populated province, particularly in its northern half where fewer than 50,000 people live in an area of more than 600,000 square miles.\(^1\) While the far north is peopled almost exclusively by aboriginal nations, the rest of the province is populated with people from many ethnic backgrounds who engage in a wide range of economic activities such as farming, mining and manufacturing. The total population of Saskatchewan is about one million. Demographically, it has a high dependency ratio and the proportion of the dependent population is projected to increase in coming years.\(^2\)

However, during the last two decades, there has been a marked shift in government support for human services in much of the industrialized western world. The trends started by Mulroney/Reagan/Thatcher in the 1980s were continued by governments until the late 1990s. Although the CCF government of Tommy Douglas was the precursor to the current NDP initiated medicare in this country, the current Saskatchewan NDP government completed the privatization of the Potash Corporation of Saskatchewan, sold off its stake in the Lloydminster Husky Heavy Oil Upgrader project, and significantly altered the face of health care in the province by reducing the number of personnel and hospital beds (especially in rural areas).

While the Saskatchewan government said it acted to improve the quality and efficiency of healthcare in the province,\(^3\) some third sector mental health NGOs speculate that it was because of the privatization agenda, which started in the 1980s, and the deficit reduction agenda, which followed in the 1990s, that governments systematically offloaded the delivery of services onto third sector NGOs (Riches and Maslany, 1995). Whatever the reason for the shift in government support for human services, more research is needed in order to understand the effects of offloading onto the third sector and the issues surrounding third sector service delivery.

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\(^1\) See Appendix A for map and information.
\(^2\) The combined social and economic implications of shifting demographics factors, such as the aging of the population, the growth rate of aboriginal people, the rural to urban shift caused by changes to the agriculture sector, as well as the continued exodus of educated youth to other provinces and countries, put additional pressure on existing human service systems and suggest increasing future needs for effective and culturally appropriate human services delivery.

\(^3\) According to S.O Brown, former Ministerial Assistant: "Ideologically, a dramatic shift in health care policy occurred in Saskatchewan in the early nineties. Previously, centralization of public institutions was believed to be the key for increasing the quality and efficiency of human services in the province. Children were bussed further and sick people traveled greater distances to obtain the benefits accrued from the pooling of resources. With the increased levels of specialization that centralization provided, individuals were persuaded to defer to, and, thereby, developed a greater degree of reliance upon specialists. However, reliance had a price both in psychological as well as monetary terms. Recognizing the monetary cost—the Department of Health utilized more than a third of the provincial budget—the Saskatchewan government instituted a number of strategies to encourage individuals to assume a greater responsibility for their personal health care. It initiated a number of “wellness” programs such as the disinstitutionalization of mental healthcare, designed to assist its healthcare citizens improve their lifestyles."
of information about the role of third sector mental health NGOs in Saskatchewan is especially noticeable.\(^4\)

During the Spring of 2000, the Social Policy Research Unit (SPR) of the Faculty of Social Work at the University of Regina identified, mapped and surveyed segments of the third sector mental health NGOs in Saskatchewan. The purpose was to discover the role of NGOs in providing for essential mental health services, the major difficulties NGOs face in attempting to provide such services, the nature of their funding sources, and their relation to government.

In this paper, we review the situation of the third sector mental health NGOs in Saskatchewan and highlight how human rights implementation\(^4\) may serve to empower those NGOs.\(^6\) We suggest that a resolution to their major problem—responding to the great geo-cultural diversity of the province within the context of inappropriate funding constraints—may be assisted by orienting social policy towards governmental achievement of human rights obligations. Thus, in elaborating the role and the main concern of Saskatchewan mental health NGOs, we also draw attention to the possibility of a significant complementary linkage between social need fulfillment and human rights implementation.

**Methodology**

Our survey received information from a sample of 27 community-based organizations in selected areas of the province of Saskatchewan.\(^7\) The United Way, district health boards, and Canadian Mental Health Associations in these areas were asked to compile a list of mental health-related organizations that they funded.

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\(^4\) In Saskatchewan, communities were free to choose the configuration of the health district boundaries which they felt best represented their own needs and interests. Thus, all health services were regionalized and mental health services were de-institutionalized. (See Appendices for a map of health board boundaries, the regions surveyed and the responsibilities of health boards.) Comments on de-institutionalization of mental health services suggest that most third sector organizations viewed this as a positive occurrence that would allow the mentally ill to live more normal lives in their home communities; however, with government cutbacks in hospital beds and personnel, more research is required to determine budget cut consequences on the benefits of de-institutionalization of mental health clients.

\(^5\) Here we refer specifically to the human right to the highest standard of attainable health care: i.e., Article 12 of the Covenant on Economic, Social and Cultural Rights.

\(^6\) Here we speak specifically of their reported need for sufficient and appropriate funding which allows for culturally specific and rural-oriented programming as reported in our survey.

\(^7\) Community-based organizations that provide mental health services in the four target areas of Regina, Swift Current/Shaunavon area, North Battleford area and extreme Northwest portion of Saskatchewan. **Regina:** Mobile Crisis Services, Rainbow Youth Centre, Phoenix Residential Society, Canadian Mental Health Association Regina Branch, Autism Resource Centre, Ehriio Counselling, Family Service Bureau, Peyakowak Committee, Regina Mental Health Clinic, Regina Residential Resource Centre, Regina and District Association for Community Living, Survivors of Road Trauma, Regina Home Economics for Living, Circle Project, Catholic Family Services, Street Workers Advocacy Project, Open Door Society, Crisis Management Services, Caring Place; **Swift Current/Shaunavon area:** Canadian Mental Health Association Swift Current Branch; **North Battleford area:** Battlefords Community Mental Health Centre, Addictions Services, Canadian Mental Health Association Battlefords Branch; **North West area:** Kiyenaw Centre and Meadow Lake Tribal Council. The Schizophrenia Society of Saskatchewan and the Alzheimer Society of Saskatchewan are provincial organizations.
Phone calls were made to the 27 community-based organizations in an attempt to gain a commitment to complete a questionnaire and return it by mail. If they agreed, then a questionnaire, consent forms and a self-addressed stamped envelope were mailed to them. If the questionnaires were not returned within 14 days, a follow-up phone call was made and, in some cases, duplicate questionnaires were mailed to respondents. Seventeen responses were received. Fifteen questionnaires were used (in relation to the preparation of this paper) to identify the main thematic issues of concern to the NGOs surveyed. This involved recording all the issues of concern identified by the NGOs and then determining the overriding themes. Five themes emerged from this process. An international legal analysis of the thematic issues was then conducted to determine if they represented demands or needs which by government’s international legal obligation has become a human right.

Definition of Key Terms
A difficult task associated with this survey was to arrive at a functional definition for the concepts "mental disorder," "mental health services" and "third sector NGOs" (community-based service providers). If definitions were too narrow, then the picture presented by the survey may not have sufficiently represented the reality of the concerns of the third sector NGOs; conversely, if the definitions were too inclusive, the task would have grown beyond the purpose and scope of this research project.

For the purposes of the survey, we decided upon Yves Vaillancourt’s definition since it best describes the NGOs selected as well as our own views on a third sector NGO. Note that by this definition, government or quasi-governmental organizations would have difficulty meeting requirements #3 and #4, and therefore government or quasi-government-operated NGOs would not be considered third sector mental health organizations.

Many references were consulted in attempts to arrive at definitions suitable for the purpose of this survey. Particular attention was given to the Canadian Criminal Code, the Mental Health Act of England and Wales, The Mental Health Services Act (Saskatchewan), The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, several online sources

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8 The Quebec Task Force on the Social Economy has enunciated five principles to distinguish genuine social economy initiatives: 1) has as a primary goal service to members or the community rather than the accumulation of profit; 2) autonomous management (as distinguished from public programs); 3) democratic decision-making processes; 4) primary of persons and work over capital and redistribution of profits; 5) operations based on the principles of participation, empowerment and individual and collective accountability. (Levésque and Ninacs, 1997, 6)
and the literature on the nature of the social economy. These efforts resulted in the use of the following definitions:

**Mental Disorder:** a behaviour, illness or mental state that causes an individual great suffering or worry, is self-defeating or self-destructive or is maladaptive and disrupts the person’s relationships, daily functioning or the larger community.

**Mental Health Service:** (by extension, mental health service was functionally defined as) a response, in an attempt to assist the sufferer of a mental disorder.

**Third Sector NGOs:** community-based, non-profit and non-governmental organizations which are board driven and/or client or constituent oriented and are directly accountable and responsive to the needs of their clients and/or communities.\(^9\)

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**Selection of Areas for Survey**

The most substantial difficulty faced in selecting the areas and NGOs to be surveyed related to the socio-cultural and geographic diversity of the province of Saskatchewan. Due to the probable significance of unorthodox NGO mental health services in the aboriginal and rural communities, it was difficult to assure accuracy concerning the size and scope of both traditional and unorthodox third sector services offered across the various regions of the province. For example, the far north of the province, with its sparse population, high unemployment, low level of education and high aboriginal population has substantially different culturally specific third sector service delivery methods and societal institutions, (i.e., sweat lodges, healing circles, etc.) from those in the extreme south. The south has more urban areas than the north and is predominantly populated by persons of European descent who are employed in the resource sector and have access to modern and orthodox services and community resources which simply do not exist in the north. Similar differences exist between urban and rural areas. Urban areas have access to orthodox emergency resources twenty-four hours a day, whereas in rural areas such services are often not available and mental health service may often be delivered by Alcoholics Anonymous and other 12-step anonymously run, community-based organizations.\(^10\)

Time and resources did not permit inclusion of any rural or aboriginal unorthodox third sector mental health NGOs, although we are aware of their existence and their possibly significant contributions to third sector mental health service delivery. Thus, given the vacuum of

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\(^9\) Ibid
\(^10\) Ibid.
knowledge in all sectors of what is often referred to as the social economy in Saskatchewan, we limited our survey in order to provide a nominal description of the situation of orthodox mental health third sector NGOs in Saskatchewan, which, we hope will whet the provincial appetite for more exhaustive surveys.

After due consideration of Saskatchewan’s situation as well as our own limitations, we chose four types of regions to represent the state of third sector mental health services:

1) **Urban areas** such as Regina, Saskatoon, Prince Albert, Swift Current and Moose Jaw. We believed these areas have a good baseline of services that extend to a large segment of the population.

2) **Urban/Rural mix** such as North Battleford and Yorkton, which are smaller urban centres located some distance from a major centre and with a large surrounding rural area. These areas are often also populated with aboriginal communities, especially in the Parkland region of Saskatchewan.

3) **Southern Rural** portion of the province, which has large areas not located near a major centre, where economies are agriculture or resource-based, and where the population is fairly homogeneous.

4) **Northern Rural/Remote** region. Most of the province north of Prince Albert is populated with a large proportion of aboriginal people, both Status and Non-Status. There are often widespread social problems due to extremely high unemployment, poverty and isolation in this region,\(^\text{11}\) and the third sector social delivery institutions are significantly different from the rest of the province.

The Saskatchewan Health District boundaries were used to decide the boundaries between areas targeted for this survey. During its reorganization of the health care system in the early 1990s, the provincial government established the health district boundaries.\(^\text{12}\) Because the communities were free to choose the configuration of the health district boundaries which they felt best represented their own needs and interests, it can be argued that the configuration chosen signifies a meaningful social/community boundary from the perspective of the area residents. This makes

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\(^{11}\) Frideres in Bolaria, 1991, p. 116

\(^{12}\) According to the Saskatchewan Government Web Site, health services in Saskatchewan are administered and delivered through 32 health districts and one health authority. A board composed of elected and appointed members governs each health district and authority. This board is responsible, under *The Health Districts Act*, for planning, managing and delivering health services to Saskatchewan residents. (See also Appendix)
the use of the health district boundaries particularly appropriate to this study as we are focussing on third sector mental health NGOs which are community-based organizations.

The following specific cities or town areas of the province were chosen from which to secure data samples:

a) The City of Regina was chosen to represent the urban area partly because the researchers work in the City of Regina, and partly because it was felt that Regina and Saskatoon (Saskatchewan’s two largest cities) are similar enough that the data obtained from the City of Regina could be generalized to the City of Saskatoon. (A later sampling of responses to our questionnaire from a few third sector mental health NGOs in Saskatoon supported this assumption.)

b) The North Battleford area was chosen to represent the urban/rural mix. This area, located in the west central portion of the province, is quite typical of the urban/rural mix.

c) The Shaunavon area was chosen to represent the southern rural portion of the province. Here, the geography is mixed between the Cypress Hills and the Grasslands areas, and industry ranges from ranching and mixed farming to oil and gas.

d) The extreme Northwest was chosen to represent the northern rural/remote portion of the province. The KeewatinYathe Health District, while constituting almost one fourth of the geographic area of the province, is extremely sparsely populated.

**Classification According to Funding Source**

In order to identify the third sector NGO providers of mental health services in each of the four regions chosen for study, we contacted organizations which seemed to be responsible for providing much of the available funding. These were the United Way, which provided no mental health services itself but funded organizations that did, and the Canadian Mental Health Association and its branch offices, which provide services as well as funding to mental health NGOs. The district health boards were also contacted to determine which organizations they funded. Supplementary efforts included consulting the Internet, the yellow pages and
community directories. Once the third sector mental health NGOs were identified, they were contacted and invited to fill out our questionnaire.\textsuperscript{13}

Central Themes Emerging

Five thematic areas of concern emerged from an analysis of the survey findings.

1. The first theme relates to \textit{the role of the community-based organization in the provision of mental health services}. It appears that these organizations play an essential role in the care of mental health clients. Once the primary service provider (that is, the medical profession) addresses the nature of a mental health problem, then community-based organizations can be a secondary source of support and supervision. They play an important role in the life of the mental health client as s/he attempts to gain functional independence and social integration.\textsuperscript{14}

The fact that under the present conditions in Saskatchewan, third sector NGOs may play an essential role in the delivery of mental health services does not imply that they should or should not play such a role.

2. The second theme relates to \textit{inappropriate constraints on funding}. Many respondents said their programs were subject to qualitative and quantitative measurements and program evaluation (written and oral, internal and external) conditional upon their receiving funding. It would appear that most third sector mental health NGOs in Saskatchewan feel they are accountable to the funder and obliged to use funds as proscribed. They do not object to having to provide evidence of accountability and undergo evaluations; however, our survey indicated that they feel too often obliged to drop or cut back on programs which are beneficial to their clients due to inappropriate constraints placed on them by funders. Thus, it is the nature of the constraints (who is responsible, the procedure used, etc.) that raises an issue for third sector NGOs.

\textsuperscript{13} Upon examining the potential subject of study for this project, three types of third sector mental health NGOs, classified according to their funding sources, appear to exist. First, there are those directly funded by government, whether provincial or municipal. These include organizations such as the Community Living Division of Saskatchewan, Social Services and the Canadian Mental Health Association. Second are the member funded NGOs. These organizations survive by collecting membership fees or donations from members and include the various anonymous 12-step programs as well as the Canadian Mental Health Association. (The 12-step organizations present a special challenge because by their very nature they are anonymous. This is one type of third sector NGOs in Saskatchewan that we suggested may make a significant contribution to mental health services in rural Saskatchewan but could not be included in our survey. It was impossible for us to ascertain the numbers of people involved, the extent of their involvement or the exact types of services provided.) The third type of NGOs are the third party/charity/umbrella groups such as the United Way. Of course, there is considerable overlap between these categories as some organizations receive funding from a variety of different categories of sources. Thus, some organizations such as the Canadian Mental Health Association fit into more than one category.

\textsuperscript{14} This was verified by our discussion with the directors of third sector mental health NGOs in Saskatchewan.
Future research is required to determine the exact nature of what our survey refers to as inappropriate constraints, the effect constraints may have on the overall quality of services provided and how well the agencies are able to respond to client needs if they feel hampered by outside constraints.

3. The third theme to emerge has to do with insufficient funding in general. The United Way and the district health boards appear to be the most common funding agencies. Five of the respondents stated that they negotiate future funding with the United Way, while six reported receiving funding from their respective local health district. Different provincial government departments and agencies also play a role in funding. However, most NGOs surveyed felt that there were too few funding sources. Respondents also indicated that greater funding would better allow them to create alliances with other community-based organizations, thereby eliminating much of the overlap as well as filling some of the service gaps.

4. The fourth major theme relates to culturally relevant services. Although only one completed questionnaire was received from a First Nations agency, conversations with other First Nations community-based organizations and non-First Nations community-based organizations which provide mental health services revealed a similar theme: the lack of mental health services which are sensitive to the cultural differences within the province of Saskatchewan. This is generally viewed as partially due to the program priorities placed on funds received or the lack of appropriate funding priorities.

5. A final theme emerging for the survey and its analysis concerns the effect of intense competition for funds. Competition for funds is so severe as to create conditions that encourage NGOs to succumb to inappropriate constraints on funds, thereby crippling their efforts to provide essential services to their clients and communities. With one exception, all respondents indicated degrees of frustration at the intense competition for funding. Several organizations called attention to the fact that there were too few funding sources outside of the urban areas. This point is directly related to theme three, as constraints and limited funding sources operating in an atmosphere of intense competition may negatively affect the effectiveness and efficiency of third sector organizations by limiting their ability to cooperate in areas where cooperation would produce better service delivery.

Responses also indicated that the level of financial support reported as received by the community-based organizations ranged from nothing (for a support group that meets
occasionally) to over $800,000 for a major third sector NGO providing a wide range of services. As well, according to the responses received, third sector NGOs spent most of their budgets on staff salaries. All but one agency spent at least 50 percent of their annual budgets in this way. Most allocated over 75 percent to staff wages.

Themes Concerning Human Rights

From the perspective of human rights, which advises us that the government has the obligation to provide the means whereby its citizens may enjoy the “highest attainable standard of mental health,”15 it is relevant to ask whether the role of third sector NGOs is necessary in Saskatchewan in order for the government to fulfill its legal/moral human rights obligations, and whether the fulfillment of such obligations could provide the conditions under which the thematic concerns reported in our Saskatchewan survey could more easily be resolved.

The first theme emerging from the survey indicates that third sector mental health NGOs in Saskatchewan do play a role in providing essential services for mental health clients. “Once the ongoing source of a mental health problem is addressed by the medical profession, community-based NGOs are the source of support and supervision, etc. as s/he attempts to gain and in some cases regain functional independence and social integration into society.”16 Here we are not suggesting that third sector NGOs should or already do play an essential role in service delivery. In assessing the results of the survey, it thus appears that, in this case, NGOs are playing an essential role and this apparent fact is sufficient to warrant an international human rights legal analysis. Note also for the purpose of international legal analysis, it is not necessary to suggest that NGOs do a better or a worse job than government.17 The legal issue is simply whether in the present situation/case they can be considered essential.

15 The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with Article 12.1 of the Covenant, States parties recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health care.”
16 As reported by N. Eddy, and S. Payne, Third Sector Involvement in Mental Health Services, unpublished survey report, p. 5, SPR, Faculty of Social Work, University of Regina. August, 2000.
17 Note that while it is easy to dismiss the significance of the shift of services to third sector organizations as deficit driven government offloading, the situation may not be that simple. Due to the structure of community-organizations, it is possible that third sector organizations represent an improvement in the service delivery mechanism for mental health services. Given that they are community based, they offer a direct link between consumer and service provider, independent boards of directors, and the narrower scope of responsibilities. Also we have seen that most of these organizations spend the bulk of their budgets on staff and the provision of services. They are often run by volunteer boards of directors who have a stake in the services being provided. A study of the effectiveness and efficiency of these organizations would be valuable for future projects. If community-based organizations are able to meet the needs of mental health service consumers more effectively for less money than the traditional system, it may be prudent to increase their role in the system. Suffice it to repeat that the responses to this survey indicated a great deal of potential for an increased role for third sector NGOs.
Thus it appears we should investigate the possibility and significance of possible governmental obligations in human rights law to assure that third sector mental health NGOs are able to efficiently and effectively perform their essential human service role. In international law, health is a fundamental human right indispensable for the exercise of other human rights. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights, when interpreted in conjunction with other articles, including Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), affirms that everyone regardless of class, religion, etc, has the right to the highest attainable standard of health and social service. Similarly, Article 12.2 of the ICESCR affirms that required steps should be taken to achieve the full realization of this right. Other instruments affirming this right in relation to special societal sectors include the International Convention on the Elimination of All Forms of Racial Discrimination Article 5(e)(vi); the Convention on the Elimination of All Forms of Discrimination against Women, Article 11 (1)(f); the Convention on the Rights of the Child Article 24 (1); and The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988. Therefore, it is reasonable to assume health care obligations as recognized in the ICESCR (which Canada ratified on behalf of all of its provinces [See J. Symonide and Vladimir Volodin, Human Rights: Major International Instruments Status as at 31 May, 1996. UNESCO, Paris, 1996]) should have legal and moral effect in a manner whereby they relate to healthcare problems and the Saskatchewan government’s legal/moral obligations.

Note that international human rights law defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (Article 1, Constitution of WHO as reported in ST/HC/2rev9, p. 30). The ICESCR embraces a wide range of interpretive latitude.
of socio-economic factors required for good health and takes into consideration both the individual's biological and socio-economic preconditions and a government's available resources. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary (such as those reported in our survey) to be offered by third sector mental health NGOs in Saskatchewan, for the realization and maintenance of the highest attainable standard of health (HASH).

Our search for HASH should contain three essential elements: a) availability, b) acceptability, and c) quality.21

**Covenant Legal/Moral Obligations**

As with all human rights, the right to health imposes three types or levels of obligations on governments: the obligations to respect, protect and fulfil.22 Note that the obligation to fulfil requires governments to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. When viewed in light of the second theme emerging from the Saskatchewan survey, it suggests that government should assure that third sector NGOs can secure required funding without having to compromise the quality or scope of services offered.

The second theme emerging from the survey suggested the financial challenge of providing for the highest attainable standard of mental health care while competing for sufficient funding. Eddy and Payne23 concluded from the survey data that “many respondents said that while they fully accepted the concept and necessity of funders’ evaluations and accountability, their

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21. a) Availability: functioning public health and health-care facilities, goods and services, as well as programs, have to be available in sufficient quantity within the State party. (b) Acceptability: all health facilities, goods and services must be respectful of medical ethics and culturally appropriate (i.e. respectful of minorities, sensitive to gender, etc.) This suggests that government may have a legal/moral obligation to assure that health programs are culturally sensitive, particularly with regard to First Nations in Saskatchewan. (c) Quality: As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. Even in States with severe resource constraints—far from conditions in Saskatchewan—the vulnerable members of society must be protected by adopting relatively low-cost target programs: (a) government has immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination and (b) government has a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of Article 12. If any deliberately retrogressive measures are taken, the government has the burden of proving that they have been introduced after the most careful consideration of all alternatives, and that they are duly justified by reference to the totality of the human rights provided for in the Covenant in the context of the full use of the government's maximum available resources. See Newman and Weissbrodt, 1990, pp. 359-384, and Manual on Human Rights Reporting, HR/Pub/91/1, pp. 3-38, 39, 97.  

22. The obligation to fulfil contains obligations to facilitate, provide and promote. The obligation to respect requires governments to refrain from interfering directly or indirectly with the enjoyment of the right to healthcare. The obligation to protect requires governments to take measures that prevent third parties from interfering with Article 12 guarantees. According to General Comments Nos. 12 and 13 by the Committee of the ICESCR, the obligation to fulfil incorporates an obligation to facilitate and an obligation to provide. In the present General Comment, the obligation to fulfil also incorporates an obligation to promote because of the critical importance of health promotion in the work of WHO and elsewhere.  

23. Eddy and Payne, p. 6, *op. cit.*
programs often suffered from injurious funding constraints which were inappropriately preformed.”

It would appear from the survey that third sector NGOs “feel they are accountable to the funder and obliged to use the designated funds as proscribed.” While accountability is considered reasonable and expected, our researchers, through analysis of the survey and direct contact with third sector mental health NGOs suggest that clients may often not be provided with the highest attainable standard of health care, due to lack of funding, intense competition for funding, or inappropriate constraints attached to funding or any combination of the aforementioned. As noted by John Hylton, not one NGO surveyed opposed evaluation or accountability “in principle”:

In fact, they recognize evaluation is part of continuous improvement and that funders have a responsibility to ensure that good value is being achieved for the resources that are being expended. The “unnecessary and injurious constraints” that are referred to are more likely to arise from how evaluations are carried out and how accountability is achieved. For example: 1) who is going to do the evaluating? 2) What standards and criteria will be used to judge effectiveness and efficiency? 3) Have these been agreed upon? 4) Do they reflect the NGOs' perceptions of needs and priorities, the perceptions of families and consumers who require services, or those of the funding agency? 5) Is the funder in a conflict of interest since they (usually the district health boards) are also delivering services with limited budgets and may, in fact, be in a competitive position quite different from an independent, third-party evaluator? 6) Has the funder provided the NGO with the resources that are needed to develop effective systems of evaluation and accountability? 7) Does the NGO have the necessary time, money and expertise to be an effective participant in a meaningful evaluation?

The responses received relative to theme three (insufficient funding) seem to reinforce the interpretation of the respondents’ responses indicated within theme two. The survey analysis suggests that a major problem facing third sector mental health NGOs in Saskatchewan relates to inappropriate constraints placed on funding as well as insufficient funding.

The fourth major theme emerging from the data analysis related to the need for culturally relevant services. This lack of culturally relevant services suggests the state’s human rights obligations under Article 12:1-2 of the ICESCR to provide such services to Saskatchewan’s aboriginal populations so as not to violate their human rights to nondiscrimination.

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24 In order to protect the identity of our respondent organizations we chose not to ask for or report any specific examples of inappropriate funding constraints that may have been cited.

25 Ibid., p. 6.

26 Here nondiscrimination relates to the right to be different. Article 27 of the International Covenant on Civil and Political Rights, to which Canada is a signatory, provides persons belonging to national minorities with the right to be different. If their being different is not given due
Emerging from our analysis of the survey data is a clear indication that the major problems for third sector NGOs have to do with issues of adequate and appropriate funding (without inappropriate constraints) that permit NGOs to provide for the highest attainable standards of mental health care without discrimination. It is important to note that all health care professionals consulted did not feel that the role of the third sector NGOs could be transferred to the health sector or any other societal sector.

Given the above conclusions derived from an analysis of the survey data, coupled with what is the clear human rights obligation of governments under Article 12:1-2 of the ICESCR, a human rights developmental approach suggests that social need fulfillment, as it relates to the Saskatchewan survey, complements human rights implementation. It also raises the pertinent question of whether a solution to the problem of providing for appropriate, sufficient funding and culturally sensitive mental health care in Saskatchewan is amenable to a human rights development approach. That approach would attempt to effectively organize all present efforts and societal sectors (including relevant government agencies and business leaders) so as to assist government in meeting its international human rights obligation to promote, respect and provide for the human right to the highest attainable mental health care in Saskatchewan. The failure of government to sincerely prioritize this goal may result in serious violation of the human rights of the citizens/clients of the mental health system.

Survey Themes and How Governments May Violate Human Rights

In order to give due consideration to the question raised, we may in turn ask: In what specific international legal ways can government violate the human right to the highest attainable mental health care of its citizens/clients, and how are these specific ways related to the thematic concerns of the third sector health NGOs we surveyed? Governments violate the right to health care when

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27 As used by the United Nations Volunteers and United Nations Development Program.

28 If human rights and social needs fulfillment can be complementary as suggested by the correlation of themes emerging from the survey with human rights, then the failure to resolve the problematic of concern, which in the Saskatchewan survey calls for appropriate/sufficient funding and the introduction of increased culturally sensitive programming, could be said to result from the absence or failure to implement a human rights developmental orientation. We have found that the most difficult aspects of explaining to NGO leaders and activists the relevance of the human rights development approach to issues of community development is that the legal institutions can be marshaled to support the moral/legal obligations and thus significantly empower the ongoing socio-political societal needs fulfillment demands. The legal aspect of human rights calls for a resort to legal authority that often appears removed from the issues of concern. While it can be said to be removed by its normative nature, it is relevant to the
a) the normative content or authority of Article 12 (Part I) of the ICESCR, etc. is not upheld. In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under Article 12. This follows from Article 12.1, which speaks of the highest attainable standard of health, as well as from the Covenant, which obliges each government to take the necessary steps to the maximum of its available resources. If resource constraints render it impossible for a government to comply fully with its Covenant obligations, it has the burden of verifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, its obligations;

b) through the adoption of any retrogressive measures incompatible with the core obligations. Violations through acts of commission include the formal repeal or suspension of legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health. This adds legal/moral obligation to adopt appropriate measures, including laws and institutions, and challenges the rights of government for political or philosophic reasons, to repeal laws that protect a human right;

c) through violations of the core right to health through acts of omission, including the failure to take appropriate steps towards the full realization of everyone's right to the enjoyment of the highest attainable standard of mental health; the failure to create an appropriate social policy; and the failure to enforce relevant laws. This would apply if budgetary restraints arguments were used as an excuse for not appropriately funding or evaluating third sector NGOs when the real reason is ideological instead of resource based;

d) through the failure to remove or avoid State actions, policies or laws that contravene the standards set out in Article 12 of the Covenant. This would apply if it is known that a certain law, institution or policy prevents providing for appropriate funding and evaluations, and government does nothing to remove this law, institution or policy;

e) through the failure of a government to take all necessary measures to safeguard persons within their jurisdiction from infringements on the right to health by third parties. This includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others. (i.e., this would become applicable if government failed to intervene to prevent a corporate interest from acting in such a manner as to restrict the ability of appropriate funding for health care, say, in the name of globalization); and

issues of concern and adds a legal/moral societal avenue for change to the more familiar socio-political and economic avenues. It is the understanding and the advantages of normative relevance as it relates to law in the particular situation that requires clarification.
f) through the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; this includes insufficient expenditure or misallocation of public resources resulting in the lack of culturally sensitive programs and consequently, the non-enjoyment of the right to health by individuals or groups such as Saskatchewan First Nations and other vulnerable or marginalized groups.

All of these points can be viewed and acted upon from the perspective of human rights violations or an unwillingness to meet obligations. Governments often excuse their failure to provide for a human right such as the highest standard of attainable mental health care (which in our survey would necessitate sufficient and appropriate funding to encourage more culturally sensitive NGO programming) by simply pleading lack of resources or money. However, as mentioned, international human rights law requires that the government prove lack of resources and thus makes a functional distinction between government unwillingness and its genuine inability to comply due to lack of resources. While it is not within the scope of this survey and human rights analysis to investigate the methods available to distinguish between the lack of resources (money) and the governments’ unwillingness to provide appropriate resources, such methods do exist and are used by international organizations. An example is the method used by the UN Committee on Economic, Social and Cultural Rights to make an authoritative functional distinction in the 1995 case, The National Anti-Poverty Organization vs. Canada. We speak of a functional distinction in the sense that if an investigation points more towards unwillingness than towards inability in any given situation, then the human rights development approach provides social movements and the institutions they represent with the moral/legal legitimacy necessary to unleash broad socio-political, economic and legal/moral democratic societal processes towards arriving at a remedy.

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29 The human rights process where such distinctions occur when a human rights monitor investigates to determine if a human right is being violated. Once this legal determination is made, a prima facie case is taken to the correct tribunal, committee or court. This tribunal is given the authority by the treaty concerned to determine whether the apparent violation results from the unwillingness or inability of government.

30 1) Any person or group victim of a violation of the right to health has access to effective judicial or other appropriate remedies at both national and international levels. Regardless of whether groups as such can seek remedies as distinct holders of rights, both the collective and individual dimensions of Article 12 bind State parties. Collective rights are critical in the field of health; modern public health policy relies heavily on prevention and promotion which are approaches directed primarily to groups (e.g., national ombudsmen, human rights commissions, consumer forums, patients’ rights associations, national and international courts and political and quasi-legal forums). 2) The incorporation in the domestic legal order of international instruments recognizing the right to health to enhance the scope and effectiveness of remedial measures. (See General Comment No. 2, para. 9) 3) The education of judges and members of the legal profession to encourage States parties to pay greater attention to violations of the right to health in the exercise of their functions. 4) States parties can avail themselves of technical assistance and cooperation of the world’s health organizations, WHO and UNICEF, the Human Rights Committee and other treaty bodies, etc.
The international human rights developmental approach to resolving the third sector mental health NGOs’ issues of inappropriate/insufficient funding and lack of culturally sensitive and other services would valorize the logic of implementing human rights law as an important criterion for government social policy (in this regard) and for deciding if a government was either unwilling or unable to provide the necessities for the highest standard of mental health services.

The ICESCR is prescriptive and can militate against the status quo, insofar as the status quo may have demonstrated itself unable to provide human beings with lives free from fear and want, as stated in the Preamble.\(^3\)

The human rights obligation to “take appropriate measures” to achieve the highest attainable standard of health services suggests that government should restructure their spending to enable them not only to reduce overall spending, but also to concentrate more on projects that help to accelerate the creation of conditions necessary for the realization of economic and social rights. (In relation to our survey, this means the highest standard of mental health care.) To do so, it may be necessary for government policy to set criteria that can distinguish what is essential from what is inessential for human rights. Without criteria, it may be impossible to establish democratically agreed priorities for separating the more essential (human rights) from the less essential and the more productive from the less productive, or wasteful use of resources as it concerns human-centered democratic sustainable development (HCDSD). The third paragraph of the Preamble of the Covenant reads:

> The ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights.

While we may be able to identify and define "ideals," determining their correspondence to realities may be problematic.

\(^3\) Thus governments are requested to marshal national and international resources and give priority to the expenditure of those resources in achieving the full realization of human rights. Socio-economic human rights are violated where a State either neglects their realization while enjoying adequate resources, or implements them in a discriminatory way. By asserting that these goals require “the creation of conditions” and that States must “take steps,” the International Covenant indicates there is a requirement incumbent on states to act on a governmental social policy level with regard to economic policies, insofar as it is only at this level that action can have sufficiently widespread effect as to be said to alter or “create” conditions - “conditions” referring to the total economic and political environment where the recognition of human rights can be implemented. That the creation of these conditions should apply to all of the citizenry is established in the nondiscrimination concept. In legal terminology, the above suggests in relation to the thematic concerns emerging from the Saskatchewan survey, that the government is required to act in such a manner, to the best of its ability, as to create the political and economic conditions and circumstances that permit the third sector mental health NGOs to effectively play their role essential to the realization of the highest attainable standard of mental health care, and that every step in conformity with the rights and orientation of the Declaration on the Rights of Indigenous Peoples, and
Implications
If government were to fulfill obligations under the Covenant for the highest standard of health service in Saskatchewan in accordance with the logic inherent in international human rights law, then the following conceptual framework for governmental spending and social policies becomes relevant:

i) A principal criterion for all expenditure allocations should be creating conditions for HCDSD whereby everyone may enjoy their economic, social and cultural rights, as well as their civil and political rights. Since these rights are universally accepted as fundamental to human dignity needs of all human beings, we may refer to them as collectively representing a criterion for the general well-being of the population;

ii) Thus the removal of hardship and the inability of all citizens to exercise these rights must take precedence over the provision of comforts. (See Part II, Article 2 of the ICESCR);

iii) Non-discrimination requires that the larger interest of the needs of the majority should take precedence over the narrower interest of the unnecessary wants of a minority (see Part II, Article 5);

iv) Thus a private sacrifice or loss may be inflicted to save a public sacrifice or loss, and a greater sacrifice or loss may be averted by imposing a smaller sacrifice or loss (see Part II, Articles 3 and 4). This can be logically derived from statement ii; and

v) “Creating conditions” and “taking steps” as called for in the Covenant implies that those things without which an obligation cannot be fulfilled (such as sufficient and appropriate funding to third sector mental health NGOs in Saskatchewan and increased culturally sensitive programming) are also obligatory. This can be logically derived from ii) and is generally accepted as an axiom of positive law.

Those of Article 2:1 of the ICESCR, should be taken to assure that First Nations enjoy equal status in relation to mental health standards.
Conclusion

Our survey analysis suggests that under present conditions in Saskatchewan, third sector mental health NGOs are essential to the delivery of the highest attainable standard of mental health care in Saskatchewan and that the main problem these NGOs face is finding sufficient funding from sources which do not cripple the NGOs' ability to animate and deliver culturally specific and other essential services to their geo-culturally diverse communities.

In relation to human rights, our analysis suggests a complementary linkage between human rights implementation and the empowerment of these NGOs. It is equally indicated that the human rights development approach, which brings into play the pressures of legal/moral obligation and promotion of international human rights as appropriate criteria for allocating governmental spending, represents a developmental option that could effectively address the specific needs of the third sector Saskatchewan mental health NGOs as well as NGOs in other sectors of Saskatchewan’s social economy.

Therefore, we hope to encourage further research on the significance of this complementary linkage between human rights implementation and third sector social needs fulfillment. There may be a potential use for the human rights approach to development\(^{32}\) as an additional tool for creating the kind of dynamism required to realize, in Saskatchewan, the highest attainable human service standards in all social sectors.

\(^{32}\) As used by the United Nations Volunteers/United Nations Development Program.
Appendix A

Saskatchewan Health Covered Population 2000

Map of Health Districts
Appendix B*

District Health Board History

The renewal of the Saskatchewan Health system began in 1992. Health districts were established through a community development process in which local residents developed the health district boundaries. The number and size of health districts was based on location of communities, population distribution, geographic barriers, trading and commuting patterns, location of current health facilities and population health status.

Twenty-nine health districts and boards were established between February 1992 and August 1993. Three health districts were added later. The Athabasca Health Authority in northern Saskatchewan was established in January 1999 to complete the current structure (32 health districts and one health authority) for the entire province.

In April 1995, Saskatchewan Health transferred the delivery of community-based services such as public, mental, community health and addictions to district health boards. As part of this process, service areas comprising groups of districts were established to provide these and other services on a regional basis, thus allowing for a more complete range of health services than smaller districts could provide by themselves.

The district health boards are responsible for planning, managing and delivering health services to their district residents. The main services of responsibility are hospitals; health centres, wellness centres and social centres; emergency response services; supportive care such as long-term care, day programs, respite care, palliative care and programs for patients with multiple disabilities; home care; community health services such as public health nursing, public health inspection, dental health and speech pathology; mental health services; and rehabilitation services. Some services are provided through contractual arrangements between district health boards and affiliated and other health agencies.

The health boards are linked to the provincial government via the District Management Services Branch of Saskatchewan Health. The branch communicates and facilitates an understanding of government priorities and policies, supports and assists districts in implementing initiatives to address government and district priorities, and monitors the progress of districts in meeting provincial health system objectives.

The Branch is responsible for:

- supporting health district program planning and development, including the development of strategic plans and annual budget plans;

- managing the provincial Health Capital Budget and supporting health districts in managing the complete life cycle of facilities—from property purchase, needs analysis, design, tendering, construction, ongoing maintenance to regeneration or demolition;

- district health board accountability, including: ensuring that service agreements between the Minister of Health and district health boards are in place and that reporting requirements as identified in *The Health Districts Act* are met; monitoring and evaluating the outcomes of the services provided by district health boards to ensure the Minister’s responsibilities to Saskatchewan residents for a sustainable, quality health system are met; assisting health districts in resolving issues; and developing innovative and effective solutions related to the delivery and management of programs and services.

- health district governance. This includes administering *The District Health Board Election Regulations*, supporting districts in their management of district health board elections, and administering the process for ministerial appointments to district health boards.

**District Health Boards**

Each health district and authority has a board that is a governing body responsible for health district operations in its district.

*The Health Districts Act*, the main legislation applying to district health board operations, was enacted in May 1993. Health districts and district health boards were created under this legislation. It provides boards with a broad range of powers to plan for and manage the provision of health services in their districts and also provides for district health board elections and appointments.

*The Health Districts Act* provides for the election of one candidate in each of the eight wards of the health district. In addition, the Saskatoon and Regina District Health Boards may have up to six board members appointed by the Minister of Health. With the exception of the Lloydminster Health District, the remaining southern boards may have up to four appointed members. All members of the Lloydminster Health District, two northern boards and the health authority are appointed.
Ten residents of the health district must nominate Saskatchewan residents interested in running for election for a district health board. Eligible nominees must meet certain minimum residency and age requirements.

A ward system ensures that residents have an opportunity to choose their local representative and enables district health board members to have regular contact with their constituents. Elections are held every two years in alternating wards and elected members serve four-year terms. The last election was held in the odd-numbered wards in October 1999.

**Mental Health Services**

District health boards deliver mental health services within all health districts or within service areas involving multiple health districts. The overall goal of Saskatchewan's mental health services is to promote, preserve and restore the mental health of the population.

The mental health program has four distinct program areas: Child and Youth Services, Adult Community Services, Inpatient Care Services, and Psychiatric Rehabilitation Services. The mental health program operates in accordance with *The Mental Health Services Act* and its Regulations.
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Legal Documents Consulted

1. The 1983 Mental Health Act of England and Wales.
2. The Mental Health Act of Saskatchewan.
5. The Universal Declaration of Human Rights (UDHR).
6. The Vienna Convention.

List of Interviews

1. Ms. S. O. Brown, Former Assistant to the Saskatchewan Minister of Health.
2. Ms. Kathleen Thompson, Consultant on Health Management, Faculty of Administration, University of Regina.
3. Mrs. Eunice Eddy, President of the Multicultural Workshop on Health of Manitoba.
4. Dr. Tilak Gunawardhane of Physicians Concerned with Human Rights, Ottawa, Ontario
5. Ms. Norma-Gene Byrd, Director of the Rainbow (ABORIGINAL) Youth Center, Regina, Saskatchewan.