

CANADIAN MENTAL HEALTH LAW: THE SLOW PROCESS OF REDIRECTING THE SHIP OF STATE

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Introduction: Struggling Against a Backward Tide

Canadians with mental health problems are entitled to be bemused at the current state of mental health legislation. The post-*Charter* era would have seemed a propitious time for intrusions upon their liberty to be minimized and for their equality interests to be comprehensively advanced. The slowly emerging recognition of the excesses of centuries of segregative responses and of the value of community-based supports and services ought to have augured for minimally coercive legislation. The new prominence of the need to destigmatize mental illness and to combat the harmful effects of prejudice would suggest a logically consistent shift away from laws based on the facilitation of intervention, towards legislation fostering social inclusion. However, the reality of the contemporary statutory landscape is startlingly inconsistent with these indicators of progress. Instead, the early twenty-first century substantive legislative regime emerges as more paternalistic and interventionist than its predecessors of the previous three decades. While offering some modest procedural protections, there are virtually no guarantees of supports and services to minimize the risk of disabling crises and to maximize the likelihood of optimal social functioning. Current law has largely made a volte-face, away from the ostensible promises of contemporary discourse. Mental health statutes make it easier to use the law to compel examinations, to detain patients and treat them forcibly in hospitals, and to extend controls over behaviour into the community. Positive entitlements to supports and services and to the enjoyment of the full panoply of rights of Canadian citizenship are elusive or simply absent.

The author contended in 2003 that Canadian mental health law needed to evolve “to satisfy the largely unmet needs of Canadian mental

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health consumers,¹ arguing that “Legislation should speak with a remedial and reformist voice,”² keeping “recovery and community participation in the foreground, as integral to the notion of equality.”³ A draft statute was presented, with an equality-promoting preamble and with complementary provisions extending positive rights to receive supports and services, while relegating existing involuntary hospitalization statutes to last resort status, “when all other ways of responding have been tried and have failed.”⁴ The centrality of statutory reform was emphasized, promoting “a leadership role for legislation:” “Statutory standards indicate authoritative democratic support and legitimacy for equality aspirations.” In addition, it was argued that “legislative guarantees offer the prospect of enforceability of positive rights, without which the deprived consumer may be left with comparatively hollow promises and illusory entitlements.”⁵ In positing the essential function of law in effecting transformative change, the author was acknowledging Clive Unsworth’s insistence on the constitutive function of law “in the sense that it authoritatively constructs, empowers, and regulates the relationships between the agents who perform mental health functions.”⁶

This admittedly ambitious statutory agenda has not been embraced in Canada, despite the call by many, as Peter Carver has put it, for legislation with “greater emphasis on social supports and access to therapeutic programs sought out by clients themselves, not mandated by Canadian society,”⁷ although he has also soberly observed: “We are not there yet.”⁸ Disappointment at the trend of legislation seems justified, but the essence of the analysis herein will be to discern not only where “we are,” but how

1 H. Archibald Kaiser, “Imagining An Equality Promoting Alternative to the Status Quo of Canadian Mental Health Law” (2003) Special Edition Health L.J. 185 at 185.

2 *Ibid.* at 186.

3 *Ibid.* at 190.

4 *Ibid.* at 203.

5 *Ibid.* at 187.

6 Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford: Clarendon Press, 1987) at 5.

7 Peter Carver, “Mental Health Law in Canada” in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 3d ed. (Markam: Lexis Nexis, 2007) 399 at 435-6.

8 *Ibid.* at 436.

we might eventually move on to a more progressive legislative regime. Ironically, perhaps *because* of the leading edge role of law, all too frequently mandates for improvements of the mental health system are not accompanied by concomitant suggestions for law reform, as if proponents of change are unable or unwilling to tackle the barriers erected by legislation. As an illustration, a recent New Brunswick report which called for “sweeping changes”⁹ was virtually silent on the necessity for a legal shift, notwithstanding the urgency of its tenor: “People want us to do more than tinker with the *status quo*; they want a transformed system.”¹⁰

Beyond the author’s previous discussion, there have been other proposals for seismic reforms of mental health legislation in Canada and beyond. For example, in 1993, Robert Gordon, while arguing for a problematic conflation of guardianship and mental health law, posited the need for the complete replacement of existing statutes and, in the same vein as this article, noted that:

mental health legislation identifies and provides for the separate care and treatment of a particular group of ill people...this curious arrangement segregates and stigmatizes mental health patients, their families, and their health care providers but without necessarily providing any counter-balancing benefits in the form of, for example, larger fiscal allocations and better services.¹¹

This need for thoroughgoing reform is being recognized in the international domain as well, as will be discussed more extensively later. For instance, Bernadette McSherry has observed that Australian mental health legislation is currently “very much geared towards involuntary detention and treatment of those with very serious mental illnesses,” “with low prevalence,”

9 “Judge’s report calls for sweeping changes to N.B. mental health system” *CBC News* (27 February 2009), online: CBC News <<http://www.cbc.ca/health/story/2009/02/27/nb-mental-health.html>>.

10 The Honourable Judge Michael McKee, *Together Into the Future: A transformed mental health system for New Brunswick*, online: <<http://www.gnb.ca/cnb/Promos/MentalHealth/NBMHS-e.pdf>> at 5.

11 Robert M. Gordon, “Out to Pasture: A Case for the Retirement of Canadian Mental Health Legislation” in Jill Peay, ed., *Seminal Issues in Mental Health Law* (Burlington: Ashgate, 2005) 425 at 426-7.

whereas “laws regulating access to services and voluntary treatment warrant more attention.”¹²

The argument herein endeavours to respond to this broad level of frustration with the overall tenor of mental health law by isolating the barriers inherent in current legislation and then identifying modern lodestars capable of guiding its reinvention and providing some redress for generations of inequality and abuse.

This paper will explore several conundrums and will attempt to suggest ways of redirecting the Canadian ship of state. It will first present an overview of some of the salient features of the array of mainly coercive provincial and territorial mental health statutes. The failure in the main of the *Charter* to deliver on its early ostensible promises for people with mental health problems will be assessed. Next, it will be argued that extant legislation remains anchored in the medical model, when other human rights promoting paradigms would transform the statutory agenda. Some hopeful outlooks on the evolution of the law will be identified, and ways of assessing the state and progress of legislation will be advanced, drawing from international organizations and some inspiring efforts in other countries. Potential contributors to the evolution of Canadian mental health law will be surveyed. The article concludes that there are coherent ways of changing tack, although in this fraught legislative field, no one can make confident predictions about the future.

12 Bernadette McSherry, “Opening minds not locking doors” (50th Anniversary Public Lecture, delivered at Monash University Law, 9 October 2008), online: <<http://www.law.monash.edu.au/rmhl/docs/bmcs-educate08-openingminds.pdf>> at 4-5. See also the program led by Professor McSherry, *Rethinking Mental Health Laws: An Integrated Approach*, “a five year Australian Research Council Federation Fellowship which will focus on developing a research program into mental health laws.” See Monash University Law, “Rethinking Mental Health Laws: An Integrated Approach,” online: Monash University Law <<http://www.law.monash.edu.au/rmhl/>>.

An Overview of Canadian Mental Health Legislation: “Some governments are intent on legislating for more coercion”¹³

The image of the pendulum has often been used to describe the oscillations of mental health law in Canada¹⁴ and further afield.¹⁵ This metaphor is meant to convey the regular movement of public policy between the points of an easy interventionism based on an assumption of treatability and confidence in the beneficence of intrusions and, at the other pole, a vigorous assertion of autonomy, the right to refuse unwanted treatment and the ability to assert one's preferences. Commentators may choose this depiction in part owing to the reality of fluctuations on this continuum, but also to reassure the community that, despite the potential extremism of the day, there is an inherent mutability of law, suggesting that a reversal is possible.

In 2009, the pendulum may have stopped moving, although one hopes this inertia of rest is not permanent. Canadian mental health legislation has continued its devotion to specifying conditions for coercive interventions, with its historic concentration on involuntary assessments, detention and treatment within psychiatric facilities, and its more recent extension of its tentacles well into the community through leave certificates and community treatment orders (CTOs). The typical mental health statute evinces almost complete silence on human rights protections, equality rights and discrimination, health promotion, crisis prevention and positive rights to supports and services based upon a broad conception of health determinants.¹⁶ There is a concomitant minimization of advocacy supports, key procedural protections, judicial or tribunal scrutiny and the least restrictive, least intrusive and least onerous principle. The ersatz pendulum has fixed its position at a point where paternalism, interventionism, coercion and clinical discre-

13 Patrick J. Bracken & Philip Thomas, *Postpsychiatry* (Oxford: Oxford University Press, 2005) at 2.

14 *Supra* note 7 at 403: “It seems fair to suggest that in recent years, the pendulum has shifted back” [towards the “public safety dimension”].

15 Michael L. Perlin, *Mental Disability Law: Civil and Criminal*, 2^d ed., vol. 1 (Charlottesville: Lexis, 1998) at 34: “The ‘pendulum swing’ has resulted in a call for *expanded* commitment powers in many jurisdictions.”

16 For a preamble contemplating this more expansive array of statutory aims, see *supra* note 1 at 192-94.

tionary powers have continued to dominate. The concrete statutory tools ensuring this slowing or cessation of movement appear in recent amendments providing lower and broader standards for involuntary assessments, detention and treatment, vastly expanded techniques of control in the community and, in general, heightened prominence of the medical model with more authority for psychiatrists.

For example, the bases for the issuance of medical certificates to compel a psychiatric examination have expanded in several jurisdictions, with a parallel amplification of grounds to justify detention as an involuntary patient. Until only a few years ago, the convention had been to permit such interventions only on the basis of a causal relationship between a subsisting mental disorder and the presence of mainly physical danger or harm to the patient or others. Most provinces and territories have added to the panoply of causes justifying coercion, appending factors relating to the likelihood of suffering physical or mental deterioration or lack of competence to care for oneself.

A comprehensive analysis of these benchmarks of intervention is beyond the scope of this paper, but it is noteworthy that in three provinces which have recently introduced amendments, an amplified interventionism is evident. In 2007, the Nova Scotia *Involuntary Psychiatric Treatment Act*¹⁷ replaced the former reliance on “danger to his own safety or the safety of others”¹⁸ as a basis for involuntary admission with a much broader ground for detention: “threatening or attempting to cause serious harm... or...unlikely to suffer serious physical impairment or serious mental deterioration, or both.”¹⁹ In 2007, Newfoundland embraced a similar policy in its comprehensive amendments to its *Mental Health Care and Treatment Act*.²⁰ Finally, in Alberta, in 2007, the *Mental Health Amendment Act* was passed, repealing the predecessor “danger to the person or others” criterion, and substituting a comparable “likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment” standard.²¹

17 *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42.

18 *Hospitals Act*, R.S.N.S. 1989, c. 208, s. 36(2)(b).

19 *Supra* note 17, s. 17(c).

20 *Mental Health Care and Treatment Act*, S.N.L. 2006 c. M-9.1, s. 17(1)(b).

21 *Mental Health Amendment Act, 2007*, S.A. 2007, c. 35, s. 6. The Amendments are being proclaimed in two phases: September 30, 2009 “for broader mental health admission criteria” and January 1, 2010 “for regulations governing community

As a further instance of the rise of the tide of intrusion, one only has to look at the vast expansion of statutory controls over citizens' lives in the community. Now, a majority of provinces permit the issuance of long-term leave certificates and community treatment orders (CTOs), control devices which are within the enhanced powers of psychiatrists.

CTOs have provoked a lively policy debate, with the proponents optimistically positing a reduction of the revolving door syndrome of illness, hospitalization, recovery, release, relapse and rehospitalization, while skeptics have cast doubt on their apparent utility:

community treatment orders may not be an effective alternative to standard care ... compulsory community treatment results in no significant difference in service use, social functioning or quality of life ... no evidence of cost effectiveness.²²

Despite the paucity or, at best, inconclusiveness of evidence supporting the efficacy of CTOs, Canadian jurisdictions have been eager to adopt community-based coercive legislative techniques. Referring again to three current examples of ostensible law reform, Nova Scotia,²³ Newfoundland²⁴ and

treatment orders." See Alberta Health and Wellness, *Health Action Plan: Annual Report: April 2009*, online: Alberta Health and Wellness <<http://www.health.alberta.ca/documents/Health-Action-Plan-April-09.pdf>> at 3.

- 22 See S.R. Kisely, L.A. Campbell & N. Preston, *Compulsory community and involuntary outpatient treatment for people with severe mental disorders (Review)*, online: Cochrane Library <http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004408/pdf_fs.html>. See also the "In Debate" exchange between Steve R. Kisely and Leslie Anne Campbell, as opponents of CTO's, and Richard O'Reilly, as a defender, in the *Canadian Journal of Psychiatry*: Stephen Kisely & Leslie Anne Campbell, "Community Treatment Orders for Psychiatric Patients: The Emperor With No Clothes" (2006) 51 *Canadian Journal of Psychiatry* 683; Richard L. O'Reilly, "Community Treatment Orders: An Essential Therapeutic Tool in the Face of Continuing Deinstitutionalization" (2006) 51 *Canadian Journal of Psychiatry* 686; Stephen Kisely & Leslie Anne Campbell, "Clearing Away the Smoke and Mirrors: Response to Dr O'Reilly" (2006) 51 *Canadian Journal of Psychiatry* 689; Richard L. O'Reilly, "Community Treatment Orders: This Emperor is Fully Dressed!" (2006) 51 *Canadian Journal of Psychiatry* 691.

23 *Supra* note 17 ss. 47-59.

24 *Supra* note 20 ss. 40-54.

Alberta²⁵ have just adopted CTOs. The orders are generally issued by psychiatrists and refer to eligibility standards comparable to those for involuntary hospitalization. They impose conditions relating to treatment and are subject to revocation in the event of non-compliance, which then triggers detention and reassessment.

Another litmus test of a more restrained contemporary legal environment would be the emphatic and pervasive assertion of the least restrictive, least onerous and least intrusive principle. This is a canon demanding state restraint, where its American roots referred to “the constitutional principle that, in pursuing legitimate state interests, the government must use means that least restrict fundamental liberties.”²⁶ Four jurisdictions do not mention this basic norm in their Mental Health Acts: British Columbia,²⁷ Saskatchewan,²⁸ Ontario²⁹ and Quebec.³⁰ Three provinces minimally advert to the notion: Alberta,³¹ Manitoba³² and Prince Edward Island³³ refer to the notion sparsely with respect to treatment authorizations by substitute decision makers. Six jurisdictions present preambular or purposive declarations of the principle, in addition to some invocation on treatment-related matters: Newfoundland,³⁴ Nova Scotia,³⁵ New Brunswick,³⁶

25 *Supra* note 21 ss. 8-13.

26 Robert M. Levy & Leonard S. Rubenstein, *The Rights of People with Mental Disabilities: The Authoritative ACLU Guide to the Rights of People With Mental Illness and Mental Retardation* (Carbondale: Southern Illinois University Press, 1996) at 32.

27 *Mental Health Act*, R.S.B.C. 1996, c. 288.

28 *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1.

29 *Mental Health Act*, R.S.O. 1990, c. M.7.

30 *An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others*, R.S.Q., c. P-38.001. See also the *Civil Code of Quebec*: Arts. 26-31 C.C.Q.

31 *Mental Health Act*, R.S.A. 2000, c. M-13.

32 *Mental Health Act*, C.C.S.M. c. M110.

33 *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1.

34 *Supra* note 20, s. 3(1)(c).

35 *Supra* note 17, s. 2(c).

36 *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 1.1(c). At the time of writing, New Brunswick had just completed a comprehensive review of its mental health policy. See Department of Health, *Issues and Options: For Engagement Discussions Leading to a Mental Health Strategy* (Fredericton: Province of New Brunswick, 2008). See also Judge McKee's report that emerged from this process, *supra* note 10.

Yukon,³⁷ Nunavut,³⁸ and the Northwest Territories.³⁹ No province or territory provides diffuse, repeated and forceful iterations of this requirement to protect individuals from an overly interventionist state.

In terms of more positive provisions, broad guarantees of human rights are largely absent from Canadian mental health statutes. Earlier international declarations have established that “all human rights and fundamental freedoms are indivisible and interdependent,”⁴⁰ and that they “unreservedly include persons with disabilities.”⁴¹ The content of such promises could demand that health care and social service providers consider the qualitative protections offered by their systems from rights-promoting perspectives, and could empower persons with mental health problems to require more of recalcitrant governments. The range of interests that could be articulated could include: summative references to the need to promote human rights; equal access to services compared to physical health care; invocation of health determinants extending beyond provision of treatment *simpliciter*; explicit references to the need to comply with the *Charter*; dedication to psychosocial, rehabilitative and community-based approaches; prevention of crises; health promotion; and general assurances of non-discrimination. This latter undertaking of non-discrimination is the only one given voice, with at least some minimal coverage in Saskatchewan,⁴² Prince Edward Island,⁴³ Yukon⁴⁴

37 *Mental Health Act*, R.S.Y. 2002, c. 150, Preamble.

38 *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, Preamble, as duplicated for Nunavut by s. 29 of the *Nunuvut Act*, S.C. 1993, c. 28..

39 *Mental Health Act*, R.S.N.W.T. 1988, c. M-10, Preamble.

40 *Declaration on the Right to Development*, UNGAOR, 97th Plen. Mtg., UN Doc. A/Res./41/128 (1986), Preamble. This Preamble of the Declaration also urged that “equal consideration and urgent attention should be given to the implementation, promotion and protection of civil, political, economic, social and cultural rights.”

41 *Vienna Declaration and Programme of Action*, UNGAOR, UN Doc. A/Conf. 157/23 (1993), s. 63. Section 64 also prescribes that: “The place of disabled persons is everywhere. Persons with disabilities should be guaranteed equal opportunity through the elimination of all socially determined barriers be they physical, financial, social or psychological, which exclude or restrict full participation in society.”

42 *Supra* note 28, s. 14.

43 *Supra* note 33, s. 33(1).

44 *Supra* note 37, s. 40(1). The Yukon *Mental Health Act* was amended but none of the changes have enhanced the protections inherent in the least restrictive or

and Nunavut/Northwest Territories.⁴⁵ The Yukon⁴⁶ and Saskatchewan⁴⁷ also contain some preventative or health promoting references and Nova Scotia refers to community proximity as well.⁴⁸ In terms of indicators of fidelity to broad equality and human rights standards, Canadian mental health statutes present a barren landscape, with only a few cursory mentions that these fundamental issues must influence, let alone infuse, mental health statutes.

If Canada has reached the apogee of legislative development in 2009, there will continue to be a huge opportunity cost for persons with mental health problems and for society in general. The country will remain mired in an enthusiastic paternalism, while a more progressive legislative environment will continue to be elusive. Given its prominence, Canadians might well have expected the *Charter of Rights and Freedoms* to rescue people with mental health problems from a discriminatory legislative history and to mandate a more contemporary range of statutes.

The Promise and Disappointment of the *Charter*

The *Charter of Rights and Freedoms* initially appeared to be a promising ally in the struggle for equality by persons with mental health problems. On its face, the section 15 guarantee against discrimination based on mental disability ought to have been a powerful accelerant for the redress of historic inequalities. Other provisions, such as sections 7, 9, 10 and 12, seemed to provide bulwarks against many statutory and common law coercive excesses. Indeed, some early *Charter*-based decisions did seem to live up to these promises.⁴⁹ This phase was short-lived, as – owing to pervasive mental illness preju-

non-discrimination principles. See *Adult Protection and Decision Making Act*, S.Y. 2003, c. 21, Sch. A, s. 19.

45 *Supra* note 38, s. 41; *supra* note 39, s. 41.

46 *Supra* note 37, s. 2(1)(b)-(c), (e) (authorizing funding, facilities and employment relating to “promotion, preservation, or restoration of mental health”).

47 *Supra* note 28, s. 3(b)-(c), (e) (similar to the Yukon provisions, *ibid.*).

48 *Supra* note 17, s. 2(g).

49 For example, see *Thwaites v. Health Sciences Centre Psychiatric Facility*, 48 D.L.R. (4th) 338 at 351, [1988] 3 W.W.R. 217 (Man. C.A.), in which the Court struck down compulsory admission procedures of the Manitoba *Mental Health Act*, concluding that they offended s. 9 of the *Charter*, which forbids arbitrary detention, and noted that its then provisions compared “unfavourably with the legislation in force in many other provinces,” which used the “safety” or “dangerousness” standards.

dice or the expedient of the section one justificatory framework – the courts performed a fairly quick change in direction, often welcoming the interventions sanctioned by mental health law.⁵⁰ Such reversals may seem inevitable at times, given Michael Perlin’s admonition that “sanism” (“a variation of other types of stereotypical and discriminatory thinking patterns”) permeates the legal system, wherein “decision making in mental disability law cases is inspired by (and reflects) the same kinds of irrational, unconscious, bias-driven stereotypes and prejudices that are exhibited in racist, sexist, homophobic and religiously and ethnically bigoted decision making.”⁵¹

By 1992, Isabel Grant presciently lamented the courts’ unwillingness to recognize “the most appropriate analogy” to forced treatment and commit-

50 In the paternalistic vein, see *Re Jenkins; Reference Re Mental Health Act* (1984), 45 Nfld. & P.E.I.R. 131, 5 D.L.R. (4th) 577 at 588-89 (P.E.I.S.C.) (Where the Court considered s. 15(1) of the *Charter*, “the spectre of which has been advanced,” in relation to the *Mental Health Act*, determining that “the word ‘safety’ goes beyond mere protection from the infliction of physical injury” to include “the provision of creature comfort in appropriately congenial physical surroundings” and “If this be discrimination ... then so be it”); see also *McCorkell v. Riverview Hospital*, [1993] B.C.J. No. 1518, [1993] 8 W.W.R. 169 at 191(B.C.S.C.), in which the Court rejected a s. 7 challenge to the *Mental Health Act*, referring to the inappropriateness of the criminal law analogy, the “extremes of the civil libertarian view,” and the “perception that Canadians want to live in a society that helps and protects the mentally ill, and that they accept the burden of care.” In 2009, the spirit and holdings of the PEI *Reference* case and *McCorkell* continue to be endorsed by the courts. In *Mullins v. Levy*, 2009 BCCA 6, 304 D.L.R. (4th) 64 at para. 142, the Court noted approvingly “the helpful passage” of the *McCorkell* decision which had cited the extract from the P.E.I. *Reference* case. The application by Mullins for leave to appeal to the Supreme Court of Canada was dismissed on June 12, 2009. Suzan Fraser, an Ontario practitioner with considerable experience in mental health law, concluded in a recent lecture that “attempts to facilitate access to the *Charter* at the tribunals where survivors most often appear have failed.” See Suzan E. Fraser, “Sanism and the Legal Profession: Why Mad People Should Be Angry” (Paper presented to the 11th Colloquium of the Law Society of Upper Canada, November 2008), online: Law Society of Upper Canada <http://www.lsuc.on.ca/media/eleventh_colloquium_suzan.pdf> at 12. She held out some hope for an extended remedial reach of the *Charter* for Review Boards in *Conway v. Ontario*, 14 O.R. (3d) 543, [1993] O.J. No. 4566 (leave to appeal to the S.C.C. granted on February 26, 2009).

51 *Supra* note 15 at 524.

ment offered by the criminal law, concluding that “a person accused of a crime in Canada has far more protections built into the law than does a person facing civil commitment.”⁵² She observed that Canadian courts seemed unwilling to act as “an effective check on the exercise of state power by psychiatrists,”⁵³ instead clinging to a paternalistic outlook on mental health law and depriving litigants of the full potential of constitutional challenges. Little has changed since this early pessimistic evaluation, despite some fleeting glimpses of *Charter*-based progress.

There have been some major judicial statements and powerful substantive decisions which have acknowledged the fundamentally discriminatory character of Canadian society, but, however welcome, these cases have failed to fuel major shifts in mental health legislation. *R. v. Swain*,⁵⁴ a criminal case, is illustrative of the utility of the *Charter*. There the Supreme Court accepted the notoriety of the marginalization of people with mental health problems.

The mentally ill have historically been the subjects of abuse, neglect, and discrimination in our society. The stigma of mental illness can be very damaging. The intervenor, C.D.R.C., describes the historical treatment of the mentally ill as follows:

For centuries, persons with a mental disability have been systematically segregated from the mainstream of society, devalued, ridiculed, and excluded from participation in ordinary social and political processes.

The above description is, in my view, unfortunately accurate and appears to stem from an irrational fear of the mentally ill in our society.⁵⁵

Beyond these hortatory flourishes, *Swain* also resulted in some major statutory improvements in the consequent creation of the more procedurally fair Mental Disorder Amendments of Part *XX.I* of the *Criminal Code*. Some subsequent cases echoed the general outlook of *Swain*, such as *Eldridge*, wherein the Supreme Court added these condemnatory conclusions about Canada:

52 Isabel Grant, “Mental Health Law and the Courts” (1991) 29 Osgoode Hall L.J. 747 at 788.

53 *Ibid.* at 787.

54 [1991] 1 S.C.R. 933, [1991] S.C.J. No. 32 [*Swain* cited to S.C.R.].

55 *Ibid.* at 973-74.

It is an unfortunate truth that the history of disabled persons in Canada is largely one of exclusion and marginalization...excluded from the labour force, denied access to opportunities for social interaction and advancement, subjected to invidious stereotyping and relegated to institutions.⁵⁶

Other cases in the civil domain, such as *Fleming v. Reid*⁵⁷ and *Starson v. Swayze*⁵⁸ have been influential in their willingness to connect this acceptance of the reality of discrimination with concrete issues surrounding determinations of capacity to make treatment decisions, still without compelling major legislative reforms.

None of these incremental curial gains have altered the juridical landscape at the fundamental level that seemed to be promised by the *Charter* and the decisions themselves. As Dianne Pothier cautioned following *Eldridge*, “the resulting optimism for those committed to equality for persons with disabilities should be, at best, guarded,”⁵⁹ for the “Court’s analysis does not fundamentally challenge the construction of the world according to able-bodied norms” and “governments are given deference as to how to meet the needs of persons with disabilities.”⁶⁰

Some comments in *Granovsky v. Canada* would seem to have provided further impetus to the march towards equality, with its apparent embrace of a social model of disability, explored further *infra*, as opposed to the contention that the focus should be on mental illness caused by biological problems. Nonetheless, mental health legislation has continued its coercive march, despite the apparent insight of *Granovsky*:

The true focus of the s. 15(1) disability analysis is not on the impairment as such nor even any associated functional limitations, but is on the problematic response of the state to either or both of these circumstances.⁶¹

56 *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, 218 N.R. 161 at 208-10.

57 *Fleming v. Reid* (1991), 4 O.R. (3d) 74, 82 D.L.R. (4th) 298.

58 *Starson v. Swayze*, 2003 SCC 32, [2003] 1 S.C.R. 722.

59 Dianne Pothier, “*Eldridge v. British Columbia (Attorney General)*: How the Deaf Were Heard in the Supreme Court of Canada” (1997-1998) 9 N.J.C.L. 263 at 263.

60 *Ibid.* at 276.

61 *Granovsky v. Canada (Minister of Employment and Immigration)*, 2000 SCC 28, [2000] 1 S.C.R. 703 at para. 26.

Canadians with mental health problems will remain at best ambivalent about the role of the *Charter*. Despite the gains associated with a handful of major cases, there have been many rollbacks. Although some decisions seem to have provided a basis for limited confidence that individual autonomy would no longer be as susceptible to the easy erosion of the pre-*Charter* era, the new tide of more extensive statutory bases for intrusion and their concomitant lowered thresholds belies these apparent victories. Moreover, there have not been any broader judgments which alter the material inequalities inherent in the orphan or poor relative characterizations of the Romanow and Kirby Reports.⁶²

The *Charter* is not a reliable foundation for the reversal of the contemporary coercive wave or the promotion of equality promoting statutory supplements. The *Charter* may still be strategically useable on occasion as a safeguard of individual rights in the courtroom or perhaps to instigate broader advocacy efforts in less legalistic settings. The disappointments of the post-*Charter* era may be laid at the feet of the verdict that “law as discursively represented and law as lived are fundamentally at odds.”⁶³

Alternatively, the *Charter*, with its heavy procedural justice emphasis, may “represent a departure from and therefore an indirect attack on, the normative conception of right that defines social rights.”⁶⁴ The most realistic posture may be to selectively rely on the *Charter*, rather than renounce it as a tool to attain progressive ends, to see it from a “critical pragmatic view,” as “simply one of several available avenues for realizing rights and advocating change.”⁶⁵ Despite the unrealized potential of the *Charter*, it has not been an

62 “Mental health law has often been described as one of the ‘orphan children’ of Medicare:” Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (Ottawa: Public Works and Government Services, 2002) at 178 (Commissioner: Roy J. Romanow). “Mental illness is funded as a poor second cousin compared with physical illness:” Canadian Psychiatric Association, “Senator Michael Kirby Challenges Community to Define New Canadian Mental Health Care Model” *Bulletin* (December 2003).

63 Vera Chouinard, “Legal peripheries: struggles over disAbled Canadians’ places in law, society and space” (2001) 45 *Canadian Geographer* 187 at 187.

64 Candace Johnson Redden, “Health Care as Citizenship Development: Examining Social Rights and Entitlement” (2002) 35 *Canadian Journal of Political Science* 103 at 120.

65 Sarah Armstrong, “Disability Advocacy in the Charter Era” (2003) 2 *J.L. & Equality* 33 at 91.

influential brake on any momentum towards intrusions on autonomy, nor has it offered much to the quest for the advancement of broader collective goals. What other forces have conduced to the stabilization of an unsatisfactory legislative status quo?

The Reification of the Medical Model Despite the Availability of Progressive Alternatives

There is no single narrow explanation for Canadian mental health law being mired in coercion and being prevented from advancing a more ambitious agenda. Instead, the obstruction is more ubiquitous, in the unquestioning acceptance of a critically distorted view of the world, represented by reliance on the medical model. Having been used to provide the exclusive explanation of our social and legal reality in this field, wholesale dependence on it has resulted in societal responses which are flawed and diversionary, or, at times, pernicious and destructive. The medical model has purportedly provided the answers to the puzzle of lawmaking in the mental health domain, but its embrace has impeded the evolution of legislation and policy.

At its broadest, a paradigm or model subsumes “ways of thinking and talking about disability,” within which “certain analytical frameworks or mindsets have been established:”⁶⁶ “A set of assumptions, concepts, values, and practices that constitute a way of viewing reality for the community that shares them.”⁶⁷ With respect to mental health law, the medical (or rehabilitative) model is unquestionably in the ascendancy, and alternative equality promoting paradigms are relegated to the normative margins. The critical elements of the medical model portray the individual as having a health problem (or illness), in which suffering is diagnosed and treated by physicians. Disability becomes a “defect or sickness which must be cured through medical intervention,”⁶⁸ wherein the physician becomes the authority figure

66 World Bank, “Disability Paradigms and Philosophies,” online: World Bank <<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTDISABILITY/0,,contentMDK:20194561~menuPK:420459~pagePK:148956~piPK:216618~theSitePK:282699,00.html>>.

67 Philip A. Atkin cited this definition as “The one that applies most closely to medical literature.” See Philip A. Atkin, “A paradigm shift in the medical literature” (2002) 325 *BMJ* 1450 at 1451.

68 Deborah Kaplan, “The Definition of Disability,” online: Center for an Acces-

and decision maker, wielding the wide discretionary powers provided by legislation, to ensure that ill individuals, once several preconditions are present, can be forcibly assessed, hospitalized and treated. The extensive authority provided for psychiatrists in particular is seldom modulated effectively, despite the fact that “psychiatrists are not experts in statutory interpretation,” nor “in the other values and considerations assessed in taking away a person’s right to consent to treatment,” nor “in balancing civil liberties and human rights.”⁶⁹

The hegemony of the medical model has been assured through society’s assumptions about people with mental health problems that comport readily with notions of curable defects. People subject to mental health law are too readily depicted as being incapable of making decisions and dangerous to themselves or others owing to their supposed individual pathologies. Under the medical model, interventions are portrayed as benign, as they are believed to protect people from harming themselves when incapacitated by illness and to shield society from those whose ailments make them threatening to others. Society is comforted by the deflection of broader questions involving discrimination and inequality, and responsibility for the remedia-

sible Society <<http://www.accessiblesociety.org/topics/demographics-identity/dkaplanpaper.htm>>.

69 See *Crewe (Re)*, 2007 NSSC 322, 259 N.S.R. (2d) 273 at para. 15, Lynch J. This same need for caution in considering the evidence of psychiatrists was recently reiterated in two decisions by the Quebec Court of Appeal, wherein the Court was interpreting the provincial requirement of proof of dangerousness to justify involuntary hospitalization. See *Centre de santé et de services sociaux Pierre-Boucher c. A.G.*, 2009 QCCA 2395, [2009] J.Q. no. 15514 at para. 28 [*Pierre-Boucher* cited to J.Q.]. Thibault J.C.A. noted that “The dangerousness of a person who has mental illness must be appraised from the evidence presented to the court and not on the prejudice that such a person is or must be dangerous.” And noted at para. 23: “The decision to confine rests with judges who must, in a sense, test the conclusions of doctors who recommend the confinement in an institution, and come to their own opinion over the dangerousness of the person and the necessity of the confinement.” In *G.G. c. CSSS Richelieu-Yamaska*, 2009 QCCA 2359, [2009] J.Q. no. 15215 at para. 23, Morin J.C.A. reemphasized the centrality of dangerousness, as opposed to best interests determinations. “Confinement in an institution cannot constitute treatment in the absence of a dangerous factor,” Morin J.C.A. ruled. Translations are by Luis Millan. See Luis Millan, “Psychiatric confinement more difficult following Quebec CA rulings” *Lawyers Weekly* 29:32 (25 December 2009) 1.

tion of these societal blemishes is avoided. Instead, we are invited to accept medical diagnostic schema as legitimate bases for distinguishing among individuals. The medical model comfortably relies “on the prestigious and authoritative academic disciplines of medicine and science,” which are credited with “strong explanatory power,” based on the public’s assumed “intuitive understanding of medical diagnosis.”⁷⁰ Any harmful effects of legally mandated interventions are thereby accepted as unavoidable by-products of a caring health care system motivated by “the normative principles of charity and accommodation,” as opposed to confronting “questions of justice” and “the rights of people with disabilities.”⁷¹

A 2005 speech by Chief Justice McLachlin provides an evocative illustration of the extent to which the medical model has permeated the law and society:

The challenge for the law is to keep pace with medical developments and ensure that the legal regime governing mentally ill persons is responsive to the current state of scientific knowledge. Our common challenge as doctors and lawyers is to work together in addressing the problems posed by mental illness. Law cannot heal people, only services and treatment provided by medical professionals can achieve that ultimate goal.⁷²

Mental health law would be reconfigured were it to be drafted on the basis of a social model (with variations referred to as the disability, resistance, minority group, sociopolitical, socioecological, social constructionist, human rights or empowerment models),⁷³ which explains “the ways in which

70 Julie Smart, “Challenges to the Biomedical Model of Disability” (2006-2007) 12 *Advances in Medical Psychotherapy and Psychodiagnosis* 41 at 41.

71 Lyn Jongbloed, “Disability Policy in Canada: An Overview” (2003) 13 *Journal of Disability Policy Studies* 203 at 207.

72 Supreme Court of Canada, “Remarks of the Right Honorable Beverley McLachlin, P.C.: Medicine and the Law: the Challenges of Mental Illness February 17 and 18, 2005,” online: Supreme Court of Canada <<http://www.scc-csc.gc.ca/court-cour/ju/spe-dis/bm05-02-17-eng.asp>> at 9.

73 Although the choice has been made within this article to simplify or aggregate the labelling of alternatives to the medical model, the literature provides extensive discussions of the many variants. For example, Julie Smart refers to the “**Sociopolitical** Model of Disability,” wherein disability is “a loss or limitation of opportunity brought about by social and physical barriers and, therefore, the

appropriate solutions are the transformations of policies, laws and public attitudes." *Supra* note 70. Susan Gabel and Susan Peters contend that "the social model, itself, is the result of resistance to the medical model, to the oppression of disabled people, and to ableism," and promote **resistance theory** as "a way for disabled people to push against dominance while also attempting to pull society into disabled people's way of seeing." See Susan Gabel & Susan Peters, "Presage of a paradigm shift? Beyond the social model of disability toward resistance theories of disability" (2004) 19 *Disability & Society* 585 at 592, 594-95. Christopher Donoghue critically reviews the "**minority group** position on disability, that discrimination is a product of the stereotyped notions about people with disabilities," and the "**social constructionist paradigm**," wherein "society normally creates a negative social identity for people with disabilities," "an effective ideological rejoinder to the established medical model." See Christopher Donoghue, "Challenging the Authority of the Medical Definition of Disability: an analysis of the resistance to the social constructionist paradigm" (2003) 18 *Disability & Society* 199 at 204. Denise G. Tate and Constance Pledger celebrate "a renewed focus on a **socioecological framework** for understanding disability," which "acknowledges the dynamic interaction between the person and the environment," is aware of "the importance of consumer participation," and contests or recognizes "the limitations of traditional, more medically oriented, definitions and measures of disability." See Denise G. Tate & Constance Pledger, "An Integrative Conceptual Framework of Disability: New Directions for Research" (2003) 58 *American Psychologist* 289. T.W. Harding posits a **human rights model**, where "very little legislative action" "establishes the right of the mentally ill to adequate treatment, social support rehabilitation and protection from discrimination," promoting "more effective protection" "through more imaginative and energetic application of general human rights law." See T.W. Harding, "Human rights law in the field of mental health: a critical review" (2000) 101 *Acta Psychiatrica Scandinavica* 24 at 26, 29. The World Bank conflates the "**Social Model or Human Rights Model**," preferring a view where both "focus on the role of society in gaining equality for all its citizens," as "society has a responsibility to address barriers" and move "disability into the field of community development." *Supra* note 66. Under the **disability model** (or social disability movement), as discussed by Claudia Werneck, the difficulties "faced by people with disabilities are the outcome" of the way in which society deals with individuals, "the total status of the individual worsened by physical, economic and social barriers." See Claudia Werneck, *Manual on Disabilities and Inclusive Development for the Media and Social Communications Professionals* (Washington D.C.: World Bank, 2005) at 7. Geoffrey Nelson, John Lord and Joanna Ochocka identify the **empowerment paradigm**, in which mental health is seen "as a construct that

disability is constructed by society” and which provides “a call to action against the oppression of disabled people.”⁷⁴ The key insight of the related theories comprising this stratum is that “Disability is not intrinsic, but rather extrinsic ... situated not in an individual pathology, but in society’s failure to embrace diverse ways of being in the world.”⁷⁵ Society is chastised for its choice “not to remove structural constraints that would enable more people to participate and gain access to social resources.”⁷⁶ In this paradigm, disabilities “reflect the total status of the individual worsened by physical, economic and social barriers.”⁷⁷ The prevention and alleviation of social discrimination, then, must become the stimulus of the public policy agenda, and must animate mental health law, as society has a “responsibility to address barriers that prevent the participation of persons with disabilities.”⁷⁸

The acceptance of the social or disability model as a driving force for mental health legislation would not require an abandonment of all the potential benefits of science and medicine: “[T]he social model of understanding disability does not undermine the importance of medicine, care, protection or rehabilitation services.”⁷⁹ A rigorous challenge to the dominance of the medical model is still demanded, which would ensure that the focus shifts from the present emphasis on facilitating coercion to the provision of supports and services to encourage societal integration and to help prevent crises. The social or disability model recognizes that one of the many indices of discrimination is inequitable access to mental health supports, including conventional medical care, when citizens actually want it, given

needs to be addressed beyond the mental health system,” as “fixing the current system will have limited benefits, and...economic, political, and community changes are also necessary to enhance empowerment and mental health.” See Geoffrey Nelson, John Lord & Joanna Ochocka, “Empowerment and mental health in the community: narratives of psychiatric consumer/survivors” (2001) 11 *Journal of Community and Applied Social Psychology* 125 at 126.

74 Gabel & Peters, *ibid.* at 588.

75 Catherine Frazee, “Disability Studies: The Unexpected Guest in Health Law Discourse” (2003) Special Edition *Health L.J.* 257 at 260.

76 Donoghue, *supra* note 73.

77 Werneck, *supra* note 73.

78 *Supra* note 64.

79 Annegret Kämpf, “The Disabilities Convention and its Consequences for Mental Health Laws in Australia” in Bernadette McSherry, ed., *International Trends in Mental Health Laws*, (Annandale: Federation Press, 2008) 10 at 11.

that such services have been in short supply. With primacy being accorded to the social model, the current array of interventionist mental health legislation would then be relegated to a subsidiary role, to be used fairly, with restraint and as a last resort, only when society has failed in its primary duty to remove obstacles to enjoying the fruits of full citizenship. If Canadian mental health law were to embrace the implications of the social model, it would instead concentrate on “altering environmental barriers, changing attitudes and programs, plus advancing human rights.”⁸⁰ As a recent Report from WHO Europe has insightfully put it: “A focus on social justice may provide an important corrective to what has been seen as a growing over-emphasis on individual pathology.”⁸¹

While the call for re-envisaging mental health legislation normally originates in sources external to the dominant medical paradigm, the recognition of this twenty-first century imperative is beginning to emerge within psychiatry, where “until recently there has been little discussion about the coercive aspects of psychiatric practice.”⁸² Some psychiatrists are suggesting the same fundamental questions:

Can we imagine a relationship between medicine and madness which is different from that forged in the asylums and hospitals of a previous age?

How can we separate mental health care from the agenda of social exclusion coercion and control to which it became bound in the last two centuries?⁸³

80 Michael J. Prince, “Canadian Disability Policy: Still a Hit-and-Miss Affair” (2004) 29 *Canadian Journal of Sociology* 59 at 62.

81 Lynne Friedli, *Mental Health, resilience and inequalities* (Copenhagen: WHO Europe, 2009) at v.

82 *Supra* note 13 at 8.

83 *Ibid.* at 11-12. See also Jonathan Kenneth Burns, “Mental Health and Inequity: A Human Rights Approach to Inequality, Discrimination, and Mental Disability”, (2009) 11:2 *Health and Human Rights Journal* 19, at 21, in which Dr. Burns, a psychiatrist, has similarly observed that “... full integration of persons with mental disabilities is a complex challenge that cannot be met through the narrow confines of a purely biomedical or even public health model.” Instead, he prefers “a rights-based approach to mental disability” which acknowledges “the social, economic, and political forces that result in the disability experienced by people with impairments.” He recommends “Legislative reform to

The move away from involuntary psychiatry, ever more facilitated by an obliging legislature, towards a regime which provides a generous, supportive, inclusive, depathologized and equality enhancing legislative framework cannot be marginalized as being idealistic and divorced from reality. There are now perceptible signs of a radical shift in the course of mental health law, if not yet in Canada.

Accelerating the Redirection

It would be naive, despite its seeming moral and juridical necessity, to believe that the course of Canada's mental health legislation will inevitably be altered. The move from the medical to a social or disability model will require a dramatic and pervasive change in attitude, and neither the pace nor even the direction of the required legal reforms is ineluctable. What combination of forces might propel the legislators of this country to take what some would perceive as a radical turn? The following discussion will isolate some influences which could hasten the nascence of a new Canadian mental health law, drawing from the United Nations, the European Union, the Council of Europe, the WHO and some countries which are in the process of changing course.

Statutory and Declaratory Benchmarks from the International Realm: United Nations Conventions

Several human rights treaties may have been thought likely to produce a revision of mental health legislation, as some of their provisions relate to the broad ideals of the social or disability model, such as the *International Covenant on Civil and Political Rights* (ICCPR); the *International Covenant on Economic, Social and Cultural Rights* (ICESCR); the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW); the *Convention on the Rights of the Child* (CRC); and the *International Convention on the Elimination of All Forms of Racial Discrimination* (CERD). Unfortunately, none of these instruments have been credited with producing meaningful mental health law reforms: "the reality is that international human rights law has been largely ineffectual" in dealing with both cases of service abuse as well as chronic legislative

abolish discrimination, to outlaw abuse and exploitation, and to protect personal freedom, dignity, and autonomy" (at 25) and "to enforce equality of opportunity, access, and participation in all aspects of life." (at 26)

neglect.⁸⁴ Annegret Kämpf has suggested that these instruments “did not sufficiently recognize what disability means in the context of human rights,” and that any purported “protection of persons with disabilities lacked clarification and amplification of specific rights.”⁸⁵

Other Conventions contain provisions which appear to be more substantively relevant, especially to the law facilitating coercive treatment. The *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (CAT) has been argued to forbid “non-consensual psychiatric intervention and psychiatric detention as a form of torture.”⁸⁶ Although extreme misuses of psychiatric treatment have been acknowledged to potentially come within the concepts of torture (article 1) or cruel, inhuman, or degrading treatment or punishment (article 16),⁸⁷ it would be argued that Canadian law already provides a bulwark against such “violence and abuse,” and that Canada does not therefore need “stronger legal protection and redress for violations of human rights.”⁸⁸ Similarly, the “Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care” (U.N.G.A. Resolution 46/119, 1991), while not a treaty, could have ushered in a human rights climate, but it has been criticized as “justifying the coercive use of medical power and undermining mental patients’ rights,”⁸⁹ with a risk that they actually “interfere with or impede protection of mentally ill persons.”⁹⁰

84 Aaron A. Dhir, “Relationships of Force: Reflections on Law, Psychiatry and Human Rights” (2008) 25 Windsor Rev. Legal Soc. Issues 103 at 106.

85 *Supra* note 79 at 18.

86 Office of the High Commissioner for Human Rights, *Expert Seminar on Freedom From Torture and Ill Treatment and Persons with Disabilities: Report* (Geneva: United Nations Office, 2007) at 6.

87 Manfred Nowak, *Torture and other cruel, inhuman or degrading treatment or punishment*, UNGAOR, 63d Sess., UN Doc. A/63/175 (2008) at 10.

88 *Ibid.* at 2.

89 Harding, *supra* note 73 at 28.

90 *Ibid.* at 29. The World Network of Users and Survivors of Psychiatry called on the UN to “revoke the Principles.” See World Network of Users and Survivors of Psychiatry, “Position paper on Principles for the Protection of Persons with Mental Illness,” online: World Network of Users and Survivors of Psychiatry <<http://wnusp.rafus.dk/position-paper-on-principles-for-the-protection-of-persons-with-mental-illness.html>>

The prospects for genuine inspiration by international law have been heightened with the recent promulgation of the *Convention on the Rights of Persons with Disabilities* (UNGA A/61/661, December 2006), signed by Canada on March 30, 2007, and ratified on March 11, 2010.⁹¹ Michael Perlin's comments are representative of a broad consensus on the potential of this

91 See Foreign Affairs and International Trade Canada, News Release, No. 368, "Government of Canada Tables Convention on Rights of Persons with Disabilities" (3 December 2009), online: Foreign Affairs and International Trade Canada <<http://www.international.gc.ca/media/aff/news-communications/2009/368.aspx?lang=eng>>. The accompanying "Backgrounder-Convention on Rights of Persons with Disabilities" notes that "The Convention embodies an *important shift toward a human dignity approach to disability and away from a charity and medical model approach*" [emphasis added]. The Convention was ratified by Canada on March 11, 2010, albeit with a Declaration and Reservation in which "Canada declares its understanding that Article 12 permits supported and substitute decision-making arrangements in appropriate circumstances and in accordance with the law" and "With respect to Article 12(4), Canada reserves the right not to subject all such measures to regular review by an independent authority, where such measures are already subject to review or appeal." United Nations Enable, *Rights and Dignity of Persons with Disabilities*, Declarations and Reservations, online, <<http://www.un.org/disabilities/default.asp?id=475>>. These reservations are of concern owing to the risk that they suggest a diluted commitment to the Convention on the crucial issues of substitute decision-making and access to justice, a worry amplified by Canada's complex federal structure. Notwithstanding these warning signs, early reaction by advocacy groups was positive. For example, Marie White, Chair of the Council of Canadians with Disabilities observed that "Ratification of the Convention puts an end to the medical model and opens exciting new opportunities for building a more inclusive and accessible Canada", Foreign Affairs and International Trade Canada, News Release, "Canada Ratifies UN Convention on the Rights of Persons with Disabilities", (No. 99 – March 11, 2010). The Canadian Association for Community Living (CACL) described the Convention as "a road map that explains where, why and how the rights of people with disabilities have been neglected and what steps are required to realize human rights for people with disabilities in meaningful ways." CACL, News Release, "Canada Ratifies Historic UN Treaty on Disability Rights", March 11, 2010. Community Living Ontario was celebratory, indicating its beliefs that the "treaty will continue to drive change" and "shift our understanding of disability from a 'deficit' or problem located within the person, to an understanding of the combination of environmental and attitudinal barriers that a person faces." Community Living Ontario, News Release, "Ratification

Convention. It “infuses new hope,” although the thoroughness with which it is “honored” and “given life” will reveal much about the Convention’s ultimate “‘real world’ impact,” determining whether any “victories” “are more than ‘paper’ ones.”⁹² This Convention supersedes the 1991 Principles, and its Preamble frames what should herald a novel approach to mental health law, shifting towards the social or disability model and acknowledging conditions of deprivation for people with the disabilities:

- (e) *Recognizing* that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others,
- (t) *Highlighting* the fact that the majority of person with disabilities live n conditions of poverty, and in this regard recognizing the critical need to address the negative impact of poverty on persons with disabilities.

Referring to these and other provisions, early assessments are firm that the Convention “rests on a social rather than a medical model of disability,”⁹³ representing “a significant paradigm shift in the understanding of disability: it recognizes that ‘disability resides in society, not in the person.’”⁹⁴

Several other articles require a close comparison of existing statutes with the rights enshrined in the Convention: article 3(a) recognizes “the freedom to make one’s own choices;” article 8 requires “awareness-raising,” including combatting “stereotypes, prejudices and harmful practices;” article 12(3) requires “measures to provide access by persons with disabilities” to supports “in exercising their legal capacity;” article 14(1)(b) demands that “the existence of a disability shall in no case justify a deprivation of liberty;” article

of UN Convention on Disability Rights: A Historic Moment for All Canadians”, March 11, 2010.

92 Michael L. Perlin, “International Human Rights Law and Comparative Mental Disability Law: The Universal Factors” (2007) 34 Syracuse J. Int’l. L. & Com. 333 at 334, 349.

93 Bernadette McSherry, “International Trends in Mental Health Laws: Introduction” in Bernadette McSherry, ed., *International Trends in Mental Health Laws* (Annandale: Federation Press, 2008) 1 at 5.

94 *Ibid.* at 22.

17 protects the “right to respect for his or her physical and mental integrity on an equal basis;” article 19 recognizes the “equal right of all persons with disabilities to live in the community with choices equal to others,” including “access to a range of in-home, residential and other community support services;” and article 28 recognizes the “right of persons with disabilities to an adequate standard of living,” “including adequate food, clothing and housing.” With implementation and monitoring required of state parties (article 33) and the Optional Protocol (article 1) permitting complaints to the Committee on the Rights of Persons with Disabilities, upon ratification of the Convention and Protocol, there will be an obligation for Canada to measure its level of compliance in mental health statutes and a redress mechanism for aggrieved citizens.

The Convention has been portrayed as “the climax in a linear development toward the recognition of disability as a true human rights issue.”⁹⁵ While it is early to speculate on the transformative potential of the Convention, it is urgent that Canada’s mental health legislation be freshly examined to see the level of revisions that its shortcomings may demand. For example, there is some international discussion of the currently lawful detention of people with disabilities “for their care or treatment” or because “they might cause harm” and observations that “All such practices, policies and laws are in contravention of existing international standards.”⁹⁶ Similarly, on capacity issues (article 12), there are concerns that “national laws impose barriers to the exercise of legal capacity” “or deny access to needed supports,” requiring states to “modify these laws to bring them in consonance.”⁹⁷ The Convention has been argued to have such force as to require the “review of the anti-torture framework in relation to persons with disabilities.” Its final iteration is posited as confirming the earlier contention that “acceptance of involuntary treatment and involuntary confinement runs counter to the provi-

95 Aart Hendriks, “UN Convention on the Rights of Persons with Disabilities” (2007) 14 *Eur. J. Health L.* 273 at 279.

96 Office of the High Commissioner for Human Rights, “Dignity and Justice for Detainees Week,” online: Office of the High Commissioner for Human Rights <http://www.ohchr.org/EN/UDHR/detention_infonote_4.pdf> at 2..

97 See World Network of Users and Survivors of Psychiatry, “IDA CRPD Forum Principles for the Implementation of Article 12,” online: World Network of Users and Survivors of Psychiatry <<http://wnusp.rafus.dk/ida-crpd-forum-principles-for-the-implementation-of-article-12.html>> at Introduction.

sions of the Convention,⁹⁸ and as reaffirming the “right to refuse psychiatric procedures, since this Convention recognizes the right to free and informed consent with no discrimination based on disability.”⁹⁹ Other experts have dampened the enthusiasm of those who contend that the Convention goes so far as to require the abolition of involuntary treatment: “From a practical viewpoint, it is difficult to imagine legalized involuntary treatment schemes readily disappearing.”¹⁰⁰ Its effects may instead be to develop “limitations on certain practices and unbeneficial and overly intrusive treatment”¹⁰¹ in terms of negative rights. With respect to positive rights, “it systematically addresses many aspects of daily life and the connection between disability, exclusion, poverty, lack of education, unemployment and health.”¹⁰² Overall, the Convention, with its primary emphasis on the disability model and its amalgamation of legal standards, equality aspirations and social development and inclusion mandates, should provide the impetus for a new course for Canadian mental health law.

European Initiatives

The European Union (EU)

Law and policy making in the EU is extremely complex, at times “impenetrable and opaque,”¹⁰³ and the current legal landscape is quite disparate, with many states having mental health legislation which is broadly similar to Canada. Unfortunately, there has been “no overall common approach to safeguarding patients’ rights in the legal frameworks.”¹⁰⁴ Moreover, despite

98 *Supra* note 87 at 9-10.

99 European Network of (ex-) Users and Survivors of Psychiatry, *et al.*, *Declaration of Dresden Against Coerced Psychiatric Treatment*, online: European Network of (ex-) Users and Survivors of Psychiatry <<http://www.enusp.org/dresden/ddec.pdf>>.

100 Bernadette McSherry, “Protecting the Integrity of the Person: Developing Limitations on Involuntary Treatment” in Bernadette McSherry, ed., *International Trends in Mental Health Laws* (Annandale: Federation Press) 111 at 121.

101 *Ibid.* at 123.

102 *Supra* note 79 at 23.

103 Brendan D. Kelly, “The emerging mental health strategy of the European Union: A multi-level work-in-progress” (2008) 85 *Health Policy* 60 at 60.

104 Harald Dressing & Hans Joachim Salize, “Compulsory admission of mentally ill patients in European Union Member States” (2004) 39 *Social Psychiatry and Psychiatric Epidemiology* 797 at 802. See also M. Zinkler & S. Priebe, “Detention

“achievements in safeguarding the human rights of compulsorily admitted or treated mentally ill persons, it has been criticized as not being enough.”¹⁰⁵ In light of these verdicts, what can Canada learn from EU Member states as to how to make the legal transition from the coercive medical model to an inclusive social model? In the EU, there are signs that this process is beginning to occur.

By 2003, an EU/WHO Ministerial Conference recognized that “Combating stigma and discrimination requires effective legislation and the capacity to implement it,” and that “Promotion of social inclusion requires a multiplicity of strategies.”¹⁰⁶ This stance was subsequently supported by the Council of the European Union in its recognition of the “importance of promoting effective actions across all relevant policies to increase social inclusion and equity,”¹⁰⁷ and in its later Green Paper, identifying the importance of improving “the quality of life of people with mental ill health or disability through social inclusion and the protection of their rights and dignity.”¹⁰⁸ Organized through the WHO European Ministerial Conference, fifty-two European Member States collaborated to produce a Mental Health Declaration for Europe¹⁰⁹ in 2005. The Declaration evinces a broad consensus on the

of the mentally ill in Europe – a review” (2002) 106 *Acta Psychiatrica Scandinavica* 3; Hans Joachim Salize & Harald Dressing, “Epidemiology of involuntary placement of mentally ill people across the European Union” (2004) 184 *British Journal of Psychiatry* 163.

105 Hans Joachim Salize, Harald Dressing & Monika Peitz, *Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States: Final Report* (Mannheim: European Commission, Health & Consumer Protection Directorate-General, 2002).

106 Athanassios Constantopoulos, “Mental Illness and Stigma in Europe,” online: <http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/ev_20060316_rd04_en.pdf> at 3.

107 Council of the European Union, Press Release, 9688/1/03 REV 1, “2512th Council Meeting: Employment, Social Policy, Health and Consumer Affairs – Luxembourg, 2 and 3 June 2003,” online: Council of the European Union <<http://www.consilium.europa.eu/App/NewsRoom/load/Book.aspx?target=2003&bid=79&lang=EN&id=351>> at 13.

108 Support Project, *European Commission Green Paper: Improving the Mental Health of the Population. Towards A Strategy on Mental Health for the European Union: Summary of Consultation Meetings* (Brussels: European Commission, Health & Consumer Protection Directorate-General, n.d.) at 3.

109 World Health Organization Europe, *Mental health: facing the challenges, building*

necessity to reformulate mental health legislation and policy, which would “no longer exclusively focus on treating and institutionalizing,” and which would move towards “innovative community-based care and policies to achieve social inclusion.”¹¹⁰ The Declaration recorded that “a transformation,” a “striving to achieve social inclusion and equity,”¹¹¹ was taking place, with priorities including tracking “stigma, discrimination and inequality”¹¹² and integrating mental health with “other public policy areas such as human rights, social care, education and employment.”¹¹³ Crucially, the Declaration required action to “implement the necessary legislation in order to empower people at risk or suffering from mental health problems and disabilities to participate fully and equally in society.”¹¹⁴

Subsequent investigations by WHO Europe have predicted “High activity in policy making and legislation,”¹¹⁵ in part animated by the Declaration: “Since 2005, 57% of countries have adopted new mental health policies and 48% have introduced new legislation.”¹¹⁶ Adding a note of caution, the assessment notes that, despite this flurry, “in some countries, desks in ministries are collapsing under the weight of policies that have never been implemented,” due to political unacceptability, defiance by practitioners, human capital and funding shortfalls.¹¹⁷ How far this process has gone in law will vary considerably, as noted below, with some entities (the Council of Europe and Scotland) making very considerable normative and legal progress, but with subsisting concerns about reinstitutionalization and increases in compulsory admissions “in many, although not all, European countries.”¹¹⁸ That said, the EU does seem to be trying to come to grips with

solutions: Report from the WHO European Ministerial Conference (Copenhagen: World Health Organization, 2005) [*Helsinki Declaration on Mental Health*].

110 *Ibid.* at x.

111 *Ibid.* at 10.

112 *Ibid.* at 11.

113 *Ibid.* at 11.

114 *Ibid.* at 12.

115 World Health Organization Europe, *Policies and practices for mental health in Europe: Meeting the challenges* (Copenhagen: World Health Organization, 2008) at 11.

116 *Ibid.* at 16.

117 *Ibid.* at 17.

118 Stefan Priebe & Trevor Turner, “Reinstitutionalisation in mental health care: this largely unnoticed process requires debate and evaluation” (2003) 326 *British Medical Journal* 175 at 175.

the equality imperative, and its struggle should be instructive for Canadian legislators. As a 2009 WHO Europe Report noted: “Mental health itself is produced socially,” and “important as specific interventions are...the urgent policy priority is to promote and protect respect and justice – the underlying principles that support mental wellbeing.”¹¹⁹

Council of Europe

In the Council of Europe, whose “political mandate was defined by the third Summit of Heads of State and Government” in 2005,¹²⁰ there is progress towards the social model. The 2005 Recommendation of the Committee of Ministers recognizes the need for common action to “promote better protection of the human rights and dignity of persons with mental disorder, in particular those subject to involuntary placement or involuntary treatment” and for member states “to adapt their laws and practice.”¹²¹ The Recommendation emphasizes “measures to eliminate discrimination” (II, 3(2)), the promotion of mental health (II, 5), “the principle of least restriction” (II, 8) and access to alternatives to involuntary treatment (II, 10, i). The accompanying Explanatory Memorandum strengthens the spirit of these principles, as it highlights the right to a personal advocate (52) and recognizes that some persons may prefer “to live with some symptoms of their illness (142).”

In 2005, the Parliamentary Assembly provided additional momentum to these proposals, inviting members to “reform their legislation so as to ensure respect for the rights of people with mental disorder” in compliance with the Recommendation and to “*give the political dimension of mental health legislation due prominence and to reaffirm its grounding in the sphere of humanist legislation.*”¹²² The Report (at 9-13) emphasizes the necessity of “a broad

119 *Supra* note 81 at 57, 41.

120 Council of Europe in Brief, “Our objectives,” online: Council of Europe in Brief <<http://www.coe.int/aboutCoe/index.asp?page=nosObjectifs>>..

121 Council of Europe Committee of Ministers “Recommendation Rec (2004) 10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder,” online: Council of Europe <[https://wcd.coe.int/ViewDoc.jsp?Ref=Rec\(2004\)10&Language=lanEnglish&Site=CM&BackColorLogged=F5D383](https://wcd.coe.int/ViewDoc.jsp?Ref=Rec(2004)10&Language=lanEnglish&Site=CM&BackColorLogged=F5D383)> at Preamble.

122 Council of Europe, P.A., *Improving the response to mental health needs in Europe: Report: Social, Health and Family Affairs Committee*, Documents, Doc. 10544 (2005), online: Council of Europe Parliamentary Assembly <<http://assembly.coe>.

range of rehabilitation and treatment activities,” not just pharmacotherapy, and the involvement of civil courts in involuntary admissions. Crucially, the attached Explanatory Memorandum faults “technical legal mechanisms which often fail to emphasize sufficiently the political dimension of mental health,” which laws give “no indication of the role of mental health policies in improving the quality of life of all citizens,” concluding (80) that “reforms of mental health policies should aim to achieve social inclusion and equity.” These latter statements demand contextualized mental health laws, with a proactive, preventative and equality-promoting component. They may conduce to improve “the protection of human rights of people with mental disorders, but this will only occur if governments act upon its recommendations”¹²³ and provide “appropriate resources for care and measures to destigmatise mental disorder.”¹²⁴ Subsequent to Recommendation (2004)10, work continued apace within the Council to facilitate state action in “Improving the response to mental health needs in Europe,” culminating in “a consolidated policy tool leading to reviews of mental health-related policies”¹²⁵ in 2009, of which more will be said shortly. The processes, goals and advancements of the Council of Europe should be followed closely by legislators wishing to extricate Canada from its current allegiance to a medical model relying on coercion.

The World Health Organization (WHO)

Given the extreme disparities among nations with respect to programs, policies and legislation,¹²⁶ WHO pronouncements may have a limited role in the development of Canadian mental health law. Nonetheless, several

[int//main.asp?link=http://assembly.coe.int/documents/WorkingDocs/doc05/EDOC10544.htm](http://main.asp?link=http://assembly.coe.int/documents/WorkingDocs/doc05/EDOC10544.htm) [emphasis added].

123 Roland Jones & David Kingdon, “Council of Europe recommendation on human rights and psychiatry: a major opportunity for mental health services” (2005) 20 *European Psychiatry* 461 at 464.

124 David Kingdon, Roland Jones & Jouko Lonnqvist, “Protecting the human rights of people with mental disorder: new recommendations emerging from the Council of Europe” (2004) 185 *British Journal of Psychiatry* 277 at 279.

125 Council of Europe, P.A., *Improving the response to mental health needs in Europe: Recommendation 1715 (2005): Reply from the Committee of Ministers adopted at the 953rd meeting of the Ministers’ Deputies (18-19 January 2006)*, Documents, Doc. 10793 (2006).

126 World Health Organization, *Mental Health, Human Rights and Legislation: WHO’s*

important publications have emerged that could hasten the emergence of more progressive Canadian legislation. The pivotal World Health Report 2001, *Mental Health: New Understanding, New Hope*, while still grounded in the medical model, fostered greater awareness of the influence of social factors in the genesis and course of mental disorders. It encouraged “an evolution of care towards a community care paradigm,” including an emphasis on “respect of the human rights of individuals with mental disorders”¹²⁷ and “empowerment of people with mental and behavioural disorders.” The Report also promoted “legislation to support”¹²⁸ this new direction, which it portrayed “as essential to guarantee that the dignity of patients is preserved and their fundamental human rights are protected.”¹²⁹

WHO has recognized the constraints of legislation, noting that it “does not necessarily guarantee the protection of the human rights of persons with mental disorders,” and may contain “provisions that lead to the violation of human rights.”¹³⁰ The centrality of legislation and its role in shaping mental health policy is still stressed: “Mental health policy relies on the legal framework to achieve its goals, and protect the rights and improve the lives of persons affected by mental disorders.”¹³¹ Legislation has been seen as “needed to prevent discrimination” in its “many forms,” including “access to adequate treatment and care, as well as other areas of life, including employment education and shelter” and, overall, the ability “to integrate properly into society.”¹³² These pronouncements on the vital linkage between human rights-promoting mental health policy and legislation are echoed in another more recent WHO publication:

Framework, online: World Health Organization <http://www.who.int/mental_health/policy/fact_sheet_mnh_hr_leg_2105.pdf> at 2: “64% of countries do not have any mental health legislation or have legislation that is more than 10 years old.”

127 World Health Organization, *The World Health Report 2001: Mental Health: New Understanding, New Hope* (Geneva: World Health Organization, 2001) at 54.

128 *Ibid.* at 50.

129 *Ibid.* at 84.

130 World Health Organization, *The Mental Health Context* (Geneva: World Health Organization, 2003) at 32.

131 World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation* (Geneva: World Health Organization, 2005) at 3.

132 *Ibid.*

Policies need to be grounded in the principles of respect for human rights, and of fulfillment, promotion, and protection of those rights. ... Mental health law codifies and consolidates the fundamental principles, values, aims, and objectives of mental health policies and programmes. It provides a legal framework to prevent violations, to promote human rights, and to address critical issues that affect the lives of people with mental disorders.¹³³

An important insight promulgated by WHO, as yet not evident in Canadian law, is that: “*Mental health legislation is thus more than care and treatment legislation that is narrowly limited to the provision of treatment in institution-based health services.*”¹³⁴ Instead, WHO urges that “Countries should adopt” laws that “promote the rights of people with mental disabilities and empower them to make choices about their lives, provide them with legal protections, and ensure their full participation into the community.”¹³⁵

As a rich nation, with a strong legal and service infrastructure compared to many other countries, Canada should be able to accept a WHO challenge to Europe, to adopt progressive legislation which will “ensure that critical issues affecting the lives of people with mental disorders are addressed” and which will “increase opportunities for people with mental disorders to live fulfilling lives in the community.”¹³⁶ Although Canada could rest on its laurels (“more than 75% of people suffering from mental disorders in the

133 World Health Organization, *mhGAP Mental Health Gap Action Programme: Scaling up care for mental, neurological, and substance use disorders* (Geneva: World Health Organization, 2008) at 16.

134 World Health Organization, *Mental Health Legislation and Human Rights* (Geneva: World Health Organization, 2003) at 2 [emphasis added].

135 World Health Organization, *Mental Health Legislation and Human Rights: Denied Citizens: Including the Excluded*, online: World Health Organization <http://www.who.int/mental_health/policy/legislation/1_PromotingHRofPWMD_Infosheet.pdf>.

136 *Supra* note 109 at 112. See also World Health Organization Europe, *Mental Health Declaration for Europe: Facing the Challenges, Building Solutions* (Helsinki: World Health Organization Europe, 2005). At 3, the *Helsinki Declaration* called for “implement[ation of] the necessary legislation in order to empower people at risk or suffering from mental health problems and disabilities to participate fully and equally in society.”

developing world receive no treatment or care”),¹³⁷ it ought to target the highest goals. WHO has concluded that “we are facing a global human rights emergency in mental health,”¹³⁸ and Canada should ensure that its legislation is a model of responsiveness.

The principal changes which would be wrought in the Canadian legislative agenda by incorporating WHO standards are at the equality-promoting level. The WHO concludes that the conditions for societal participation, including “community services and protections” – such as “access to treatment and care, a supportive environment, housing, rehabilitative services (e.g. occupational and life skills training), employment, non-discrimination and equality, and civil and political rights” – “*can be implemented through legislation.*”¹³⁹ Canada’s mental health law would be improved were legislators to accept that these are areas which are “equally important” but “which have been neglected historically.”¹⁴⁰

The WHO Checklist on Mental Health Legislation provides another valuable guide for reforming Canadian mental health law, starting with a demand for a preambular emphasis on “the human rights of people with mental disorders” and “the importance of accessible mental health services for all.”¹⁴¹ Other areas in the Checklist are relatively ignored in Canadian law: provisions “aimed at stopping discrimination” relating to housing, employment, social security and civil issues, as well as protection of “vulnerable groups,” including minors, women and minorities.¹⁴²

Despite Canada’s state of legal development and its immense relative prosperity, the country’s mental health legislation lags behind the contemporary equality-promoting standards of the WHO. Based upon the normative inspiration of the WHO, and the experience of other countries, it is possible to imagine the transformation of mental health law, policy and practice. The

137 World Health Organization, New Release, “Millions with mental disorders in the developing world Are deprived of necessary treatment and care” (9 October 2008), online: World Health Organization

<<http://www.who.int/mediacentre/news/releases/2008/pr37en/index.html>>.

138 World Health Organization, “A Global Human Rights Emergency in Mental Health,” online: World Health Organization

<http://www.who.int/mental_health/policy/legislation/en/>.

139 *Supra* note 131 at 6 [emphasis added].

140 *Ibid.* at 81.

141 *Ibid.* at 121.

142 *Ibid.* at 149-153.

Italian example is instructive in assessing the viability of introducing a new legal landscape. In 1978, deinstitutionalization was given additional strength with the passage of Law 180, which “decreed the shift from segregation and control in the asylum to treatment and rehabilitation in the context of society,”¹⁴³ and which resulted in admissions to psychiatric facilities being “dwindled dramatically and eventually stopped almost completely,”¹⁴⁴ as a response to the “Prohibition of all admissions to state mental hospitals, including readmissions.”¹⁴⁵ Italy’s reconfiguration of its legal foundations and service delivery methods indicates that it is feasible to implement significant reformist initiatives such as those contemplated herein. The monitoring of the pace of legal change and its effectiveness can also be planned, as discussed next.

Methods of Monitoring and Advancement of Human Rights in Mental Health Legislation

“Honest self-assessment by governments” seems to be an oxymoronic phrase. Public authorities are reluctant to commit to a process which has the potential of exposing shortcomings in law, policy and the delivery of services. This unwillingness is amplified in the mental health law setting, where a deconstructionist approach challenges the hegemonic medical model and would impose additional fiscal responsibilities arising out of a genuine commitment to equality and inclusion. The WHO-type Checklist noted above could be imposed externally by evaluators, and it would provide a modest reference point for our legislation. Some jurisdictions and organizations have taken a more ambitious approach to the process of advancing the rights of people with mental health problems, and their efforts are worthy of Canadian exploration. The creation of standards for the evaluation of human rights protections in legislation and beyond provides a basis for assessment and accountability and a platform for reform.

143 L. Burti, “Italian psychiatric reform 20 plus years later” (2001) 104 Supplement 410 *Acta Psychiatrica Scandinavica* 41 at 41.

144 Angelo Barbato, “Psychiatry in transition: outcomes of mental health policy shift in Italy” (1998) 32 *Australian & New Zealand Journal of Psychiatry* 673 at 674.

145 *Supra* note 143 at 42.

The Use of a Rights Analysis Instrument: Australia and the Council of Europe

In the early 1990's, Australia developed its first National Mental Health Plan, which included commitments to examine human rights protections and to create legislation which conformed with the 1991 United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* and the *National Mental Health Statement of Rights and Responsibilities*. The Attorney-General's Department developed a Rights Analysis Instrument (RAI) to assess the level of legislative compliance, intending "an objective evaluation to be made of existing reforms to State and Territory mental health legislation in terms of their responsiveness to these obligations."¹⁴⁶ Some rights were considered initially to be "not readily capable of legal enforcement" and more suitable for recognition through "extra-legal means such as administrative guidelines and standards," but many of these targets were eventually included.¹⁴⁷ Among the rights which were the subject of this controversy were: "General and Aspirational Human Rights;" embracing "international human rights instruments;" and "elements of prevention and promotion programs ... [such as] protection from negative factors increasing the risk of developing mental illness, including poverty, exploitation and other major adverse social influences."¹⁴⁸ Given the support of participants ("consumers and others") in the consultations,¹⁴⁹ and prior criticism of their omission from legislation by the National Inquiry into the Human Rights of People with Mental Illness (the "Burdekin Report"), there was some coverage of these issues in the final RAI. Legislative provisions were examined in terms of the extent of compliance ("substantial," "significant," "partial" or "minimal") against thirteen indicators:

1. General and Aspirational Human Rights
2. Human Rights in Mental Health Facilities
3. Determination of Mental Illness

146 Austl., Attorney-General's Department, *Report on A Rights Analysis Instrument for Use in Evaluating Mental Health Legislation* by Helen Watchirs & Greg Heesom (Canberra: Attorney-General's Department, 1996), online: Department of Health and Ageing <<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-r-rights>> at 1.

147 *Ibid.* at 78.

148 *Ibid.*

149 *Ibid.* at 5.

4. Criteria for Admission
5. Involuntary Admission Review/Appeals Body
6. Involuntary Admission Review/Appeals Process
7. Appointment of a Personal Representative
8. Procedural Safeguards in Mental Health Facilities
9. Consent to General Medical Treatment
10. Consent to Special Procedures
11. Treatment and Medication
12. Accountability, Standards and Monitoring
13. General Legal Provisions (not usually found in mental health legislation)

Recommendations made with the release of the initial RAI included that of extending commitments in legislation even beyond the areas surveyed to “improve upon these human rights norms” in “best practice legislation” so as to emphasize “more positive (as opposed to providing protection for negative) human rights” by “incorporating the national standards” “in mental health legislation.”¹⁵⁰

The criticisms and limitations of the Australian RAI are relevant in the Canadian context. Within the process,¹⁵¹ one of the original anchors of the RAI, the 1991 U.N. Principles, was impugned for being out of date and under-inclusive. Scoring evenness, fairness and accuracy were questioned. There were concerns about persons with mental illness not being required to be informed of their rights, rendering some guarantees “empty rather than protective.”¹⁵² There was also the recurring theme “about the role of the law in promoting and protecting rights in the mental health area,” with no consensus about “including large objects clauses” or “whether good administrative practice should be specified or codified in legislation.”¹⁵³

Subsequent evaluations of the Australian RAI remain mixed. There are criticisms of its effectiveness as a measurement tool, of the legislation itself

150 *Ibid.* at 20.

151 See Helen Watchirs, *Application of Rights Analysis Instrument to Australian Mental Health Legislation: A Report to Australian Health Ministers' Advisory Council Mental Health Working Group* (Canberra: Commonwealth of Australia, 2000).

152 *Ibid.* at 3.

153 *Ibid.*

as not “protecting consumers and carers against abuses” and of insufficient focus on “implementation and adherence”¹⁵⁴ of legislative goals, exposing the gap between legislative provisions and administrative compliance.¹⁵⁵ While these critiques are helpful, the positive features of the RAI approach still commend it for adoption in Canada. Helen Watchirs has offered several cogent arguments based upon her RAI experience: compliance with human rights standards and concomitant legal reform may be enhanced with a better evidentiary base; advocacy organizations are better equipped to argue for change using RAI findings; and human rights concerns are seen by the public as being a government priority.¹⁵⁶ She concludes that such audits “cannot resolve all mental health human rights issues” and are merely “a modest step to attempt to increase accountability,” but she contends that the RAI recognizes the “symbolic and authoritative power” of legislation, encouraging second-stage audits, examination of “broader and more complex issues related to enforcement” and “experiences of vulnerable populations,” and “equity of resource allocations.”¹⁵⁷

While the Australian example remains the most salient for considering the utility of the RAI in advancing the correspondence between human rights and mental health legislation, other jurisdictions have recently accepted this measurement technique. The Committee of Ministers of the Council of Europe established a Committee of Experts in 2005 to develop a mental health reference tool which would “focus on the human rights aspects of mental health, preventing stigma and discrimination, enhancing disease prevention and health promotion.” The Ministers sought to create “an analytical inventory,” which would set out “the ‘essential basket’ of the human/patients’ rights, ethical and social cohesion components in national

154 Mental Health Council of Australia, *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia* (Canberra: Mental Health Council of Australia, 2005) at 6.

155 Bernadette McSherry, “Human Rights and Mental Health: The Gap Between Legislating and Implementing Human Rights” (Paper presented at the Castan Centre Human Rights 2005: Year in Review Conference, 2 December 2005), online: Monash University Law <<<http://www.law.monash.edu.au/castancentre/events/2005/mcsherry-paper.html>> at 3.

156 Helen Watchirs, “Review of Methodologies Measuring Human Rights Implementation” (2002) 30 J.L. Med. & Ethics 716 at 727.

157 Helen Watchirs, “Human rights audit of mental health legislation – results of an Australian pilot” (2005) 28 Int’l J.L. & Psychiatry 99 at 11-12.

mental health policies." What would emerge would be "a model framework" or "an ethical framework for a patient-oriented mental health policy," which could be utilized as "a European reference tool."¹⁵⁸

By 2009, the Council had made remarkable progress in achieving its goal, adopting a Recommendation that States use a checklist "as a basis for the development of monitoring tools to assist in determining their level of compliance" with its earlier Recommendation "in order to protect the dignity and human rights of persons with mental disorder and ensure appropriate care."¹⁵⁹ The standards in the checklist are quite comprehensive, addressing many key principles: (1) Non-discrimination; (2) Civil and political rights; (3) The promotion of physical and mental health; (4) The protection of vulnerable persons; (5) The quality of living conditions, services and treatment; (6) Least restrictive alternative; (7) The quality of the legal framework for mental health and its implementation and monitoring; and (8) Taking account of the rights and needs of those close to people with mental disorder. Each Principle is accompanied by an amplification of its key elements: Primary Derivation; Meaning; Examples of Measures, and Questions/Indicators.

While a detailed analysis of the substance and implementation of the Council of Europe checklist must be postponed, several features are salient in the Canadian legislative and policy context. For example, there are frequent references to the essential role of legal reforms in implementing broad goals: the "development of legal instruments" making discrimination unlawful; "legal measures to uphold the rights of the group;" "legislation to protect vulnerable people or people lacking mental capacity" and "Good quality legislation and monitoring methods," which are "indispensable to ensure that people's rights are protected." To buttress legal progress, the checklist supports the "creation of advocacy schemes to support the exercise of rights" and the encouragement of "participation via advocacy" and "advocates to provide independent support." Overall, the new European checklist is thorough and logical, but its substantive emphasis on the prohibition of discrimination and the promotion of social inclusion using rigorous legal standards, bolstered by advocacy supports, additionally commends it.

158 Council of Europe, Committee of Ministers, 959th Mtg., *Appendix 3: Specific terms of reference of the Committee of experts on developing a Council of Europe mental health reference tool (SP-MNH)* (2006).

159 Council of Europe, Committee of Ministers, 1057th Mtg. of the Ministers' Deputies, *Recommendation CM/Rec(2009)3*. Attached to this Recommendation is an Appendix which includes the checklist.

Canada should consider the Australian and European examples, building on their methods and lessons. A candid assessment of the real extent of human rights protection and advancement in mental health legislation and practice would provide reassurance in some areas and painful critiques in others. Such techniques could propel genuinely progressive law reform beyond the current emphasis on involuntary treatment, and could fundamentally alter the character of Canadian mental health legislation. Next, the paper explores Scotland's alteration of its statutory foundations by providing positive, equality-enhancing guarantees and taking further steps to ensure accountability through devices echoing the RAI approach.

Scottish Innovations: *Mental Health Act Obligations and the Scottish Recovery Indicator (SRI)*

The extensive (323 sections, 273 pages) *Mental Health (Care and Treatment) (Scotland) Act 2003* at first glance seems unremarkable among mental health statutes, given its emphasis on detention and compulsory treatment orders in the civil setting, coupled with provisions providing compulsion orders for "Mentally Disordered Prisoners" in the criminal context. Nonetheless, some provisions genuinely advance the disability model. The *Act* obliges government to deliver ("A local authority shall provide") "services which provide care and support" for persons not in hospital (s. 25(1)(a)(I)), an obligation that is designed to "(a) minimize the effect of the mental disorder on such persons; and (b) give such persons the opportunity to lead lives which are as normal as possible" (s. 25(2)). Similar obligations are imposed to deliver "services which are designed to promote the well-being and social development" (s. 26(1)(a)(I)) of persons with a mental disorder, including "social, cultural and recreational activities," "training" and assistance "in obtaining and in undertaking employment" (s. 26(2)). These core statutory obligations have profoundly influenced (or perhaps, conversely, have been influenced by) the development of correlative policies and services in the direction of equality promotion and social inclusion. The Vision in a key statement of *Delivering for Mental Health*¹⁶⁰ commits the Government to "treating and preventing illness," while promoting "mental health and well being," with a

160 Scottish Executive, *Delivering for Mental Health* (Edinburgh: Scottish Executive, 2006).

new concentration on “commitments in respect of equality, social inclusion, recovery and rights:”

Population and social inclusion approaches are important in reducing the number of people who develop mental illness and in addressing inequalities in mental health. The Executive is committed to social justice and is working to address poverty, deprivation, inclusion and exclusion across Scotland.

It is commonplace to observe the vast gap between such broad legislative and policy commitments and the actual experience of persons who are their intended targets. Scotland is taking deliberate steps to bridge this chasm. For example, the Scottish Government has accepted that sections 25-31 of the *Mental Health Act* impose “a clear statutory duty on the local authority to promote wellbeing and social development for those who have or have had a mental disorder.”¹⁶¹ Moreover, the Government also accepts that: “As these are duties under the ... Act 2003 the local authority may be subject to legal challenge on whether it has met its obligations under the Act.”¹⁶² To assist local authorities “to understand and fulfill their duties,” the Government published a document which “provides aspirational guidance and best practice,”¹⁶³ detailing both Guiding Principles and an Action Plan. There is emphasis on ending inequality, moving “away from segregated services,” strengthening “inclusive opportunities,”¹⁶⁴ promoting “wellbeing, rather than merely the alleviation of symptoms”¹⁶⁵ and the promotion of social development.

In addition to the obligations under the *Act*, a crucial element in achieving the progressive Vision in *Delivering for Mental Health* was the development of “a tool to assess the degree to which organizations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights.”¹⁶⁶

161 Scottish Government, *With Inclusion in Mind: The local authority's role in promoting wellbeing and social development: Mental Health (Care and Treatment) (Scotland) Act 2003 Sections 25-31* (Edinburgh: Scottish Government, 2007) at iv.

162 *Ibid.* at 16.

163 *Ibid.* at iv.

164 *Ibid.* at 1.

165 *Ibid.* at 5.

166 *Supra* note 160 at 1.

The resultant Scottish Recovery Indicator (SRI)¹⁶⁷ provides “a tool to assess practice against expected values,” taking into account diverse factors such as “the experience of poverty and economic inequality ... associated with poorer mental health,” “The experience of discrimination, prejudice and stigma on the basis of aspects of social identity” and “discrimination, prejudice and stigma” for people with mental health problems.¹⁶⁸ In the final version (2009),¹⁶⁹ on a scale of 1 (“no,” or “very minimal,” adherence to the indicator) to 5 (full adherence to the indicator), the SRI requires an assessment of nineteen indicators, falling under eight parts, to support societal inclusion:

1. Meeting basic needs;
2. Personalised services and choice;
3. Strengths based approach;
4. Comprehensive service;
5. Service user involvement/participation;
6. Social inclusion and community integration;
7. Advance planning;
8. Recovery focus.

Although it is early to evaluate the success of the SRI, a pilot study has provided some favourable feedback on the “extent to which the SRI enables practitioners and managers to apply the factors that promote equality, social inclusion and recovery for individuals to support system- level change.”¹⁷⁰ The conclusions included a verdict that “the SRI appears to have good potential to influence change, at the individual and individual service levels,”¹⁷¹ and that it “enhanced local efforts to improve services by further devel-

167 Scottish Government, “Scottish Recovery Indicator (SRI),” online: Scottish Government <<http://www.scotland.gov.uk/Publications/2007/06/05121030/5>>.

168 *Ibid.*

169 See Scottish Recovery Indicator, “Home,” online: Scottish Recovery Indicator <www.scottishrecoveryindicator.net/>.

170 Scottish Government Social Research, *Evaluation of the Scottish Recovery Indicator Pilot in Five Health Board Areas in Scotland* by Joanne McLean & Indiya Whitehead (Edinburgh: Scottish Government Social Research, 2008) at 59.

171 *Ibid.*

oping local participants' insights into the recovery, equalities and inclusion agendas."¹⁷² One of the "challenges and barriers" was "a lack of active involvement in and support for the SRI from psychiatrists."¹⁷³

The multi-pronged Scottish approach includes "a core set of national, sustainable mental health indicators to support the Scottish Government's drive on mental health improvement," "covering both mental health problems and positive mental health."¹⁷⁴ The fifty-four indicators include an equality analysis, which requires "analysing the other indicators by selected dimensions of equality,"¹⁷⁵ given the "impact of inequality on health," and the acceptance that "Inequality is both a cause and consequence of mental health problems."¹⁷⁶ The resultant "first ever systematic assessment of the adult populations' mental health" provides "a description of the state of mental health and the associated contextual factors," "time trends" and "differences within the adult population by selected dimensions of equality."¹⁷⁷ These equality status indicators and the Report are complemented by an *Action Plan* in which the Government commits itself to "ensuring that appropriate services are in place, but also by working through social policy and health improvement activity to reduce the burden of mental health problems and mental illness and to promote good mental wellbeing."¹⁷⁸ The *Plan* rededicates the Government to the promotion of the "social inclusion of people who have experienced mental illness" by continuing "to offer financial support" to local authorities.¹⁷⁹

Among the lessons to be drawn from the Scottish experience is the fundamental significance of statutorily guaranteeing the provision of a broad range of services in the community to promote "well-being and social development" (s. 26). From this promise, it became essential to concentrate on

172 *Ibid.*

173 *Ibid.*, at 5.

174 Jane Parkinson, *Establishing a core set of national sustainable mental health indicators in Scotland: Final report* (Edinburgh: NHS Health Scotland, 2007) at 2.

175 *Ibid.* at 3.

176 *Ibid.* at 41.

177 Martin Taulbut *et al.*, *Scotland's Mental Health and its Context: Adults 2009* (Glasgow: Health Scotland, 2009) at 1.

178 Scottish Government, *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* (Edinburgh: Scottish Government, 2009) at 5.

179 *Ibid.* at 43.

commitments “in respect of equality, social inclusion, recovery and rights,”¹⁸⁰ and to make systems accountable for service delivery, using instruments like the SRI and, ultimately, national mental health indicators. While many aspects of the Scottish legislative scheme resemble current Canadian mental health legislation, the statutory addition of equality-promoting obligations dictates parallel policy and service agendas. A similar shift from a virtually exclusive legislative stress on involuntary measures towards an expansive rights-enhancing model with measurements of accountability, such as those offered by the S.R.I. and by the national mental health status survey, is within the grasp of Canadian legislators.

Responsibility for the Necessary Redirection

As has been demonstrated, the quest for the redirection of Canadian mental health legislation towards the disability model need not proceed without guideposts and indicators of progress. If Canadian legislators are willing to look further afield and draw upon international and comparative resources, the shift towards the new paradigm will not be rudderless. Within Canada what institutions or actors can offer assistance on this journey? Clearly, no one entity has the sole responsibility for such a major law reform effort, and momentum always increases as concepts of shared duties infuse the process. Given the diversity among organizations and contributors, the level of actual subscription by each actor towards such novel legislative goals will be largely unpredictable, although a brief account of some of the current major prospective contributors will be offered, in no particular order.

Academic Influence

There is a growing, but still small, group of scholars in the Canadian mental disability law field. Their independence is a major asset, as they are free to criticize and advocate for innovation. On the other hand, there may be resource constraints on the scope of research, and the long-term nature of this reformist direction may discourage some. The actual level of influence brought to bear by academic commentators may be modest, at least in the short run, but there is a discernable trend towards a heightened recognition of disability rights.

Assessing the extent of the potential contribution of legal and disability studies scholars is somewhat elusive. As Pamela Brandwein has observed,

180 *Supra* note 166 at 1.

in a related American context, there is a poor level of understanding about the boundaries between academic disciplines and the law: "Inquiries into the nature and conditions of permeability between academic disciplines, the legal academy, and constitutional law are much needed."¹⁸¹ That said, it may be that the "unprecedented upsurge of interest in the general area of disability among social scientists in universities and colleges across the world"¹⁸² will infuse Canadian law schools (and universities) as well. Moreover, researchers oriented towards this scholarly project are likely to be committed to "a social-political approach:"¹⁸³ "Disability studies, like ethnic, women's, and gay and lesbian studies, has developed from a position of engagement and activism rather than one of detachment."¹⁸⁴

Examining only Canadian law schools, courses with a disability focus are appearing more frequently. A recent survey of titles referring to "disability" revealed classes in the Faculties of Law of the University of British Columbia, the University of Saskatchewan, Osgoode, the University of Toronto, the University of Ottawa (Common Law), Dalhousie and the University of Quebec at Montreal. Several universities – the University of Saskatchewan, Osgoode, Toronto, McGill and Sherbrooke – offered courses in Law and Psychiatry or Mental Health Law, although an analysis of their syllabi would be required to see their orientation. Finally, there are many other widely available courses with generic titles where, depending upon the outlook of the teacher, there would be considerable scope for the exploration of themes touching upon the evolution of mental health law towards the disability paradigm: Health Law, Law and Medicine, Discrimination and the Law, International Human Rights Law and general Human Rights Law. Given the number of courses in the broad field in law schools alone, and the ideology of many legal (and disability studies) scholars, the time may be more propitious for academic influence on the public policy agenda.

181 Pamela Brandwein, "Constitutional Doctrine As Paring Tool: The Struggle For 'Relevant' Evidence in *University of Alabama v. Garrett*" (2001-2002) 35 U. Mich. J.L. Ref. 37 at 55.

182 Colin Barnes, Mike Oliver & Len Barton, eds., *Disability Studies Today* (Cambridge: Polity Press, 2002) at 1.

183 *Ibid.* at 8.

184 *Ibid.* at 2.

Non-Governmental Organizations

Many associations have a long record of advocacy for the minimization of coercive reactions to mental health problems and for a linked insistence on inclusive, equality-promoting stances. Public interest in such issues “emerged in Canada at the turn of the twentieth century,” generating “organizations, which promoted reform of attitudes, policies, practices, and facilities.”¹⁸⁵ Although others have made analogous contributions, notable among such organizations is the Canadian Mental Health Association (C.M.H.A.):¹⁸⁶

its long experience, track record, and local, regional, and national networks suggest that it should continue to play a key role as an educator about mental disability, lobbyist for better funding for mental health facilities and programs, and advocate for the rights of the mentally ill.¹⁸⁷

Many NGOs have demonstrated a tradition of autonomy, although they may be compromised at times by the implicit or explicit limits placed upon them by government and other funders. That said, these associations have several essential roles: mobilizing grassroots support; anchoring the law and policy agenda in empowerment, recovery, health promotion and social participation; some service delivery; resistance against the more paternalistic and interventionist excrescences of the medical model; and being the default sites for lobbying and systemic advocacy.

185 Judith Fingard & John Rutherford, *Protect Befriend Respect: Nova Scotia's Mental Health Movement 1908-2008* (Black Point: Fernwood, 2008) at ix.

186 For an example of a widely heralded public policy statement, see John Trainor, Ed Pomeroy & Bonnie Pape, *A Framework for Support*, 3rd ed. (Toronto: Canadian Mental Health Association, 2004), which advanced a goal, “unchanged in the twenty years” since the inception of the Framework project: “To ensure that people with serious mental health problems live fulfilling lives in the community” (at 2). See also Canadian Alliance for Mental Illness and Mental Health, *Framework for Action on Mental Illness and Mental Health: Recommendation to Health and Social Policy Leaders of Canada for a National Action Plan on Mental Illness and Mental Health* (Ottawa: Canadian Alliance for Mental Illness and Mental Health, 2006) at ii: “CAMIMH adopts a population health perspective, which includes the full continuum of health determinants;” “the social determinants of health are essential for mental health.”

187 *Supra* note 185 at 138.

The Mental Health Commission of Canada (MHCC)

This newly established (2007) commission, intended to operate at arms' length from government, has been enthusiastically welcomed by conventional health care providers as well as advocacy organizations. Expectations of its potential have been very high, particularly given the pent-up needs of persons with mental health problems. The Commission may eventually promote the social or disability rights model and may become a unifying force regarding mental health issues across a neglected legislative and public policy agenda, especially as it will enjoy, however briefly, a halo effect. Its long term vision and strategy is gradually being articulated, and its goal, "to help bring into being an integrated mental health system that places people living with mental illness at its centre," is broadly compatible with the social model, as is its statement that "People living with mental illness have the right to obtain the services and supports they need" and "to be treated with the same dignity and respect as we accord everyone struggling to recover."¹⁸⁸

Conversely, its proximity to and fiscal dependence on government may jeopardize the extent of the mark of the Mental Health Commission. Further, it has yet to be seen whether the Commission is amenable to *insisting* on an equality-promoting, social inclusion model, especially given the inevitable points of conflict with the hegemonic medical paradigm to which legislation has been so firmly attached. So far, the Commission has not explicitly championed a dilution of, or severance from, the Canadian legislative norms of paternalism and coercion.

In 2009, the MHCC faces several challenges. As a new organization, it is developing its standards of governance and has just released its First Annual Report.¹⁸⁹ Its willingness to confront government when necessary is

188 Mental Health Commission of Canada, "The MHCC," online: Mental Health Commission of Canada <<http://www.mentalhealthcommission.ca/English/Pages/TheMHCC.aspx>>. (The author is a member of the Mental Health and the Law Advisory Committee of the MHCC, which has explicitly adopted an equality promoting Vision. This Advisory Committee has also received funding for a preliminary study on a Rights Analysis Instrument and the potential for the use of accountability indices in the Canadian context).

189 Mental Health Commission of Canada, *Out of the Shadows Forever: Annual Report 2008-2009* (Calgary: Mental Health Commission of Canada, 2009). Public scrutiny of and accountability for standards of governance must become more evidently familiar principles to the Mental Health Commission as it matures.

unclear. The Commission says it “can be a catalyst to stimulate change and innovation,”¹⁹⁰ but its strategy seems restrained, as it is guided by a principle that “the ultimate document must be a ‘practical’ one that assists governments.”¹⁹¹ Its ability to recognize the contributions of other mental health advocacy organizations, such as the Canadian Mental Health Association, so as to move forward collaboratively, is not always evident, particularly as the Commission seems to be influenced by “other illness-oriented organizations” (such as “breast cancer, diabetes, heart disease and stroke, and AIDS”)¹⁹² and is establishing its own “broadly-based dynamic and well-organized grassroots group.”¹⁹³

In early 2009, the Commission released a Draft of its National Strategy¹⁹⁴ in which its vision indicated some receptiveness towards the social or disability paradigm, but its anchor still appeared to be a variation of the medical model. The Draft Strategy, while evincing awareness of “many social and economic factors” and of the pernicious effects of “disparities in socioeconomic status and level of education,”¹⁹⁵ was not dedicated to a broad and overriding aim of equality promotion and social inclusion. Similarly, while there were occasional invocations of the least restrictive principle, the Draft Strategy did not strengthen its commitment to this fundamental counterbalancing norm. Neither the Draft Strategy, nor its successor, advocated for the equality-promoting potential of the law, despite the acceptance that

Fortunately, appropriate guidelines are readily available. For example, Marilyn Wyatt observes that “NGOs are accountable to their communities” and “are committed to the highest level of accountability;” that the board must be its “principal governing body,” making “decisions collectively” with officers, with members with “specific duties,” and with a Chair who “doesn’t have any special decision-making powers unless they are explicitly delegated by the full board,” all of whom safeguard “the mission of the organization” that is its “very heart.” See Marilyn Wyatt, *A Handbook of NGO Governance* (Budapest: European Center for Not-for-Profit Law, 2004) at 13, 19-20, 22, 24.

190 Mental Health Commission of Canada, *ibid.* at 1.

191 *Ibid.* at 5.

192 *Ibid.* at 20.

193 *Ibid.*

194 Mental Health Commission of Canada, *Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada: Draft For Public Discussion* (Calgary: Mental Health Commission of Canada, 2009).

195 *Ibid.* at 6.

"Discrimination can also be passive or 'structural,' meaning that it is reflected in policies, practices and laws."¹⁹⁶ Nor did the Draft Strategy indicate a willingness to support positive rights and accountability standards analogous to Scotland's. Although it recognized discrimination "under existing income support programs" and "the discriminatory gap" in the housing area, the Draft refused to "recommend or specify a guaranteed annual income for all Canadians" or to "make specific recommendations related to housing shortages in the general population."¹⁹⁷

Following the completion of its ambitious consultative process, the Commission issued a substantially revised final policy in the fall of 2009 that is more responsive to some progressive influences.¹⁹⁸ The *Framework* provides more prominence to the principle of legislative restraint: "A principle of recovery-oriented mental health policy and legislation must be to always employ the least intrusive and least restrictive interventions possible."¹⁹⁹ In several passages, the *Framework* emphasizes the importance of social context in understanding mental health problems and in devising appropriate responses (demanding, e.g., that "attention be paid to structural barriers related to housing, income, education, access to services, and other factors") and of critiquing conventional outlooks, "which typically focus on individual symptoms and disorders" while ignoring "these social, political and historical contexts."²⁰⁰ Further, although focusing on the need for changes in public attitudes, the *Framework* in general and Goal Seven in particular show a heightened awareness of the necessity of confronting discrimination and its historically marginalizing affects: "People living with mental health problems and illnesses are fully included as valued members of Canadian society."²⁰¹

On the other hand, the *Framework* evinces many of the difficulties that emerged from the Draft Strategy. There is some comfort in the fact that, as noted on its cover, later iterations will "address the many specific issues that confront different constituencies and various segments of the population,"

196 *Ibid.* at 50.

197 *Ibid.* at 51.

198 Mental Health Commission of Canada, *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada* (Calgary: Mental Health Commission of Canada, 2009).

199 *Ibid.* at 30.

200 *Ibid.* at 50.

201 *Ibid.* at 90.

as the *Framework* seeks to “define the basic shape of what a transformed mental health system will look like.” Therefore, the normative achievements within the *Framework* may be complemented by more strident assertions of a rights-based disability or social model articulated in legislation. As things stand, the document remains virtually silent with respect to the emergence of an obligation to redirect mental health legislation away from its coercive underpinnings. While sharing an awareness of “the influence of psychological, psychosocial and environmental factors,”²⁰² the *Framework* remains too reticent to invoke the concept of positive rights. It does not mention the equality-promoting potential of the *Charter*, nor does it adopt progressive policy and legislative alternatives extant in other jurisdictions. Ominously, in terms of the potential for legislative transformation towards the disability model, the *Framework* underemphasizes the applicability and significance of the U.N. *Convention on the Rights of Persons with Disabilities*. Neither does the *Framework* extrapolate from its insight that, with respect to physical disabilities, “legal and policy frameworks have been put in place that not only offer protection from discrimination but also promote full inclusion in Canadian society.”²⁰³

The Mental Health Commission is a work in progress and it retains the capacity to have a salutary effect on Canadian mental health legislation. Later, more concrete, stages of the National Strategy may present a direct challenge to the Canadian history of neglect, marginalization and discrimination, which has been facilitated through legislation. Its sequelae may advance positive rights and accountability measurements using legislation under the umbrella of the disability paradigm. In the absence of such rigorous assertions, the assessment of the potential contribution of the MHCC towards legislative reform must be cautious, although there is some evidence justifying a constructive optimism. Kimberly White seems similarly restrained in her preliminary assessment of the Commission. She celebrates “the best of intentions and the highest of hopes” in the MHCC membership, but she points out the “tunnel-vision or oversimplification in the rhetoric of the Commission’s mandate and strategic planning” and the hazard that the MHCC may “impede the possibility of affecting anything resembling a

202 *Ibid.* at 81.

203 *Ibid.* at 95. There is only a short footnote reference to the *Convention* which accompanies this quotation.

'transformation' of popular attitudes and mental health services."²⁰⁴ Even in the face of these conflicted reviews, the Mental Health Commission remains as a locus for concentrating law reform efforts.

Committees of Ministers and Officials

As noted previously, other jurisdictions (e.g., Europe) have used assemblages of government ministers and officials to good effect to advance a rights-based mental health law agenda, so it is appropriate to consider whether analogous committees might become reformist animators in Canada. If the reconfiguration of legislation is considered radical, it seems unlikely that Ministers or officials could overcome any subsisting conservative tendencies. A general reluctance to embrace change may be amplified where the move towards the social model would involve some diminution or repositioning of the dominant medical outlook and where additional fiscal resources would be required to support an inclusionary approach. Although a recognition of these countervailing tendencies is realistic, Ministers or officials may still have a role to play in recognizing or even advancing an emerging consensus.

For example, a Meeting of Ministers in 2005 "affirmed that a key priority...will be persons with disabilities," restating "their commitment to the objective of full inclusion of Canadians with disabilities in society."²⁰⁵ In terms of the role of public servants, the Continuing Committee of Officials on Human Rights (CCOHR) now has a pivotal responsibility with respect to assessments for consistency of "legislation, policies and programs" with the Convention on the Rights of Persons with Disabilities.²⁰⁶ This Committee, which has been meeting since 1975, has ongoing duties in discussing "international human rights instruments that Canada is considering for signature, ratification, or accession," "human rights instruments under development"

204 Kimberley White, *Configuring Madness: Representation, Context and Meaning* (Freeland: Interdisciplinary, 2009) at 3.

205 Canadian Intergovernmental Conference Secretariat, News Release, 830-864/004, "Federal-Provincial-Territorial Meeting of Ministers responsible for Social Services Ottawa, Ontario – October 20, 2005" (20 October 2005), online: <http://www.scics.gc.ca/cinfo05/830864004_e.html>. A "Human Resources and Social Services Retreat on Disability Issues" was held in September, 2007, indicating an ongoing interest in disability matters.

206 Foreign Affairs and International Trade Canada, *supra* note 91.

and “emerging human rights issues.”²⁰⁷ In parallel cases, the CCOHR has identified issues in respect of the *Convention on the Elimination of All Forms of Discrimination against Women*²⁰⁸ and the *International Covenant on Civil and Political Rights*.²⁰⁹ In the latter instance, Canada specifically elaborated on the role of the CCOHR, noting that, while “not a decision-making or enforcement body,” it helps to ensure “awareness of treaty obligations,” “which can influence policy and program development,” and was said to be examining ways “to improve and promote public awareness and access to human rights information.”²¹⁰

In a complex federal state, Meetings of Ministers or Committees such as the CCOHR may be important loci for advocacy in any attempts to alter the course of mental health legislation. Even if the deliberations of these bodies are not fully accessible to the public, the Ministers and public servants who comprise their membership must receive and should consider representations from interested individuals and groups.

Uniform Law Conference (ULC)

This body may well be useful in proposing harmonized mental health legislation using a disability rights lens, as it devised a *Uniform Mental Health Act* in 1987, although that project was very much in the traditional medical mode. The ULC only cites Prince Edward Island as having adopted this model, but other jurisdictions may have referred to or accepted it in part, and the rate of acceptance for other statutes has been better. Realistically, the Conference cannot singularly influence the tenor of legislation, as the Civil Section responsible for drafting its model statutes claims that it “expresses no opinion

207 Canadian Heritage, “Continuing Committee of Officials on Human Rights,” online: Canadian Heritage

<<http://www.pch.gc.ca/pgm/pdp-hrp/canada/cmtt-eng.cfm>>.

208 Government of Canada, *Convention on the Elimination of All Forms of Discrimination against Women: Sixth and Seventh Reports of Canada: April 1999 – March 2006* (Gatineau: Human Rights Program Department of Canadian Heritage (2006)).

209 Canadian Heritage, “Additional Information in Response to Supplemental Questions of the Human Rights Committee on the occasion of its review of Canada’s Fifth Report on the International Covenant on Civil and Political Rights: October 17 and 18, 2005,” online: Canadian Heritage

<<http://www.pch.gc.ca/ddp-hrd/docs/reponses-responses/info-eng.cfm>>.

210 *Ibid.*

as a matter of policy, but which it offers as a method of harmonization.”²¹¹ As a conference of “government policy lawyers and analysts, private lawyers and law reformers,” some previous consensus would have to be attained before the ULC could be expected to consolidate any major reforms. Prior to that as yet unclimbed plateau, the potential of the ULC will be somewhat restricted.

On the other hand, it is not as if the policy creation frontier has never been broached by the ULC. For example, a recent Report on *Strategic Lawsuits Against Public Participation (SLAPPs)*²¹² took up an initiative in a controversial area. Spurred by “a number of jurisdictions,”²¹³ it considered “a serious threat to the participation of citizens and groups in public debate,”²¹⁴ and recommended a working group be “expanded to include additional members, including private practice lawyers.”²¹⁵ It would appear that both with respect to policy development and expansion of its consultative capacity, the ULC may be able to have a limited constitutive role in reformulating Canadian mental health law.

Professional Associations

Professional organizations – for example, those representing the Bar²¹⁶ and physicians²¹⁷ – have occasionally taken it upon themselves to push the public policy envelope and, where necessary, to provoke or defy government, so

211 Uniform Law Conference of Canada, “What we do,” online: Uniform Law Conference of Canada <<http://www.ulcc.ca/en/about/>>.

212 Vincent Pelletier, *Strategic Lawsuits against Public Participation (SLAPPs) (and other abusive lawsuits)* (Quebec City: Uniform Law Conference of Canada Civil Section, 2008).

213 *Ibid.* at 1.

214 *Ibid.* at 2.

215 *Ibid.* at 19.

216 For example, see Quebec Bar *et al.*, “Call for the Repatriation of Omar Khadr,” online: Canadian Bar Association <<http://www.cba.org/CBA/submissions/pdf/08-56-eng.pdf>>: “The Canadian Bar Association pronounced itself in 2006 on the need to respect the Rule of Law at Guantanamo Bay and, since 2007, has called for the repatriation of Omar Khadr,” a position which has not been endorsed by the Government of Canada.

217 For example, the Canadian Medical Association (CMA) has been at odds with the Government of Canada’s rejection of “harm-reduction programs in the new national drug strategy,” viewing the stance as a dismissal of “growing scientific

it is not fanciful to suggest that such provincial or national bodies may have some potential for reorienting Canada's mental health statutes.

The Bar would have to transcend its sanist leanings and fully embrace its obligations to advocate for the equality rights of persons with mental health problems. In terms of formal Bar activities, disability rights do not appear to be a major concentration. There are many individual lawyers who have been advocates for clients with mental health problems and for systemic change. There are some Bar admission and continuing legal education events and independent professional organizations touching upon mental health law. However, an online search in mid-2009 of Provincial and Territorial Bars, as well as the Canadian Bar Association, revealed only one standing committee or working group entrusted with issues surrounding disability and mental health law (Barreau du Québec, Groupe de Travail en Santé Mentale et Justice).

Physicians would have to accept the desirability of reducing their almost exclusive control over the complexion and administration of mental health law and would need to reposition themselves as allies in a broader struggle for inclusion and fairness. While psychiatry in particular is not monolithic and it is possible that psychiatrists may come to accept a social or disability model for mental health law, by 2009, there did not appear to be many indications of this spirit in official declarations of the Canadian Psychiatric Association. While a 2005 Position Statement did acknowledge the least restrictive principle in legislation as "necessary to enable persons with mental illness to participate meaningfully in our free and democratic society,"²¹⁸ there have been no new Statements following the U.N. *Convention on the Rights of Persons with Disabilities*. The thorough reorientation of these professions does not appear to be on the immediate horizon, but it is conceivable that a groundswell of public and NGO opinion could stimulate a commitment to revisit the current anchors of Canadian mental health law.

evidence of the positive role harm-reduction programs can play." See Brian Day, "Ottawa's bad prescription on addiction" *Toronto Star* (8 June 2008) A15.

218 Grainne Neilson, *The Role of Mental Health Legislation* (Ottawa: Canadian Psychiatric Association, 2005).

The Media

Many rungs in the ladder of social change for persons with mental illness have been climbed with the active support of informed and sympathetic journalists. Although press coverage is still littered daily with stigmatizing labels and stories, there are regular examples of more respectful and penetrating analyses.²¹⁹ A comprehensive strategy to renovate Canadian mental health legislation must capitalize on any residuum of goodwill in the media for the needs of persons with mental health problems and must simultaneously combat uninformed, regressive or sensationalist coverage of events and issues with a mental health penumbra.

The media must be viewed as “essential players in any movement for change, as they have an important role in determining public attitudes to mental illness.”²²⁰ One British study has suggested that the recent “shift towards a coercive policy” relates to government’s pandering “to inaccurate public perceptions, reactions, and intolerance,” partially “as a result of misleading inaccurate mass representations of mental illness and mental health issues.”²²¹

The challenge in attracting media and public support for a new paradigm of Canadian mental health law is considerable, but “There is evidence of some ‘positive’ images being portrayed,”²²² and one can envisage deliberate

219 See “Breakdown: Canada’s Mental Health Crisis” *The Globe and Mail* (June 2008), online: globeandmail.com <<http://v1.theglobeandmail.com/breakdown>>. See also the more recent *Globe and Mail* series “Breaking Through” *The Globe and Mail* (September 2009), online: globeandmail.com <<http://www.theglobeandmail.com/special-reports/breaking-through/>>. Kimberly White has argued for a careful approach, even when assessing ostensibly better coverage such as in the *Globe and Mail* series. She notes that “neither can it be seen as an objective news report,” functioning “as a vehicle to carry the key messages of the Commission to the public,” with the risk that “the anti-stigma/anti-discrimination initiative” from which it emerges is “more likely to formalize than to transform dominant conceptualizations of mental illness.” *Supra* note 204 at 6-7.

220 Barbara Hocking, “Reducing mental illness stigma and discrimination – everybody’s business” (2003) 178 *Medical Journal of Australia* S47 at S48.

221 J.R. Cutcliffe & B. Hannigan, “Mass media, ‘monsters’ and mental health clients: the need for increased lobbying” (2001) 8 *Journal of Psychiatric and Mental Health Nursing* 315 at 318.

222 *Ibid.* at 317.

strategies for resisting the lowest common denominator of news reporting and altering media coverage towards a positive social or disability model of law. Some authors have suggested “a short course in mental-health medical legal and political concepts” for new reporters.²²³ Some educational institutions have taken on the responsibility of providing resource materials for reporters “to provide tools and information ...on ways to improve reporting on mental health issues.” Examples include “Balancing News Coverage” and “Eliminating Stigmatizing Language and Stereotypes.”²²⁴ Such deliberate and positive strategies of increasing the accuracy and fairness of media coverage should assist in adjusting the tone of the news and, hence, public perceptions of the attractiveness of mental health law reform.

Conclusion: Is The Ship of State Changing Course?

Canadian mental health legislation has not yet been forcefully redirected towards the social or disability model. The ship of state remains deeply anchored in the medical paradigm, and, if anything, its grip is becoming firmer. Those who lean towards the conventional medical outlook will celebrate this swing of the pendulum of mental health law. Those who are concerned to reverse historic patterns of discrimination, poverty and human rights abuses must despair at times as they see further evidence of the easy resort to intervention and coercion.

Increasingly, Canadians are being asked to recognize the pervasiveness of mental health problems and are being encouraged to accept the wrongfulness of stigma and discrimination. These moves toward normalization should be accompanied by greater pressure to understand the experience of their fellow citizens and the assurance that people facing such difficulties are supported, on a non-discriminatory basis, in their efforts to live as full citizens in the community. The intrusiveness of existing mental health law should be restrained, with more emphasis on less coercive alternatives and a legislative infusion of hope. Statutory recognition of the human rights dimensions of mental health legislation would replace the coercion

223 Patrick Smellie, “Feeding Stereotypes: Crime reporters fall into trap of ignorance in portraying suspects, researcher finds,” online: Judge David L. Bazelon Center for Mental Health Law

<<http://www.bazelon.org/newsroom/archive/1999/smellie.htm>>.

224 Mental Health Reporting, “Home,” online: Mental Health Reporting

<<http://depts.washington.edu/mhreport/index.php>>.

and interventionism of the status quo with state guarantees of services that would generously support social inclusion, leaving fair involuntary measures as a true last resort.

This may well be, to paraphrase Driedger's verdict, the last great civil and human rights struggle.²²⁵ If one accepts this characterization, the law has not been fulfilling a leadership role. Canada has yet to move from framing concern over mental health issues "not simply as a social problem, but as a human rights imperative."²²⁶ An examination of the potential of the social or disability model makes a major statutory shift compelling. Recent progressive developments in the international and comparative domains suggest that Canada can be redirected away from its legacy of discrimination, paternalism and coercion, and towards a brighter shore.

225 D. Driedger, *The Last Civil Rights Movement* (London: Herst and Co., 1989) at 1.

226 Lawrence O. Gostin, "International Human Rights Law and Mental Disability" (2004) 34:2 *Hastings Center Report* 11 at 11. Although dealing with a narrow issue, the jurisdiction of Criminal Review Boards under the *Charter*, Madam Justice Lang, in dissent, captured the same theme in a recent Ontario Court of Appeal decision. Persons subject to Review Board constraints are "some of the most vulnerable members of society. *How society treats them is a measure of our civilization.*" See *R. v. Conway*, 2008 ONCA 326 at para. 64, 90 O.R. (3d) [emphasis added].