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Creating a Cultural Analysis Tool for the Implementation of Ontario's Civil Mental Health Laws

Roby Dhand

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**CREATING A CULTURAL ANALYSIS TOOL
FOR THE IMPLEMENTATION OF ONTARIO'S CIVIL MENTAL
HEALTH LAWS**

RUBY DHAND

A DISSERTATION SUBMITTED TO
THE FACULTY OF GRADUATE STUDIES
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

GRADUATE PROGRAM IN LAW
YORK UNIVERSITY
TORONTO, ONTARIO

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ABSTRACT

The purpose of the study was to develop a Cultural Analysis Tool (CAT). The CAT consists of specific thematic questions that can serve as a cultural and equity analysis instrument for practitioners to use in the implementation of Ontario's civil mental health laws. The rationale behind creating the CAT is based on research suggesting that ethno-racial people with mental health disabilities experience inequities and differential outcomes while interacting with Ontario's civil mental health laws. Given the increasing multi-racial population in Ontario, there is a need to develop mechanisms to address these intersecting issues. Other countries that have created evaluative tools for mental health legislation include the United Kingdom and Australia. Such a tool does not exist in Canada, let alone in Ontario specifically. This study contributes to a better understanding of how equitable outcomes for ethno-racial people with mental health disabilities interacting with Ontario's civil mental health laws can be achieved.

I developed the CAT through an iterative process involving a comprehensive review of the literature and qualitative data drawn from thirty-five semi-structured interviews with seven members of each of the following groups: (1) ethno-racial people with mental health disabilities including in-patients and ex-patients, (2) lawyers who practice in the area of mental health law, (3) health care professionals including psychiatrists, nurses and social workers, (4) service providers such as front-line case workers at mental health agencies and (5) adjudicators, government advisors and academics. I analyzed the data using the grounded theory approach, symbolic interactionism, tenets of the theoretical framework and an analysis of the jurisprudence, legislation, international laws and literature on the existing tools used for mental health legislation. After developing a draft

version of the CAT, I refined the CAT's questions through an expert review (involving the qualitative technique of member-checking) using three focus groups of 1) ethno-racial people with mental health disabilities, 2) mental health lawyers and service providers and 3) health care professionals. Lastly, in order to develop the final version of the CAT, I analyzed and contextualized the results that emerged from the interviews through primary and secondary sources and the focus group data.

DEDICATION

This thesis is dedicated to the brave individuals who live with mental health disabilities and to those who continue to advocate on behalf of them.

ACKNOWLEDGEMENTS

I wish to thank Professor Roxanne Mykitiuk, my supervisor, for her wisdom, and guidance throughout this process. Her thoughtful analysis, critical insights and commitment to disability law are inspirational. I am grateful to the members of my supervisory committee: Dr. Kwame McKenzie at the Centre for Addiction and Mental Health for his tremendous assistance in creating and executing this study, Professor Nazilla Khanlou for her expertise and guidance in qualitative research and Dean Lorne Sossin for his generosity and mentorship. I thank the Social Science Research Council (SSHRC) for awarding me with a fellowship to pursue my academic goals, and the Osgoode Hall Graduate Program.

My sincere gratitude goes to all of the stakeholders who participated in this study. They graciously offered their time and shared their personal experiences, perceptions and narratives of how to improve legal processes and the mental health system. Their contributions were immeasurable to the creation of the Cultural Analysis Tool (CAT).

The support of the Centre for Addiction and Mental Health, the ARCH Disability Law Centre and the Mental Health Legal Committee was vital to the execution of this study. In particular, I wish to thank mental health lawyer, Anita Szigeti. Her supervision and leadership shaped my understanding of mental health law and fostered my commitment to advocacy on behalf of people with mental health disabilities. I also thank Dean Chris Axworthy and the Faculty of Law at Thompson Rivers University for giving me the opportunity to teach mental health law, complete this study and pursue further research in this area.

I am forever grateful to my wonderful family and friends. I owe a special thanks

to Dad, Mom, Amar and Neil for their unwavering support, love and strength, in particular, to my Dad for mentoring me throughout this process. A special mention must be made of Omeasoo and Shanthi for providing positive affirmations and optimism.

Finally, I wish to thank my husband, Dipesh Prema. His love, patience and understanding were significant to this journey. As the motto of Tottenham Hotspur states, “To Dare is to Do.” We did it sweetheart!

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CHAPTER 1

INTRODUCTION

In this study, I have developed a Cultural Analysis Tool (CAT). The CAT consists of specific thematic questions that can serve as a cultural and equity analysis instrument for practitioners to use in the implementation of Ontario's civil mental health laws. Ontario's civil mental health laws are distinct from forensic mental health laws. Forensic mental health laws apply to people declared not criminally responsible or unfit to stand trial by reason of mental disorder under the *Criminal Code of Canada*.¹ In contrast, Ontario's civil mental health laws concern voluntary² and involuntary psychiatric admission procedures and criteria,³ consent and capacity issues in relation to treatment,⁴ admission to long-term care facilities,⁵ substitute-decision making,⁶ community treatment orders,⁷ management of property⁸ and personal care⁹ and privacy and confidentiality of medical information.¹⁰ The Consent and Capacity Board of Ontario (CCB) is the administrative tribunal adjudicating issues arising from these laws.¹¹ This

¹ R.S.C. 1985, c. C-46, s. 2 (“unfit to stand trial”), s. 16 (“not criminally responsible”), Part. XX.1 (Mental Disorder) s. 672-672.95.

² See for example, *Daugherty v. Stall*, [2002] OTC 944, 48 ETR (2d) 8 (Ont. S.C.J.) referred to A, T0020721, 22 June 25, 2002.

³ See for example, *Mental Health Act*, RSO 1990, c M 7, s 20 [MHA].

⁴ *Health Care and Consent Act*, S.O. 1996, c.2, s.10-25 [HCCA].

⁵ HCCA, *ibid* at s. 38-49.

⁶ *Substitute Decisions Act*, S.O. 1992, c. 30 [SDA].

⁷ MHA, R.S.O. 1990, c. M.7, s. 20 at ss. 33.1 –34.1.

⁸ SDA, S.O. 1992, c. 30 at ss. 4-42 [SDA].

⁹ SDA, *ibid* at ss. 43-68 [SDA].

¹⁰ See generally *Personal Health Information Act*, S.O. 2004, c.3, Sched. A [PHIPA].

¹¹ Consent and Capacity Board, online: Consent and Capacity Board <<http://www.ccboard.on.ca/scripts/english/index.asp>>. The CCB also adjudicates matters that come under the *Long Term Care Homes Act*, S.O. 2007, c. 8 and the *Mandatory*

chapter introduces the study by articulating the rationale, overview, significance, terminology and research questions of the thesis.

1.1 Rationale of the Study

The logic behind creating the CAT is based on research, which suggests that ethno-racial people with mental health disabilities¹² experience inequities and differential outcomes while interacting with civil mental health laws. In this regard, ethno-racial people with mental health disabilities have been found to experience barriers to accessing culturally appropriate treatment,¹³ a higher involuntary admission rate,¹⁴ a higher

Blood Testing Act, 2006, S.O. 2006, c. 26; D'Arcy Hiltz and Anita Szigeti, *A Guide to Consent and Capacity Law in Ontario* (Markham: Lexis Nexis Canada Inc., 2013) at 523.

¹² I will use the term “people with mental health disabilities” to describe those who are recipients or former recipients of mental health and/or addiction services. This term is accepted amongst mental health researchers. Since there is no consensus on what the appropriate terminology should be to describe people with mental illness, other terms that have been used include: psychiatric consumer/ survivors, psychiatric disability and mental health disability. Peter Barham and Marian Barnes, “The Citizen Mental Patient” in Jill Peay and Nigel Eastman, eds., *Law Without Enforcement: Integrating Mental Health and Justice* (Oxford: Hart Publishing, 1999) at 138. The term being used by the Mental Health Commission of Canada, a non-profit organization funded by the Government of Canada is “people with lived experience of mental illness.” Since this term carries a different connotation in qualitative research, it will not be used in this particular study. Mental Health Commission of Canada, online: Mental Health Commission of Canada <<http://www.mentalhealthcommission.ca/English/Pages/default.aspx>>.

¹³ Mental Health Commission of Canada and CAMH, “Improving Mental Health Services for Immigrant, Refugee, Ethno-Cultural and Racialized Groups: Issues and Options for Service Improvement” (Toronto: Mental Health Commission, 2009) at 4; Rob Whitley, Laurence J. Kirmayer and Danielle Groleau, “Understanding Immigrants’ Reluctance to Use Mental Health Services: A Qualitative Study from Montreal” (2006) 51 *Can. J. Psychiatry* 205 at 206.

¹⁴ There are no specific statistics available in Canada and Ontario specifically on the number of ethno-racial patients being involuntarily admitted to psychiatric facilities. In the United Kingdom, the Count Me in Census is a valuable resource. Care Quality Commission, “Count Me In 2010” (London: NHS, 2011). Other studies drawing on statistics from the United Kingdom include: D.J. Vinkers, S.C. de Vries, A.W.B. van

likelihood of being diagnosed with psychosis¹⁵ and increased use of seclusion, restraint¹⁶ and emergency psychiatric medication.¹⁷

Although other jurisdictions have done qualitative research regarding ethno-racial people with mental health disabilities in the civil mental health system,¹⁸ there is currently a dearth of research on this particular topic in Ontario.¹⁹ Given the increasing multi-racial population in Ontario, there is a need to investigate and develop mechanisms to address these intersecting issues. For instance, in my LL.M thesis, the majority of

Baars and C.L. Mulder, “Ethnicity and Dangerousness Criteria for Court Ordered Admission to a Psychiatric Hospital” (2010) 45 Soc. Psychiatry Epidemiology 221 at 221; Kwame McKenzie and Kamaldeep Bhui, “Institutional Racism in Mental Health Care” (2007) 334 British Medical Journal 649 at 649. Globally, the WHO reports that minorities have a higher likelihood of being involuntarily detained. World Health Organization (WHO), *WHO Resource Book on Mental Health, Human Rights and Legislation* (Geneva: World Health Organization, 2005) at 85.

¹⁵ G. Eric Jarvis, Irene Toniolo, Andrew G. Ryder, Francesco Sessa, Carla Cremonese, “High Rates of Psychosis for Black Inpatients in Padua and Montreal: Different Contexts, Similar Findings” (2010) 46 (3) Social Psychiatry and Psychiatry Epidemiology 247 at 251. The study found that black patients from the emergency department in a community hospital in Montreal, Quebec were three to four times more likely than “white patients” to be given the diagnosis of psychosis (p 257). Also, see Suman Fernando, “Inequalities and the Politics of ‘Race’ in Mental Health” in Suman Fernando and Frank Keating, eds., *Mental Health in a Multi-Ethnic Society: A Multidisciplinary Handbook* (New York: Routledge, 2009) at 47. Drawing on research from the United Kingdom, Suman Fernando suggests that black/ethnic minorities are more often diagnosed as schizophrenic (p 47).

¹⁶ Susan Stefan, “Leaving Civil Rights to the ‘Experts:’ From Deference to Abdication Under the Professional Judgment Standard” (1992) 102 Yale L.J. 639 at 660.

¹⁷ G. Eric Jarvis, *Emergency Psychiatric Treatment of Immigrants with Psychosis* (Master of Science Thesis, Mc Gill University Institute of Community and Family Psychiatry, 2000) [unpublished]. This quantitative study was conducted in Montreal and it suggested that the administration of anti-psychotic medication may be motivated by patient ethnicity; Susan Stefan, *supra* note 16 at 660; Suman Fernando, *supra* note 15 at 47.

¹⁸ See *supra* note 14.

¹⁹ Aaron Dhir, “Relationships of Force: Reflections on Law, Psychiatry and Human Rights” (2008) 25 WRLSO 103 at 108. Dhir suggests, “as compared with other fields, there is a dearth of progressive Canadian legal literature addressing the most pressing challenges facing those with psychiatric disabilities – let alone doing so from a critical, interdisciplinary perspective” (108).

respondents interviewed in the qualitative study indicated that ethno-racial people with mental health disabilities who appear before the CCB experience procedural, systemic/structural and discretionary legal barriers throughout the pre-hearing, hearing and post-hearing processes.²⁰ The barriers included the following:

Procedural Barriers:

- 1) The procedural barriers included the inefficiencies of obtaining an interpreter; the fact that language abilities of lawyers are not indicated on the Legal Aid Ontario consent and capacity lawyer panel lists; the adversarial nature of the hearings; the cultural discrepancies in the psychiatrists' capacity assessments; and the fact that the Board does not track whether the decisions are translated for those who do not speak English.

Systemic Barriers:

- 2) The systemic barriers included the lack of consideration given to alternative and culturally appropriate treatment plans within the mental health system and the Board's limited jurisdiction impacts the extent to which the Board can address the treatment concerns of ethno-racial people with mental health disabilities.

Discretionary Barriers:

- 3) The discretionary barriers included the problems with the Board's "color-blind" approach (the omission of a racial or cultural analysis).²¹ Specifically, factors such as race, culture and ethnicity are often not considered in treatment incapacity, involuntary detention, and long-term care cases.²²

²⁰ Ruby Dhand, *Challenging Exclusion: A Critique of the Legal Barriers Faced by Ethno-Racial Psychiatric Consumer/Survivors in Ontario* (LL.M. Thesis, University of Toronto Faculty of Law, 2009) [unpublished]; Ruby Dhand, "Access to Justice for Ethno-Racial Psychiatric Consumer/Survivors in Ontario" (2011) 29 (11) Windsor YB Access Just 127-162.

²¹ Carol Aylward, *Canadian Critical Race Theory: Racism and the Law* (Nova Scotia: Fernwood Publishing, 1999) at 34. As Aylward suggests, the "colour-blind" approach to law ignores the fact that Blacks and Whites have not been and are not similarly situated with regard to legal doctrines, rules, principles and practices (p 34).

²² Ruby Dhand, *Challenging Exclusion: A Critique of the Legal Barriers Faced by Ethno-Racial Psychiatric Consumer/Survivors in Ontario*, *supra* note 20 at 89-94 and Ruby Dhand, "Access to Justice for Ethno-Racial Psychiatric Consumer/Survivors in Ontario," *supra* note 20.

The debate on the causes of these inequities is complex and contested.²³ The theory of inequity that I will use to explain the disparities of outcome for ethno-racial people with mental health disabilities interacting with Ontario’s civil mental health laws arise from the lack of consideration given to culture and equity²⁴ within Ontario’s civil mental health laws and the CCB’s processes,²⁵ the difficulties with communication and interpretation, cultural misunderstandings, internalized racism, stigma, complex familial relationships, poverty, institutional racism and challenges faced by practitioners involved in trying to understand differences in illness models, psychotherapy and preferred mental health services and treatment for ethno-racial people with mental health disabilities.²⁶ This particular theory of inequity is selected because of the theoretical tenets of the institutional racism paradigm, disability theory, intersectionality and cultural considerations in mental health law.

²³ Kwame McKenzie and Kamaldeep Bhui, “Institutional Racism in Psychiatry” (2007) 31 *The Psychiatrist* 397 at 397.

²⁴ It appears that cultural considerations are not often incorporated into the implementation of Ontario’s civil mental health laws. Ruby Dhand, “Access to Justice for Ethno-Racial Psychiatric Consumer/Survivors in Ontario” (2011) 29:11 Windsor YB Access Just 127-162. According to Wen-Shing Tseng, Daryl Matthews and Todd. S. Elwyn, “cultural considerations emphasize the need to use cultural information and knowledge throughout the legal process, including the psychiatrists’ pre-hearing capacity assessment, the formulation of the treatment plan and the legal proceedings.” Wen-Shing Tseng, Daryl Matthews, Todd. S. Elwyn, *Cultural Competence in Forensic Mental Health: A Guide for Psychiatrists, Psychologists, and Attorneys* (New York: Brunner-Routledge, 2004) at 20.

²⁵ *Supra* note 20.

²⁶ Kwame McKenzie and Kamaldeep Bhui, *supra* note 14 at 649; Kwame McKenzie and Kamaldeep Bhui, “Better Mental Healthcare for Minority Ethnic Groups – Moving Away from the Blame Game and Putting Patients First: Commentary on..Institutional Racism in Psychiatry” (2007) 31 *The Psychiatrist* 368 at 368; Michael L. Perlin and Valerie McClain, “Where Souls Are Forgotten: Cultural Competencies, Forensic Evaluations, and International Human Rights” (2009) 15:4 *Psychology, Public Policy and Law* 257 at 264.

1.2 Overview of the Study

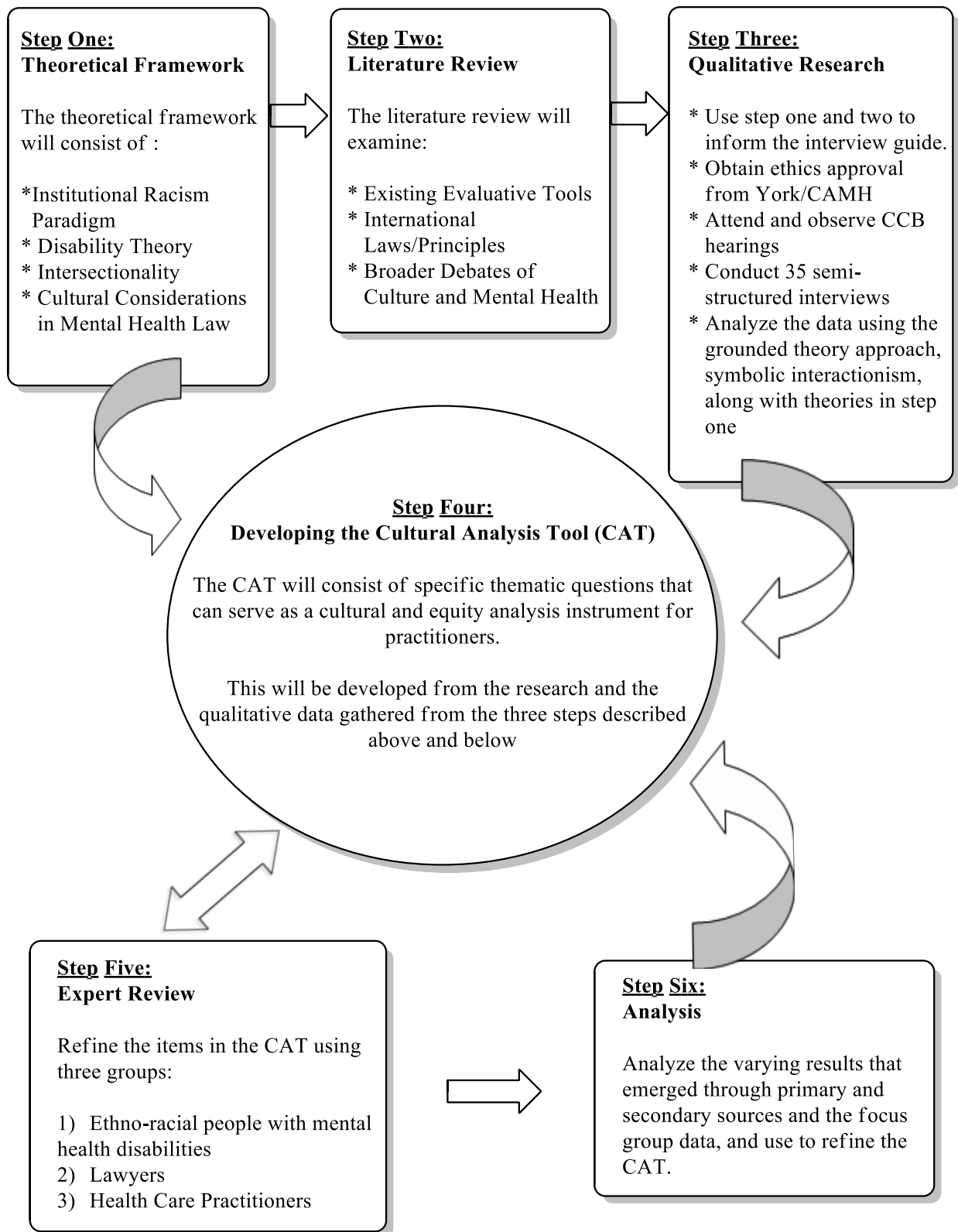
In order to address these differential disparities of outcome for Ontario's civil mental health laws, this study created and developed a CAT. The following steps, which are further explained in Chapter Four were used to create the CAT:

- 1) I used a theoretical framework consisting of tenets from the institutional racism paradigm, disability theory, intersectionality and cultural considerations in mental health law. This framework is described in Chapter Two.
- 2) I conducted a literature review, which examined the evaluative tools for mental health legislation that have been developed in other jurisdictions, international laws and the broader debates addressing culture and mental health laws. The literature review is examined in Chapter Three.
- 3) After obtaining ethics approval from York University and CAMH, I conducted 35 semi-structured interviews to gain insights and explore the experiences of stakeholders involved. The data were analyzed using the grounded theory approach, symbolic interactionism and the theoretical framework in step one.
- 4) The CAT (consisting of specific thematic questions) was developed from research and qualitative data gathered from the three steps described above.
- 5) I refined the items in the CAT through an expert review (involving the qualitative technique of member-checking) using three focus groups of 1) ethno-racial people with mental health disabilities, 2) mental health lawyers and service providers and 3) health care professionals.
- 6) Lastly, in order to develop the final CAT, I analyzed and contextualized the varying results that emerged from the interviews through primary and secondary sources and the

focus group data.

These steps are summarized in the schematic given below and it is further explained in Chapter Four.

1.2 Project Model: Cultural Analysis Tool (CAT) for the Implementation of Ontario's Civil Mental Health Laws



1.3 Significance of the Study

Currently, other jurisdictions such as Australia and the United Kingdom have created legislative evaluative tools for their civil and forensic mental health laws. These tools consist of indicators, surveys, thematic assessment scales and/or questionnaires. They are supported by a robust literature, drawing from international laws and principles. The purpose, methodology and development process underpinning these tools are distinct, and they are designed to ensure a “systematic and rights-based scrutiny of legislation and policy.”²⁷ Specifically, the Rights Analysis Tool (RAI) in Australia was created to analyze the content of legislation and policies, rather than the legal processes involved in the implementation of mental health laws.²⁸ In the United Kingdom, the Race Equality Impact Assessment (REIA) was designed to assess systematically what impact certain policies had on various racial groups.²⁹ However, such a tool for ethno-racial people with mental health disabilities does not exist in Canada, let alone in Ontario specifically.³⁰

²⁷ Angus Francis, “The Review of Australia’s Asylum Laws and Policies: A Case for Strengthening Parliament’s Role in Protecting Rights through Post-Enactment Scrutiny” (2008) 31:1 Melbourne University Law Review 83 at 83. These legislative evaluative tools are most often implemented before the legislation is enacted, although there are some that are used for post-enactment scrutiny.

²⁸ Helen Watchirs, “Human Rights Audit of Mental Health Legislation – Results of an Australian Pilot” (2008) 28 In’l J.L. & Psychiatry 99 at 99.

²⁹ Department of Health, “Race Equality Scheme” online: Department of Health <http://webarchive.nationalarchives.gov.uk/20040216034425/doh.gov.uk/race_equality/; Department of Health, *Mental Health Bill 2006: Race Equality Impact Assessment*, (London: Department of Health, 2006).

³⁰ The Mental Health Commission of Canada has created a “Mental Health and Human Rights Evaluation Instrument.” This instrument was created to “evaluate the extent to which current provincial and territorial mental health legislation, policies and standards reflect the key principles and human rights of persons living with a mental illness.” However, the instrument does not specifically address the barriers faced by ethno-racial people with mental health disabilities in the civil mental health system. Mental Health

I used interdisciplinary legal scholarship to create the CAT. The final product, along with the research involved in developing the thematic questions, addresses how issues of culture and equity pertaining to ethno-racial people with mental health disabilities can be incorporated into the implementation of Ontario's civil mental health laws and processes. The CAT is useful for practitioners to understand and identify the cultural nuances in legal processes and cases involving voluntary and involuntary admissions, consent and capacity issues in relation to treatment, substitute-decision making, community treatment orders, long term care options, management of property and personal care, etc.³¹ The eventual aim of the CAT is to contribute to a better understanding of how equitable outcomes for ethno-racial people with mental health disabilities interacting with Ontario's civil mental health laws can be achieved.

There is a need for the CAT, and the research underlying its development, because there is a dearth of ethno-specific research pertaining to the analysis and identification of the application of culturally appropriate and equitable mental health laws and policies in Ontario.³² For instance, in Ontario, there are no statistics available on the

Commission of Canada, *Mental Health and Human Rights Evaluation Instrument* online: Mental Health Commission of Canada
<<http://www.mentalhealthcommission.ca/English/issues/law?routetoken=e240252ec2dad583f7953efd6ebda18c&terminal=24>>.

³¹ D'Arcy Hiltz and Anita Szigeti, *supra* note 11 at 565.

³² In this regard, the extent of information available is limited. Mental Health Commission of Canada and CAMH, *supra* note 13 at 4. The statistics that are available include CAMH's patient profile, which unfortunately does not document the ethnicity of patients. The report refers to "unique" patients, which is based on the demographic characteristics of patients as per their sex, age, partnership status, education status, employment status, financial status, housing status, geographic distribution, citizenship, language, religious beliefs and legal status. Specifically, under the category of "citizenship," the most recent patient profile available indicates that "85% of the CAMH unique patients were Canadian citizens, 5% were landed immigrants and 9% had unknown status." Those with

ethnic backgrounds of people with mental health disabilities interacting with civil mental health laws and/or appearing before the Ontario Consent and Capacity Board.³³ This is significant as “visible minorities”³⁴ now make up over 40% of the population in some parts of Canada.³⁵ In Ontario specifically, about 25.9% of the population (one in every four) belongs to a “visible minority.” This is representative of more than half of the “visible minority” population in Canada.³⁶ It is estimated that approximately 57% of Canada’s “visible minority” population will live in Ontario by 2017.³⁷

“refugee status comprise less than 2%” of the patients. Centre for Addiction and Mental Health, *Patient Profile 2005/2006* (Toronto: CAMH, 2006) at 7. Similarly, CAMH’s 2012-2013 annual report suggests that the top four languages indicated by clients at time of admission, other than English and French were Spanish, Portuguese, Italian and Chinese. The ten countries of birth (other than Canada) were United Kingdom, Jamaica, U.S.A., India, Portugal, Iran, Italy, Poland, China, the Philippines. Centre for Addiction and Mental Health, *A New Era for CAMH: Annual Report to the Community 2012-2013* (Toronto: CAMH, 2013) at 28. Data available in 2007-2008 indicates that there were approximately 2000 requests for interpretation services and the patient population represents 150 countries. Dr. Paul Garfinkel, “CEO Program Visits,” (Toronto: CAMH 2009) [unpublished] at 9. For a discussion of the lack of ethno-specific research, see Hon. Michael J.L. Kirby & Hon. Wilbert Joseph Keon, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness, and Addiction Services in Canada*, (Ottawa: The Standing Committee on Social Affairs, Science and Technology, 2006).

³³ Mental Health Commission of Canada and CAMH, *supra* note 13 at 4.

³⁴ Census Canada uses the term “visible minorities” to refer to individuals who are not Aboriginal, Caucasian or White. Statistics Canada, *Special Interest Profile: Population Groups (28), Age Groups (8), Sex (3) and Selected Demographic, Cultural, Labour Force, Educational and Income Characteristics (309), for the Total Population of Canada, Provinces, Territories, Census Metropolitan Areas and Census Agglomerations, 2006 Census - 20% Sample Data*, online: Statistics Canada <<http://www12.statcan.ca/english/census06/data/profiles/sip/Index.cfm>>.

³⁵ *Ibid.*

³⁶ Statistics Canada, *National Household Survey 2011*, online: Statistics Canada <<http://www5.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=99-010-XIE&lang=eng#olcinfo-panel>>.

³⁷ Statistics Canada, *Population Projections of Visible Minority Groups, Canada, Provinces and Regions 2001 to 2017*, online: Statistics Canada <<http://www.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=91-541-XIE&lang=eng>>.

Research indicates that ethno-racial communities are at an increased risk of mental health problems and illness.³⁸ For instance, the Centre for Addiction and Mental Health estimates that one quarter of people who are visible minority immigrants experience discrimination, and those experiences may jeopardize mental health.³⁹ According to the Canadian Community Health Survey (CCHS), one of the few national studies examining the incidences of mental illness amongst recent immigrants to Canada,⁴⁰ second generation immigrants are at an increased risk of depression than Canadian-born residents.⁴¹ Similarly, Punam Pahwa and others are currently investigating the longitudinal trends in the mental health of Canadian immigrants and comparing these with those who were born in Canada.⁴² They are further investigating the variation of these trends amongst ethnic-groups. Using a multi-stage sampling design involving the National Population Health Survey (NPHS), one of the preliminary findings is that in Canada, “1) higher proportions of Chinese (26.5%), Western European (23.7 %) and Black (23.8 %) ancestries reported moderate/high level of mental distress than other ethnicities and 2) a higher proportion of immigrants had a moderate/high mental distress

³⁸ For a general discussion of the literature, see Mental Health Commission of Canada and CAMH, *supra* note 13 at 21.

³⁹ Centre for Addiction and Mental Health, *Research Report 2002/2003* (Toronto: Centre for Addiction and Mental Health, 2003) at 54.

⁴⁰ Jennifer Ali, *Mental Health of Canada's Immigrants*, Supplement to Health Reports, vol. 13, Statistics Canada, catalogue 82-003 (Ottawa: Statistics Canada, 2002).

⁴¹ *Ibid.*

⁴² Punam Pahwa, Chandima Karunanayake, Jesse McCrosky and Lilian Thorpe, “Longitudinal Trends in Mental Health of Canadian Immigrants,” a study currently in progress at the College of Medicine, University of Saskatchewan, Saskatoon, Saskatchewan (Saskatoon: University of Saskatchewan, 2013); Punam Pahwa, Chandima Karunanayake, Jesse McCrosky and Lilian Thorpe, “Longitudinal Trends in Mental Health of Canadian Immigrants” (2012) 32 (3) *Chronic Diseases and Injuries in Canada* 164.

than Canadian born participants.”⁴³ Factors which affect the mental health of immigrants include lack of familiarity with language, ethnicity of the participant, immigration status, education, socio-economic status, poverty, urbanicity, sex, marital status, and age.⁴⁴

Although some symptoms of mental illness are similar across cultures, its manifestations and how people express psychiatric symptoms may vary with race, ethnicity and culture. Western definitions of mental illness cannot be applied homogeneously. The meanings, definitions and understandings of mental illness are often unique amongst ethno-racial communities. For instance, the term “dhat” is an Indian folk term that refers to “severe anxiety and hypochondriacal concerns associated with the discharge of semen, discoloration of urine, and feelings of weakness and exhaustion similar to ‘Jiryān’ (India), and ‘Sukra prameha’ (Sri Lanka).”⁴⁵ However, Western culture vis-à-vis the DSM characterizes this as an anxiety disorder.⁴⁶

Similarly, the World Health Organization lists twelve culture-bound syndromes in the ICD-10 (International Classification of Diseases).⁴⁷ These syndromes, which may not arise often outside of Western society, highlight the fact that the classification of mental

⁴³ Punam Pahwa, Chandima Karunanayake, Jesse McCrosky and Lilian Thorpe, *ibid* at 12.

⁴⁴ *Ibid.* at 12-20.

⁴⁵ Michael L. Perlin and Valerie McClain, *supra* note 26 at 264.

⁴⁶ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR*. (4th ed.) (Washington: American Psychiatric Association, 2000) cited in Michael L. Perlin and Valerie McClain, *ibid*; American Psychiatric Association, “DSM-5 Development,” online: American Psychiatric Association <<http://www.dsm5.org/Pages/Default.aspx>>.

⁴⁷ World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders Diagnostic Criteria for Research* (Geneva: World Health Organization, 1993); Kamaldeep Bhui and Dinesh Bhugra, *Culture and Mental Health* (Oxford: Edward Arnold Publishers, 2007) at 101. The twelve culture bound syndromes include amok, dhat, koro, latah, nerfizo or nervios, pa-leng or frigophobia, piboktoq or Arctic hysteria, susto, taijin kyofusho or anthropophobia, ufufuyane, uqamairineq and windigo.

health disability cannot be “culture free.”⁴⁸ The unconscious biases of psychiatrists and the subjective bias inherent in the field of psychiatry may lead to inequitable outcomes for ethno-racial people with mental health disabilities in the civil mental health system.⁴⁹ For example, this may occur for those who are diagnosed for symptoms, which are “in fact, reactions against oppression or abuse.”⁵⁰ Other social determinants of mental health such as discrimination, language barriers and migration may also be factors affecting the predominance of mental illness amongst ethno-racial groups.⁵¹ Thus, as transcultural psychiatry suggests, “race based inequalities and culture-based discrepancies in mental health must be seen in context, both of the historical background of social systems, psychiatry and western psychology and of concomitant problems in other systems in society, such as criminal justice and education.”⁵²

In the development of the CAT, I examined the extent to which cultural and human rights considerations pertaining to ethno-racial people with mental health disabilities can be addressed within the application of Ontario’s civil mental health laws. For instance, the Supreme Court’s decision in *Mazzei v. British Columbia*⁵³ held that NCR (not criminally responsible) review boards do not have the power to prescribe treatment, but they should require the Directors of psychiatric facilities to “undertake

⁴⁸ Kamaldeep Bhui and Dinesh Bhugra, *ibid* at 12.

⁴⁹ Suman Fernando and Frank Keating, eds., *supra* note 15 at 47.

⁵⁰ Nayar Javed “Clinical Cases and the Intersection of Sexism and Racism” in Paula J. Caplan and Lisa Cosgrave, *Bias in Psychiatric Diagnosis* (New York: The Rowman & Littlefield Publishing Group Inc., 2004) at 77.

⁵¹ Mental Health Commission of Canada and CAMH, *supra* note 13 at 4.

⁵² Suman Fernando and Frank Keating, eds., *supra* note 15 at 42.

⁵³ 2006 SCC 7, [2006] 1 SCR 326 [*Mazzei*].

assertive efforts to enroll the accused in a culturally appropriate treatment program”⁵⁴ that are responsive to an accused’s culture and heritage.⁵⁵

However, it appears that the spirit of this decision has not been addressed in cases before mental health tribunals in Ontario such as the CCB because factors such as race, ethnicity, immigrant/refugee status, sexual orientation, class and disability are not often considered.⁵⁶ The “mixture of common law inertia and paternalism, reluctance to tread upon clinical independence and institutional governance, and unwillingness to comprehensively restate policy”⁵⁷ are factors which make it difficult to put human rights and cultural considerations at the forefront. Thus, it remains a reality that ethno-racial people with mental health disabilities interacting with Ontario’s mental health laws may face barriers such as access to culturally appropriate treatment,⁵⁸ higher rates of involuntary admission,⁵⁹ higher likelihood of being diagnosed with psychosis,⁶⁰ and

⁵⁴ *Ibid.* at para. 61.

⁵⁵ *Ibid.* at para 65. It should be noted that NCR review boards adjudicate issues arising from forensic mental health laws. But, they do have some similarities with boards such as the CCB.

⁵⁶ Ruby Dhand, *Challenging Exclusion: A Critique of the Legal Barriers Faced by Ethno-Racial Psychiatric Consumer/Survivors in Ontario*, *supra* note 20 at 89-94 and Ruby Dhand, “Access to Justice for Ethno-Racial Psychiatric Consumer/Survivors in Ontario,” *supra* note 20.

⁵⁷ Archibald Kaiser, “Seclusion in Canadian Mental Health Facilities: Accessing the Prospects for Improved Access to Justice” (2001) 19 Windsor Y.B. Access Just. 391.

⁵⁸ Mental Health Commission of Canada and CAMH, *supra* note 13 at 4; Rob Whitley, Laurence J. Kirmayer and Danielle Groleau, *supra* note 13 at 206; Ruby Dhand, *Challenging Exclusion: A Critique of the Legal Barriers Faced by Ethno-Racial Psychiatric Consumer/Survivors in Ontario*, *supra* note 20 at 89-94; Ruby Dhand, “Access to Justice for Ethno-Racial Psychiatric Consumer/Survivors in Ontario,” *supra* note 20.

⁵⁹ There are no specific statistics available in Canada and Ontario specifically on the number of ethno-racial patients being involuntarily admitted to psychiatric facilities. See *supra* note 14.

⁶⁰ *Supra* note 15.

increased likelihood of experiencing seclusion, restraint,⁶¹ and emergency psychiatric medication.⁶²

In Canada and more specifically in Ontario, the research available on the mental health of ethno-racial people with mental health disabilities often focuses on the “social determinants of mental health, the rate of mental illness and barriers to and facilitators of care.”⁶³ As it appears, these studies are primarily quantitative and may not reflect the intricate experiences and barriers experienced by ethno-racial people with mental health disabilities⁶⁴ affected by civil mental health laws. Thus, I used qualitative research to create the CAT in order to contribute to this area of research.

1.4 Terminology

The terminology for this research is academically and politically contested. Within disability and mental health discourse, the terms and language being referenced are contextual and socially constructed.⁶⁵ I adopted the following meanings of the terms given their relevance to the particular study and their common use amongst mental health and legal researchers. However, these terms are further examined and contextualized throughout this study.

⁶¹ *Supra* note 16 at 660.

⁶² G. Eric Jarvis, *supra* note 17; Susan Stefan, *supra* note 16 at 660; Suman Fernando, *supra* note 15 at 47.

⁶³ Mental Health Commission of Canada and CAMH, *supra* note 13 at 4.

⁶⁴ Mental Health Commission of Canada and CAMH, *supra* note 13 at 32. The report states, “quantitative data is important, but qualitative data will be needed so that experiences that cannot be captured by numerical data can inform service delivery. Quality of data may be improved if immigrant, refugee, ethno-cultural and racialized groups (IRER) are involved in all aspects of knowledge development from design of the investigation to analysis and presentation” (p 32).

⁶⁵ Peter Barham and Marian Barnes, *supra* note 12 at 138; Jeffrey Scott Mio and Gayle Y. Iwamasa, *Culturally Diverse Mental Health: The Challenges of Research and Resistance* (New York: Brunner-Routledge, 2003) at 58.

Culture: “Refers to conceptual structures, a flexible system of values and worldviews that people live by, define their identities by and negotiate their lives by⁶⁶ a sort of road map for living, relating to one another and so on. In a more practical sense, cultures are systems of knowledge and practice that provide individuals with conceptual tools for self-understanding and rhetorical possibilities for self-preservation and social positioning.”⁶⁷

Race: “A socially constructed concept of categorization and distinction within social relationships based on physical characteristics.”⁶⁸

Ethnicity: “Refers to cultural rather than genetic heritage. An ethnic group may be defined by its shared place of origin, history, language, religion, arts, cuisine and other cultural factors.”⁶⁹

Ethno-Racial People: This refers to people who come from an “immigrant, refugee, ethno-cultural or racialized group”⁷⁰ and have diverse service needs.⁷¹ These “groups are themselves diverse and composed of different populations with different histories, cultures and social realities and needs. There are some common experiences such as issues of status in society and difficulties with access and use of services but there is substantial and significant diversity.”⁷²

People with Mental Health Disabilities: This will be the term used to describe those who are recipients or former recipients of mental health and/or addiction services.⁷³ There is no consensus on what the appropriate terminology should be used to describe people with mental illness. Other terms that have been used include: psychiatric consumer/ survivors, psychiatric disability and mental disorder and people with mental illness.⁷⁴

⁶⁶ Suman Fernando, *Mental Health, Race and Culture* (New York: Palgrave, 2002) at 11.

⁶⁷ Laurence Kirmayer, “Culture and psychotherapy in a Creolizing World” (2006) 43:2 *Transcultural Psychiatry* 163 at 163.

⁶⁸ Jeffrey Scott Mio and Gayle Y. Iwamasa, *supra* note 65 at 58.

⁶⁹ James Hicks, “Ethnicity, Race, and Forensic Psychiatry: Are We Color-Blind?” (2004) 32:1 *J. Am. Acad. Psychiatry Law* 21 at 22.

⁷⁰ Mental Health Commission of Canada and CAMH, *supra* note 13 at 7.

⁷¹ Aseefa Sarang and Kwame McKenzie, “Access to Mental Health and Supports for Racialized Groups” in Psychiatric Patient Advocate Office, *Honouring the Past, Shaping the Future: 25th Anniversary Report* (Toronto: Queen’s Printer, 2008) at 148.

⁷² Mental Health Commission and CAMH, *supra* note 13 at 7.

⁷³ Peter Barham and Marian Barnes, *supra* note 12 at 138.

⁷⁴ The following quotation highlights why naming people in the category is problematic.

“One of the most fundamental objectives of user groups is to claim the right to self definition for people whose identity and “problems” have been defined by professionals. Reclaiming the right to define themselves and their problems is a pre-requisite for attaining other objectives. Participation within such movements can demonstrate that those formerly viewed as passive and dependent recipients

Mental Health Problems and Mental Illness: “Mental health problems and illnesses are clinically significant patterns of behaviour or emotions that are associated with some level of distress, suffering, or impairment in one or more areas such as school, work, social and family interactions, or the ability to live independently. There are many different kinds of mental health problems and illnesses. They range from anxiety and depressive disorders through to schizophrenia and bipolar disorder, and are often associated with a formal medical diagnosis. There is no single cause for most mental health problems and illnesses. They are thought to be the result of a complex interaction among social, economic, psychological, and biological or genetic factors. They may have different causes and treatments which make discussing them as one group problematic at times, but they also have some similarities in their impact on individuals, their families and society.”⁷⁵

Cultural Considerations : “Emphasizes that in addition to other factors, cultural understanding and consideration are needed in the entire legal process, including the assessment and raising opinions to be decided upon. Cultural consideration not only focuses on the need for examination and use of cultural knowledge and information but also stresses the importance of adopting an orientation and approach to the legal procedure that is culturally relevant and fulfills the basic requirement of cultural competence. Thus, cultural consideration is broadly defined and applies to every case, no matter what the ethnic or cultural background of the parties involved”⁷⁶

Cultural Evidence: “Cultural evidence is evidence about a cultural issue that is presented in the course of legal proceedings. There is an implication that significant and powerful ‘evidence’ exists that will shape the judgment about the legal matter. From a theoretical point of view, there are problems inherent in the application of this term because culture by definition is amorphous, not objective, and cannot be easily described and presented as concrete evidence. Only ethnicity or nationality can be presented as concretely recognizable evidence for legal argument.”⁷⁷

Cultural Information: “Refers to a set of information relating to cultural matters that can be presented and debated in court. It is assumed that the information is related to a rather unique or distinct cultural system, concerning a particular ethnic or minority group, and is going to have an obvious effect in court when it is presented.”⁷⁸

of welfare can be actors capable not only of controlling their own lives, but also of contributing to shaping the nature of welfare services and of achieving broader social objectives. Participation can itself contribute to a surer sense of identity.”

Peter Barham and Marian Barnes, *supra* note 12 at 138.

⁷⁵ Mental Health Commission and CAMH, *supra* note 13 at 11.

⁷⁶ Wen-Shing Tseng, Daryl Matthews, Todd. S. Elwyn, *Cultural Competence in Forensic Mental Health: A Guide for Psychiatrists, Psychologists, and Attorneys* (New York: Brunner-Routledge, 2004) at 20.

⁷⁷ *Ibid* at 19.

⁷⁸ *Ibid* at 20.

Cultural Defense: “ ‘At times, the ethnic- racial or otherwise unique background of the accused is used in the legal process as a defense against legal responsibility.’⁷⁹Using culture as a defense in this way essentially argues that having a certain ethnic or racial heritage, or a special social background (such as being a tourist, a foreigner, or an immigrant whose heritage or social status differs from the majority) should mitigate the unlawful behavior as defined by society at large.”⁸⁰

Institutional Racism: “The collective failure of an organization to provide an appropriate and professional service to people because of their colour, or ethnic origin. This can be seen or detected in processes, attitudes, and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantages people in ethnic minority groups.”⁸¹

Human Rights: Involve the “obligations to respect (abstain from interference with the enjoyment obligations to respect (abstain from interference with the enjoyment of rights), protect (prevent interference by third parties) and fulfill (taking measures to ensure realization)”⁸² “There are also human rights impacts of having a mental illness, such as discrimination, and restriction of civil rights, including arbitrary limitations on liberty of the person. A society’s treatment of people with mental illness is a reflection of its values and can be an indicator in terms of both human rights vulnerability and impact.”⁸³ For instance, Perlin points out how human rights abuses in psychiatric institutions occur internationally. These include: “ the provision of services in a segregated setting that cuts people off from society, often for life; the arbitrary detention from society that takes place when people are committed to institutions without due process; the denial of a person’s ability to make choices about their life when they are put under plenary guardianship; the denial of appropriate medical care or basic hygiene in psychiatric facilities; the practice of subjecting people to powerful and dangerous psychotropic medications without adequate standards; and the lack of human rights oversight and enforcement mechanisms to protect against a broad range of abuses in institutions.”⁸⁴

⁷⁹ B.L. Diamond, “Social and Cultural Factors as a Diminished Capacity Defense in Criminal Law” (1978) 6:2 *Bulletin of the American Academy of Psychiatry and the Law* 195.

⁸⁰ Wen-Shing Tseng, Daryl Matthews, Todd. S. Elwyn, *supra* note 76 at 21.

⁸¹ Kwame McKenzie and Kamaldeep Bhui, *supra* note 14 at 650 citing William Macpherson, *The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny* (London: Stationery Office, 1999).

⁸² Asbjourn Eide, “Economic, Social and Cultural Rights as Human Rights,” in Eide et al., *Economic, Social and Cultural Rights* (The Hague: Kluwer Law International, 2001) at 21.

⁸³ Helen Watchirs, “Human Rights Audit of Mental Health Legislation – Results of an Australian Pilot” (2008) 28 *Int’l J.L. & Psychiatry* 99 at 100.

⁸⁴ Michael L. Perlin, “Chimes of Freedom: International Human Rights and Institutional Mental Disability Law” (2001-2002) 21 *N.Y.L. Sch. J. Int’l & Comp. L* 423 at 427.

Human Rights Approach: “Human rights not only provides a normative framework of analysis for mental health, but also a morally powerful and legally binding foundation with international procedural, institutional and other accountability mechanisms that cannot be removed by ordinary political processes. Instead of being seen as internal domestic issues immune to domestic scrutiny, human rights are a legitimate subject on international as well as local debate.”⁸⁵ “This approach enables persons with disabilities to transform what is traditionally perceived as needs into claimable rights. ‘In reorienting the focus from needs to rights, people with disabilities may be recognized as active rights-bearing individuals who are participants in their own development and who should be consulted accordingly in development decision making.’⁸⁶”

1.5 Research Questions

The following research questions are examined in this study:

- 1) What specific thematic questions will the CAT (Cultural Analysis Tool) use to address issues of culture and equity for ethno-racial people with mental health disabilities interacting with Ontario’s civil mental health laws?
- 2) What does the empirical data and research underlying the development of the CAT reveal about the current implementation of Ontario’s civil mental health laws?

⁸⁵ Helen Watchirs, *supra* note 83 at 111 citing L.O. Gostin and L. Gable, “The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health” (2004) 63 Maryland Law Review 20.

⁸⁶ National Council on Disability, “Understanding the Role of an International Convention on the Human Rights of People with Disabilities: An Analysis of the Legal, Social, and Practical Implications for Policy Makers and Disability and Human Rights Advocates in the United States. White Paper,” online: National Council of Disability < <http://www.ncd.gov/publications/2002/May232002>>.

CHAPTER 2

THEORETICAL FRAMEWORK

Given the interdisciplinary nature of this research, this study uses a theoretical framework consisting of the institutional racism paradigm, the social model of disability, intersectionality and cultural considerations in mental health law. This theoretical framework enabled me to analyze and explore how culture, race, ethnicity and class should play into the legal processes and cases involving voluntary and involuntary admissions, consent and capacity issues in relation to treatment, substitute-decision making, community treatment orders, long term care options, management of property and personal care, etc.¹

In this chapter, I explain the theoretical underpinnings and tenets of the institutional racism paradigm, intersectionality and the social model of disability. Also, I examine the theoretical and practical difficulties of infusing culture into civil mental health laws. The theoretical framework informed the literature review, the qualitative research and the development of the CAT. The relationship between the theoretical framework and the grounded theory approach, a qualitative research methodology,² will be explained in Chapter Four.

¹ D'Arcy Hiltz and Anita Szigeti, *A Guide to Consent and Capacity Law in Ontario* (Markham: Lexis Nexis Canada Inc., 2013) at 565.

² Sarah Hartley and Mohammad Muhit, "Using Qualitative Research Methods for Disability Research in Majority World Countries" (2003) 14.2 *Asia Pacific Disability Rehabilitation Journal* 103 at 105.

2.1 Institutional Racism Paradigm

By acknowledging the existence of institutional racism³ within mental health services, mental health researchers use the institutional racism paradigm to understand and develop solutions aimed at “systems,” rather than “individuals.”⁴ For instance, McKenzie and Bhui suggest that the higher rates of involuntary admission and treatment by coercion amongst some minority ethnic groups in the United Kingdom can be attributed to institutional racism within the mental health care system.⁵ It appears that “these disparities reflect the way health services offer specific treatment and care pathways according to racial groups, and therefore seem to satisfy the well established and widely known definition of institutional racism.”⁶

Within this study, the institutional racism paradigm is used to examine the relationships and interaction between Ontario’s mental health care services, civil mental health laws and ethno-racial people with mental health disabilities. According to Gary King and further articulated by Kwame McKenzie,⁷ mental health researchers can use this paradigm to:

³ See the definition given in the terminology section, Kwame McKenzie and Kamaldeep Bhui, “Institutional Racism in Mental Health Care” (2007) 334 *British Medical Journal* 649 at 650 citing William Macpherson, *The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny* (London: Stationery Office, 1999).

⁴ Kwame McKenzie, “Something Borrowed From the Blues? We Can Use the Lawrence Inquiry Findings to Help Eradicate Racial Discrimination in the NHS” (1999) 318 *British Medical Journal* 616-617.

⁵ Kwame McKenzie and Kamaldeep Bhui, *supra* note 3 at 649.

⁶ Kwame McKenzie and Kamaldeep Bhui, *supra* note 3 at 649.

⁷ Kwame McKenzie, *supra* note 4. In his article, Dr. McKenzie describes the model used by Gary King, “Institutional Racism and the Medical Health Complex: A Conceptual Analysis” (1996) 6 *Ethnicity and Disease* 30.

- (1) Focus on the actions of institutions rather than individuals. People may act in good faith and not harbour racist attitudes but perpetuate discriminatory practices because of systems set up by the institution.
- (2) Target the results of practice rather than the intent. Proved disparities in health, the reasons for them, and the ways that services can change to reduce disparities between groups should be the focus for action rather than proving intent or racist ideology.
- (3) Acknowledge that the connection and interaction between medicine and a discriminatory social world may be important in producing the disparities. Poor educational provision for some minority groups limits the proportion available for entry to medical school because of the rigid academic criteria for entry.
- (4) Take into account how the history of the [mental health services] affects patients' perceptions. For example, knowledge of high rates of more coercive treatment of African-Caribbeans by psychiatrists may lead to a delay in presentation with mental illness.
- (5) Acknowledge other forms of social stratification and their effects. For instance, gender, social class, or sexual orientation may interact with racial group to increase disparities.
- (6) Acknowledge the fact that racism changes with time and with the type of institution. Overt racism may be replaced by more subtle racism, but the disparities between ethnic groups may remain the same.
- (7) Identify the problem as ideological. Health disparities are brought about and perpetuated not only by culture, class, and sociopolitical forces external to medicine but also by the ideology of the medical profession. This ideology leads to ineffective or no action in the face of disparities and to a lack of concerted effort to teach or discuss racism in medicine in undergraduate and postgraduate curriculums. Moreover, the emphasis on the biomedical model undermines the anthropological research which is needed to properly document the perceptions, needs, and aspirations of minority ethnic groups.⁸

Critics of this paradigm suggest that clinicians and researchers need to be cautious about placing an inappropriate emphasis on culture and ethnicity at the “expense of sound clinical judgment.”⁹ These concerns are analyzed and re-visited in the development of the CAT, and in the section on cultural considerations in mental health law.

⁸ Kwame McKenzie, *supra* note 4.

⁹ Swaran P. Singh, “Institutional Racism in Psychiatry: Lessons from Inquiries” (2007) 31 *The Psychiatrist* 366.

2.2 Intersectionality

Intersectionality recognizes the multi-dimensional¹⁰ and fluid construction of an individual's identity.¹¹ In this vein, "intersectional oppression..arises out of the combination of various oppressions which together produce something unique and distinct from any one form of discrimination, standing alone."¹² According to Nitya Duclos, an individual's distinctive experiences of oppression are caused by complex socio-economic and psychological factors, which occur within the system and the individual.¹³ Through an analysis of 299 reported Canadian human rights cases, Duclos found that the cases rarely mentioned racial affiliation, and there was little recognition of the intersection of religion, culture, ethnicity, class, and other social complexities.¹⁴ In later research, Duclos (Iyer) suggests that anti-discrimination laws create mutually exclusive categories, which result in individuals having to reinvent and deny their identity in order to fit into the rigid categorization being subscribed to them by the law.¹⁵ Adjudicators may treat "race, colour, ethnic origin, ancestry, and place of origin as a

¹⁰ Kimberly Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics and Violence Against Women of Color" (1990-1991) 43 *Stanford Law Review* 1264 at 1265.

¹¹ Nira Yuval-Davis, "Intersectionality and Feminist Politics" (2006) 13:3 *European Journal of Women's Studies* 193 at 194.

¹² Ontario Human Rights Commission, "An Intersectional Approach to Discrimination: Addressing Multiple Grounds in Discrimination" online: Ontario Human Rights Commission

http://www.ohrc.on.ca/en/resources/discussion_consultation/DissIntersectionalityFtnts/vi
ew> at 3.

¹³ Nitya Duclos (Iyer), "Disappearing Women: Racial Minority Women in Human Rights Cases" (1993) 6 *Canadian Journal of Women in Law* 25 at 29.

¹⁴ *Ibid.* at 31-33.

¹⁵ Nitya Iyer, "Categorical Denials: Equality Rights and the Shaping of Social Identity" 19 (1993) *Queen's Law Journal* 179 at 180.

single category.”¹⁶ This is problematic because these social categories must be seen to operate relationally and they cannot stand alone as additive categories.¹⁷

In a legal context, an intersectional approach enables one to consider the historical, social, political and cultural context, which contributes to the experiences and barriers an individual may face. An intersectional approach highlights the intersection between these grounds, which may adversely impact an individual who is identified with more than one ground.¹⁸ To avoid essentialization, the intersectional approach “shifts the gaze from the othered identity and/or category of otherness to the relational processes of othering and normalization, and their pertinent contexts of power.”¹⁹

¹⁶ *Supra* note 12 at 10.

¹⁷ Deborah Stienstra, “The Intersection of Disability and Race/Ethnicity/Official Language/Religion” (Paper presented to the “*Intersections of diversity*” seminar held at Canadian Centre for Disability Studies, March 8, 2002) [unpublished], online: Canadian Centre on Disability Studies <<http://disabilitystudies.ca/wp-content/uploads/2010/08/Intersection-of-disability.pdf>>.

¹⁸ *Canada v. Mossop* [1993] 1 S.C.R. 554 at para 152.

As Justice Claire L'Heureux-Dubé argued in *Mossop*:

“It is increasingly recognized that categories of discrimination may overlap, and that individuals may suffer historical exclusion on the basis of both race and gender, age and physical handicap, or some other combination. The situation of individuals who confront multiple grounds of disadvantage is particularly complex ... Categorizing such discrimination as primarily racially oriented, or primarily gender-oriented, misconceives the reality of discrimination as it is experienced by individuals. Discrimination may be experienced on many grounds, and where this is the case, it is not really meaningful to assert that it is one or the other. It may be more realistic to recognize that both forms of discrimination may be present and intersect. On a practical level, where both forms of discrimination are prohibited, one can ignore the complexity of the interaction, and characterize the discrimination as of one type or the other. The person is protected from discrimination in either event” (para 152).

¹⁹ Dhamoon, Rita Kaur and Olena Hankivsky, “Why the Theory and Practice of Intersectionality Matter to Health Research and Policy” in Olena Hankivsky et al. (eds.), *Health Inequities in Canada: Intersectional Frameworks and Practices* (Vancouver: UBC Press, 2011) 16 at 25.

Courts and tribunals have attempted to use an intersectional approach in human rights jurisprudence to understand the complexities of the intersecting oppressions and identities that result in discrimination. In *Falkiner v. Ontario (Ministry of Community and Social Services, Income Maintenance Branch)*,²⁰ Justice Laskin of the Ontario Court of Appeal accepted that the definition of spouse is impacted by various socio-economic and familial factors.²¹ In his analysis, he reasoned that “multiple comparator groups are needed to bring into focus the multiple forms of differential treatment alleged.”²² Similarly, in *Radek v. Henderson Development (Canada) Ltd.*,²³ the British Columbia Human Rights Tribunal used an intersectional approach to examine the intersections between the grounds of race, gender, disability and class. The tribunal recognized that Radek’s experience of discrimination was complex and unique because of the “multiple facets” of her identity.²⁴

Throughout this study, an intersectional approach enabled me to identify how multiple factors such as culture, race, ethnicity, gender, age, disability, class and sexuality affect ethno-racial people with mental health disabilities interacting with Ontario’s civil mental health laws. For instance, Dossa’s research illustrates how qualitative researchers

²⁰ (2002) 212 DLR (4th) 633, 59 OR (3d) 481 [*Falkiner* cited to D.L.R.].

²¹ *Falkiner*, *ibid.* at para 72.

²² *Falkiner*, *ibid.*

²³ 2005 BCHRT 302, [2005] BCHRTD No. 302.

²⁴ “Vancouver Shopping Mall Liable for Discrimination Against Aboriginal and Disabled People” (2005) 10:3 HIV/AIDS Policy and Law Review 1 at 2. “Radek argued she was discriminated ‘because of the way I look’ -- which the tribunal took to mean a middle-aged, economically disadvantaged Aboriginal woman with a disability. In finding that Radek had been discriminated against, the Tribunal commented: ‘I find it difficult to imagine that events would have unfolded in the same way if Ms. Radek had been white.’ The Tribunal found that Radek’s race, disability (as manifest in a limp), and her economic circumstances all formed part of how she appeared to security personnel, and as a result, determined the treatment she was subjected to at their hands.”

can use an intersectional approach for studies involving ethno-racial people with disabilities in order to highlight the interface between disability and culture.²⁵ She emphasizes how an intersectionality paradigm can be used to converge disability, often considered the “politics of disablement”²⁶ and culture, “the politics of identity.”²⁷ Using this approach for cultural claims “gives weight to the politics of recognition,” by “reversing the medical and rehabilitation model with its emphasis on normalizing the individual body.”²⁸

There are challenges for researchers using the intersectional approach in law and qualitative research. As Lori Wilkinson suggests, since qualitative studies often attempt to study only a few intersections at once, the intersectional approach is best employed in qualitative research with “small sample sizes and in-depth data gathering techniques.”²⁹ Additionally, the researcher must be cautious not to generalize the findings and perpetuate negative stereotypes when studying intersections such as race, culture and ethnicity.³⁰ There must be a constant analysis and understanding of the power dynamics at play between those who are in the mental health system and practitioners such as lawyers, service providers, psychiatrists and adjudicators working with them. Further, the lived experiences of ethno-racial people with mental health disabilities should underlie the analysis within a context that highlights how systemic racism and other forms of

²⁵ Parin Dossa, “Creating Alternative and Demedicalized Spaces: Testimonial Narrative on Disability, Culture and Racialization” (2008) 9:3 *Journal of International Women’s Studies* 79 at 83.

²⁶ *Ibid.*

²⁷ *Ibid.*

²⁸ *Ibid.*

²⁹ Lori Wilkinson, “Advancing a Perspective on the Intersections of Diversity: Challenges for Research and Social Policy” (2003) 35: 3 *Canadian Ethnic Studies* 1 at 5.

³⁰ *Ibid.*

social exclusion may have affected their experiences. Accordingly, practitioners and researchers themselves must be self-reflective about their own biases, lived experiences and prejudices when adopting the approach.

In law, despite the impact that the intersectional approach has had upon certain courts and tribunals, there has not been an explicit analytical legal framework developed for its implementation.³¹ Scholars have suggested that the approach has not been fully understood and endorsed in law because it is challenging for judges and adjudicators to simultaneously understand and discuss intersecting identities such as disability, gender, sex, race, ethnicity and class.³² When applying the analysis, there is a danger of misunderstanding individual identities and perpetuating stereotypes. In this regard, intersectionality is often critical of the notion that identities are uncomplicated. Race, sex, gender and other socially constructed categories are often viewed as a continuum. For instance, as Mary Coombs highlights, “identity is not fixed or absolute; rather, it is determined by particular persons for particular purposes at particular times in a process in which the person identified participates with varying degrees of freedom”.³³ Accordingly, these critiques inform my understanding of the “contextuality and complexity of identity” when applying an intersectional approach to a legal case and its underlying legal

³¹ See Elena Marchetti, “Intersectional Race and Gender Analyses: Why Legal Processes Just Don’t Get It” (2008) 17:2 *Social and Legal Studies* 155-176; Daphne Gilbert and Diana Majury, “Critical Comparisons: The Supreme Court Dumps Section 15” (2006) 24 *Windsor YB Access Just.* 111 at 124; Fiona Sampson, “Beyond Compassion and Sympathy to Respect and Equality: Gendered Disability and Equality Rights Law,” in Dianne Pothier and Richard Devlin, ed., *Critical Disability Theory: Essays in Philosophy, Policy and Law* (Vancouver: UCB Press, 2006) 267 at 269.

³² *Ibid.*

³³ Mary Coombs, “Interrogating Identity,” (1996) 11 *Berkeley Women’s LJ* 222 at 223.

processes.³⁴

2.3 Social Model of Disability

Within the models of disablement, the social model of disability relies on the assumption that “disability is not inherent in the individual,”³⁵ and that there is something in society that needs to be fixed to address the social consequences of impairments.³⁶

As Dianne Pothier suggests,

The social construction of disability assesses and deals with disability from an able-bodied perspective. It includes erroneous assumptions about capacity to perform that come from an able bodied frame of reference. It encompasses the failure to make possible or accept different ways of doing things.³⁷

However, when applied to mental health, the model rejects the value of psychiatric diagnosis and anti-psychotic drugs within the medical model of disability and it emphasizes the “socially constructed nature of impairment.”³⁸ For instance, the social

³⁴ *Ibid.*

³⁵ Marcia Rioux and Fraser Valentine, “Does Theory Matter? Exploring the Nexus between Disability, Human Rights and Public Policy” in Dianne Pothier and Richard Devlin, *Critical Disability Theory: Essays in Philosophy, Politics, Policy and Law* (Vancouver: University of British Columbia Press, 2006) at 51-52.

³⁶ Dianne Pothier, “Miles to Go: Some Personal Reflections on the Social Construction of Disability” (1992) 14 Dal. L.J. 526; Susan Wendell, *The Rejected Body: Feminist Philosophical Reflections on Disability* (New York: Routledge, 1996); Lennard Davis “Constructing Normalcy: The Bell Curve, the Novel, and the Invention of the Disabled Body in the Nineteenth Century” in Lennard Davis, ed., *The Disability Studies Reader* (New York: Routledge, 1997); Jerome E. Bickenbach, *Physical Disability and Social Policy* (Toronto: University of Toronto Press, 1993) at 92.

³⁷ Pothier, *ibid* at 526.

³⁸ Peter Beresford, “Madness, Distress, Research and a Social Model” in Colin Barnes and Geof Mercer, *Implementing the Social Model of Disability: Theory and Research* (Leeds: The Disability Press, 2004) at 218.

model's "elimination of the false dichotomy between mind and body"³⁹ can be used to emphasize how an individual experiences mental illness by acknowledging the effects of stigma, discrimination and institutional barriers in society.

The social model has been critiqued and debated amongst scholars. As Susan Wendell suggests, strictly adhering to the social constructionist approach and outright rejection of the biomedical model may ignore the multi-dimensionality of disablement. An understanding of disability must balance the "uncontrollable and immutable" reality of an individual's limitations along with social factors that continue to put people with disabilities at a disadvantage.⁴⁰ Secondly, it is important to note that the relationship between the psychiatric consumer/survivor movement and the disability movement is complex and contested. There are differences between the philosophical underpinnings of the disability movement and the psychiatric consumer/survivor movement.⁴¹ The social

³⁹ Rachael Andersen-Watts, "Recognizing Our Dangerous Gifts: Applying the Social Model to Individuals with Mental Illness" (2008) 12 Mich St UJ Med & L 141 at 155.

⁴⁰ Susan Wendell, "Toward a Feminist Theory of Disability" in Debra Shogan, *Reader in Feminist Ethics* (Toronto: Canadian Scholars' Press, 1993) at 213.

⁴¹ For instance, Campbell and Oliver characterize the disability movement by the following four characteristics: "1. The development of social approaches to disability; 2. The identification of strategies and goals following from the development of social understandings of disability; 3. The development of rights based approaches to disability consistent with such social approaches to disability; 4. The idea and practice of independent living based on the social model." Jane Campbell and Mike Oliver, *Disability Politics: Understanding our past, changing our future* (London: Routledge, 1996) cited in Peter Beresford, *supra* note 38 at 212. In contrast, Barnes and Mercer characterize the psychiatric consumer/survivor movement by a partnership model with five characteristics: "1. The activity has mainly been concentrated in the mental health/psychiatric system with its structures and requirements for user involvement; 2. There has been strong pressure for mental health service users'/ survivors' involvement to be in mental health service based initiatives; 3. Most of the efforts and energy of mental health service users who become involved has been focused on reforming traditional mental health services; 4. Much of the involvement of mental health service users has been related to the service, policy and practice system rather than their own agendas; 5. Much of the funded activity of mental health service users/survivors has been

model has been critiqued within the consumer/survivor movement since it was historically created for persons with physical and sensory impairments, and there is a fear that a monolithic theory or set of ideas may subordinate people with mental health disabilities similar to the illness model of psychiatry.⁴²

Despite these criticisms, the social model has provoked interest amongst mental health researchers. The model has the potential to examine the experiences of people with mental health disabilities because it may be able to highlight issues of personal experience and social oppression within a systems level analysis. As Plumb argues,

Such a model would also have to take into account of the strong sense that many survivors have that their processing in the psychiatric system is related not only to them being seen as defective but also frequently dissident, non-conformist and different in their values from dominant societal values.⁴³

Researchers adopting this model are committed to critically evaluating laws, policies, processes, health inequalities, and social exclusion impacting people with mental health disabilities.⁴⁴ According to Perlin, to combat the sanism within mental health law,⁴⁵ this model can help create a framework where individuals are given respect, dignity and

in non- user controlled voluntary and statutory organizations.” Peter Beresford, *supra* note 38 at 212.

⁴² Peter Beresford, *supra* note 38 at 212.

⁴³ Anne E. Plumb, “New Mental Health Legislation: A Lifesaver? Changing Paradigm and Practice” (1999) 18:4 Social Work Education 450 at 458.

⁴⁴ Maria Duggan, Andrew Cooper and Judy Foster, “Modernising the Social Model in Mental Health: A Discussion Paper” (London: Topss, 2002) at 19.

⁴⁵ Perlin defines “sanism” which as “an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry...” “Sanism is primarily based upon “stereotype, myth, deindividualization, and is sustained and perpetuated by our use of alleged ‘ordinary common sense’ (OCS) and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process.” Michael Perlin, “International Human Rights and Comparative Mental Disability Law: The Use of Institutional Psychiatry as a Means of Suppressing Political Dissent” (2006) 39 Isr. L.R. 69 at 74.

ownership of their condition and treatment. As Kathleen Anderson Watts suggests, the social model can “consider social structures, such as poverty, access to employment and healthcare; it would contemplate non-medical forms of treatment and look for non-medical experts to testify and inform the court; it would ensure a high standard for appointed counsel in cases such as involuntary commitment hearings.”⁴⁶ Thus, this model is used to highlight the cultural, societal and contextual factors affecting ethno-racial people with mental health disabilities in this study.

2.4 The Interplay of Culture and Mental Health Law

As civil mental health law grapples with culture and race-based inequalities, the exact reasons for these inequalities are often contested, creating differential outcomes for ethno-racial people with mental health disabilities interacting with them. It is suggested that all players in the civil mental health system should strive to understand the impact of culture, race and ethnicity on diagnosis, capacity assessments, involuntary admissions, long-term care options, treatment incapacity decisions and other legal matters. However, it is also recognized that the inherent dangers of inappropriately using cultural factors and cultural evidence in the implementation of civil mental health laws.⁴⁷ According to Hicks, although cultural context must be recognized, “generalization on the basis of ethnicity can lead to stereotyping.”⁴⁸ In this regard, Sonia Lawrence highlights the problematic nature of infusing culture, race and ethnicity into the larger legal process. She argues:

⁴⁶ Rachael Andersen-Watts, *supra* note 39 at 159.

⁴⁷ James W. Hicks, "Ethnicity, Race, and Forensic Psychiatry: Are We Color-Blind?" (2004) 32:1 *Journal of the American Academy of Psychiatry and the Law* 21.

⁴⁸ *Ibid.*

What goes on in courtrooms can be seen as a modern project of racialization, namely a more ‘sophisticated’ version of the blunt attribution of inferior traits to non-Whites that thereby attaches the inferiority label not to the individuals but rather to their culture. In belittling the content of other cultures and depicting the members of these cultures as either ignorant victims or zealous followers of deviant norms, legal processes are assigning traits to people. Of course, these ‘traits’ are ostensibly based on cultural, rather than racial, affiliations. However, given the often simplistic or confused reading that courts give to cultural material, can they be absolved because they are relying on cultural labels rather than on skin colour?⁴⁹

Similarly, Maneesha Deckha argues that “law can assist in the processes of undermining or legitimizing cultural forms.”⁵⁰ In order to address these concerns, several approaches have been put forth in both law and psychiatry. For instance, when presenting cultural evidence, Leti Volpp recognizes that people may have a “negotiated relationship with their culture” and therefore she proposes that the following guidelines should be used.⁵¹ First, there should be a focus on understanding the individual’s testimony instead of attempting to create a generalization of a certain ethnic group’s behavior and then trying to mold the behavior of the accused to fit this generalization.⁵² Secondly, transcultural psychology and psychiatry should be used to ensure that cultural differences are properly understood.⁵³ In this regard, the *DSM-V* includes specific recommendations on how cultural formulation should occur in capacity assessments and diagnostic

⁴⁹ Sonia Lawrence, “Culture (in) Sensitivity: The Dangers of a Simplistic Approach to Culture in the Courtroom” (2001) 13 *Can. J. Women and L.* 108 at 112.

⁵⁰ Maneesha Deckha, “Is Culture Taboo? Feminism, Intersectionality, and Culture Talk in Law.” (2004) 16 *Can J Women & L* 14 at 26. This quote was cited in relation to the work of Rosemary Coombe, “Contingent Articulations: A Critical Cultural Studies of Law” in Austin Sarat and Thomas R. Kearns, eds., *Law in the Domains of Culture* (Ann Arbor: University of Michigan Press, 1998) at 474.

⁵¹ Leti Volpp, “(Mis) Identifying Culture: Asian Women and the “Cultural Defense” (1994) 17 *Harv. Women’s L.J.* 57 at 57.

⁵² *Ibid.*

⁵³ *Ibid.*

interviews for ethno-racial people with mental health disabilities.⁵⁴ Thirdly, courts [and tribunals] should consider using consultants with the same cultural background (or perhaps even gender) as the individual.⁵⁵ Fourthly, dominant norms should not be construed to be neutral.⁵⁶ And lastly, the information should not be constructed in a manner, which subordinates certain groups such as women within the culture.⁵⁷

There are inherent challenges that such guidelines present. As revealed in my LL.M. thesis, some CCB adjudicators felt that having race, culture and ethnicity as factors in decision-making could create varying standards for ethno-racial people with mental health disabilities and other people with mental health disabilities. As an adjudicator explained,

We are afraid of opening up the floodgates and having all kinds of varying standards. Are we going to hear evidence from every family member about what their particular values and customs are? And could that suffer the overwhelming reasonableness of the law?⁵⁸

In contrast, if practitioners adopt a color-blind approach, this may result in differential outcomes for ethno-racial people interacting with Ontario's civil mental health laws. Specifically, respondents interviewed for my LL.M. thesis suggested that inequities occurred for ethno-racial people with mental health disabilities when the CCB applied a

⁵⁴ American Psychiatric Association, "DSM-5 Development," online: American Psychiatric Association <<http://www.dsm5.org/Pages/Default.aspx>>; American Psychiatric Association, "Cultural Concepts in DSM-5," online: American Psychiatric Association <<http://www.dsm5.org/Pages/Default.aspx>>.

⁵⁵ Leti Volpp, *supra* note 51.

⁵⁶ *Ibid.*

⁵⁷ *Ibid.*

⁵⁸ Interview with a CCB adjudicator on February 17, 2009, Ruby Dhand, *Challenging Exclusion: A Critique of the Legal Barriers Faced by Ethno-Racial Psychiatric Consumer/Survivors in Ontario* (LL.M. Thesis, University of Toronto Faculty of Law, 2009) [unpublished] at 82; Ruby Dhand, "Access to Justice for Ethno-Racial Psychiatric Consumer/Survivors in Ontario" (2011) 29 (11) Windsor YB Access Just 127-162.

color-blind approach in cases involving involuntary detention for risk of harm to another person and cases concerning long-term care of an aging family member.⁵⁹ In this vein, Lopez suggests,

In order to get beyond racism [in law], we need to take race into account. There is no other way...This is the basic flaw of color-blindness as a method of racial remediation. Race will not be eliminated through the simple expedient of refusing to talk about it. Race permeates our society on both ideological and material levels.⁶⁰

Despite the contested views on these issues, it appears that guidelines such as those proposed by Volpp may help ensure that mental health practitioners, lawyers and adjudicators are cautious, informed, critical and ethical when deciding whether or not to use cultural factors and cultural evidence in cases involving ethno-racial people with mental illness. These types of guidelines and the debate surrounding them will be used to inform the theoretical framework within this study.

⁵⁹ *Ibid.*

⁶⁰ Haney Lopez, *White By Law: The Legal Construction of Race* (New York: New York University Press, 1996) at 176-177.

CHAPTER 3

LITERATURE REVIEW

In this chapter, I give an overview of Ontario's civil mental health laws and the legal processes involved for those interacting with these laws. Then, I critique the types of evaluative tools developed in other jurisdictions for mental health legislation. Specifically, I discuss and analyze the methodology used to create the tools, along with the types of indicators that relate directly to this study. I will begin with examining the Rights Analysis Tool (RAI) ¹ developed in Australia and the United Kingdom's Race Equality Impact Assessment (REIA).²

At the outset, it is important to note that Australia's RAI was created on a model of human rights monitoring. ³ Human rights monitoring refers to legislative evaluative tools using human rights indicators, which measure the extent to which human rights obligations vis-à-vis international law are realized or enforced within a particular context.⁴ The human rights indicators provide specific information regarding the

¹ Helen Watchirs, "Application of Rights Analysis Instrument to Australian Mental Health Legislation" (Canberra: Public Affairs, Parliamentary and Access Branch, 2000).

² Department of Health, "Race Equality Scheme" online: Department of Health <http://webarchive.nationalarchives.gov.uk/20040216034425/doh.gov.uk/race_equality/>; Department of Health, *Mental Health Bill 2006: Race Equality Impact Assessment*, (London: Department of Health, 2006).

³ Helen Watchirs, "Human Rights Audit of Mental Health Legislation – Results of an Australian Pilot" (2008) 28 In'l JL & Psychiatry 99 at 99.

⁴ Maria Green, "What We Talk About When We Talk About Indicators: Current Approaches to Human Rights Measurement" (2002) 23 Human Rights Quarterly 1062 at 1065.

existence and content of a law, policy or condition through statistics and thematic categories.⁵

Human rights monitoring tools are often developed using a quantitative methodology and are primarily concerned with measuring the content, rather than the implementation of laws.⁶ In this regard, the methodology and the purpose of the CAT will be distinct in comparison to these tools. However, in order to inform the research and qualitative data gathering process underlying the CAT's development, I will analyze the tools themselves, the robust literature surrounding their development and the international laws and principles relevant to mental health laws. This will include a discussion of the *Convention on the Rights of Persons with Disabilities* (CRPD),⁷ the Council of Europe's recommendations,⁸ the Scottish Recovery Index,⁹ and the World Health Organization's checklist.¹⁰

⁵ *Ibid* and *supra* note 3 at 99.

⁶ *Supra* note 4 at 1065; Philip Alston, *Concluding Remarks: Benchmarks for the Realization of Economic, Social and Cultural Rights, A Round-Table Discussion Organized By the High Commissioner for Human Rights* (High Commission: Geneva, March 1998).

⁷ *Convention on the Rights of Persons with Disabilities*, G.A. Res. 61/106, at 25(d), U.N. Doc. A/RES/61/106 (Dec. 13, 2006) [hereinafter CRPD].

⁸ Council of Europe, "Recommendation CM/Rec (2009)3 of the Committee of Ministers to Member States on Monitoring the Protection of Human Rights and Dignity of Persons with Mental Disorder," online: Council of Europe <[https://wcd.coe.int/ViewDoc.jsp?Ref=CM/Rec\(2009\)3&Language=lanEnglish&Ver=original&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383](https://wcd.coe.int/ViewDoc.jsp?Ref=CM/Rec(2009)3&Language=lanEnglish&Ver=original&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383)>.

⁹ Scottish Recovery Network, "Scottish Recovery Indicator," online: Scottish Recovery Network <<http://www.scottishrecovery.net/SRI/sri.html>>.

¹⁰ The checklist can be found in World Health Organization (WHO), *WHO Resource Book on Mental Health, Human Rights and Legislation* (Geneva: World Health Organization, 2005) at 121.

3.1 Ontario's Civil Mental Health Laws

As previously mentioned, Ontario's civil mental health laws concern voluntary¹¹ and involuntary psychiatric admission procedures and criteria,¹² consent and capacity issues in relation to treatment,¹³ admission to long-term care facilities,¹⁴ substitute-decision making,¹⁵ community treatment orders,¹⁶ management of property¹⁷ and personal care¹⁸ and privacy and confidentiality of medical information.¹⁹ The legislation includes the *Mental Health Act* (MHA),²⁰ the *Health Care Consent Act* (HCCA),²¹ the *Substitute Decisions Act* (SDA)²² *Long Term Care Homes Act*,²³ the *Mandatory Blood Testing Act, 2006*²⁴ and the *Personal Health Information Act*.²⁵

The CCB is the administrative tribunal established under the HCCA, which holds hearings and adjudicates legal matters arising from Ontario's civil mental health legislation. It is an independent body created by Ontario's provincial government and the

¹¹ See for example, *Daugherty v. Stall*, [2002] OTC 944, 48 ETR (2d) 8 (Ont. S.C.J.) referred to A, T0020721, 22 June 25, 2002.

¹² See for example, *Mental Health Act*, RSO 1990, c M 7, s 20 [MHA].

¹³ *Health Care and Consent Act*, SO 1996, c 2, s 10-25 [HCCA].

¹⁴ HCCA, *ibid.* at ss. 38-49.

¹⁵ *Substitute Decisions Act*, SO 1992, c 30 [SDA].

¹⁶ MHA, *supra* note 12 at ss 33.1 –34.1.

¹⁷ See for example SDA, *supra* note 15 at ss 4-42.

¹⁸ See for example SDA, *supra* note 15 at ss 43-68.

¹⁹ See generally PHIPA, SO 2004, c 3, Sched. A [PHIPA].

²⁰ MHA, *supra* note 12 at s 20.

²¹ HCCA, *supra* note 13 at s 10-25.

²² SDA, *supra* note 15.

²³ S.O. 2007, c 8.

²⁴ S.O. 2006, c 26.

²⁵ PHIPA, *supra* note 19.

Lieutenant Governor in Council appoints its board members.²⁶ According to the 2011-2012 annual report, over 80% of the applications to the CCB involve a review of involuntary status or a person's capacity to accept or refuse treatment.²⁷ The Board must ensure that elements of safety, interests of the community, dignity and autonomy of the individual and the right to have treatment when required are paramount to its decisions.²⁸ A CCB panel consists of a lawyer, a psychiatrist, and a member of the public.²⁹ From 2011 to 2012, the Board had 129 appointed members³⁰ and it heard approximately 2797 cases.³¹

In the development of the CAT, the jurisprudence, applicable statutory provisions, and legal processes relevant to the implementation of the laws are analyzed. For example, in order to complete a certificate of involuntary admission or a certificate of renewal in Ontario, the attending physician must be of the opinion that after personally examining the patient, the patient is suffering from a mental disorder that will likely result in "serious bodily harm to the person, serious bodily harm to another person or serious physical impairment of the person, unless the patient remains in the custody of a psychiatric facility and the patient is not suitable for admission or continuation as an informal or voluntary patient."³² These are referred to as the "Box A," risk of serious

²⁶ Consent and Capacity Board, online: Consent and Capacity Board <<http://www.ccboard.on.ca/scripts/english/index.asp>>.

²⁷ This is the most recent public report available. Consent and Capacity Board, *Annual Report 2011/2012*, online: Consent and Capacity Board <<http://www.ccboard.on.ca/scripts/english/governance/Annual-Reports.asp>> at 5.

²⁸ Consent and Capacity Board, *Annual Report 2011/2012*, online: Consent and Capacity Board <<http://www.ccboard.on.ca/scripts/english/governance/Annual-Reports.asp>> at 3.

²⁹ *Ibid* at 5.

³⁰ *Ibid* at 6.

³¹ *Ibid* at 14.

³² MHA, *supra* note 12 at s 15 (1) (d) (e) and (f), 16 (1), 17 and 20 (5).

harm/impairment, criteria. The other criteria used for patients incapable of consenting to treatment, referred to as the “Box B” requirements, include two additional grounds of committal, which are “substantial mental deterioration and substantial physical deterioration.”³³ In *Starson v. Swayze*,³⁴ the Supreme Court affirmed that a person is capable of making a treatment decision if they have the ability to understand the “nature, purpose, risks and benefits of the particular treatment being proposed; the foreseeable benefits and risks of treatment; the alternative courses of action available” and the ability to appreciate the “expected consequences of not having the treatment.”³⁵

When examining Ontario’s civil mental health laws, Szigeti and Hiltz suggest that the legislation can be grouped into the areas of “property, treatment/placement, detention and personal health information.”³⁶ Similarly, the legal processes underlying Ontario’s Mental Health Laws are examined through the CCB’s pre-hearing, hearing and post-hearing processes in Chapters Five and Six.

3.2 Australia’s Rights Analysis Tool

Australia created a “Rights Analysis Tool” (RAI) in 1996. The tool used a model of human rights monitoring that attempted to “bridge broad international obligations to more specific national practice.”³⁷ It was created to evaluate and measure compliance of state and territory mental health legislation with the 1991 *United Nations Principles for*

³³ MHA, *supra* note 12 at s 15 (1.1), 16 (1.1) and 20 (1.1).

³⁴ *Starson v. Swayze*, 2003 SCC 32, [2003] 1 SCR 722 (SCC).
[*Starson*].

³⁵ *Ibid* at para 80 and 81.

³⁶ D’Arcy Hiltz and Anita Szigeti, *A Guide to Consent and Capacity Law in Ontario* (Markham: Lexis Nexis Canada Inc., 2013) at 1.

³⁷ Helen Watchirs, *supra* note 3 at 99.

*the Protection of and for the Improvement of Mental Health Care*³⁸ (“MI Principles”) and also the National Mental Health Statement of Rights and Responsibilities.³⁹ The MI Principles, which are not formally binding, are based in the *United Nations Bill of Rights*,⁴⁰ and they have been “recognized as the most complete standards for the protection of the rights of persons with mental disability at the international level.”⁴¹

³⁸ General Assembly Resolution 46/119 of 17 December 1991 (“MI Principles”). The principles include the “promotion of mental health and prevention of mental disorders, access to basic mental health care, mental health assessments in accordance with internationally accepted principles, provision of the least restrictive type of mental health care, self-determination, right to be assisted in the exercise of self-determination, availability of review mechanism, automatic periodical review mechanism, qualified decision maker, respect the rule of law.”

³⁹ Australian Government: Department of Health and Ageing, “Mental Health: Statement of Rights and Responsibilities” online: Australian Government <<http://www.mhlcwa.org.au/wp-content/uploads/2013/02/rights.pdf>>.

“This statement recognises that high standards of mental health care are essential for the treatment and rehabilitation of people who have mental health problems or mental disorders. The standards include the following: The consumer has the right to mental health services which are resourced, organised and administered to provide care as set out in this statement. The consumer has the right to have explicit standards set for all sectors of service delivery and that such standards should have operational criteria by which they can be assessed. The consumer has the right to access mechanisms established for the development and regular review of standards. Such mechanisms should be used for the evaluation of services, including both the process of service provision and the outcome of treatment. The consumer has the right to mechanisms of complaint and redress regarding standards of service delivery. The consumer has the right to have services subjected to quality assurance to identify inadequacies and to ensure standards are met. The consumer has the right to be informed and consulted about proposed changes to services and standards. The consumer has the right to mental health services which comply with standards of accountability to consumers, the community and governments. The consumer has the right to expect governments to ensure adequate levels of professionally trained and qualified staff in mental health services. The consumer has the right to expect that services will ensure a capacity for, and a commitment to, the maintenance and further development of staff knowledge and skills.”

⁴⁰ The “Universal Declaration of Human Rights (1948), along with the International Covenant on Civil and Political Rights (ICCPR, 1966) and the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966) together make up what is known as the “International Bill of Rights.” World Health Organization (WHO), WHO Resource Book on Mental Health, Human Rights and Legislation (Geneva: World Health

The report of the National Inquiry into the Human Rights of People with Mental Illness (the ‘Burdekin Report,’ October 1993) and the Reconvened Inquiry in Victoria (the ‘Sidoti Report,’ December 1995) identified how Australia’s mental health legislation lacked consistency with the UN Principles.⁴² Thus, in 1993, the Australian Health Ministers’ Advisory Council (AHMAC) National Mental Health Working Group designed a draft analysis tool, which was applied to all Australian jurisdictions. However, it was used for information purposes only because of the methodological problems, lack of input from community stakeholders and the failure to recognize the difference between “core and subsidiary rights.”⁴³ Consequently, a new consultative process began in 1996, which involved national stakeholders with “members of consumer advisory groups, peak mental health non-government organizations, academics, professionals, service providers, advocates, carers, members of mental health tribunals and guardianship boards, and officers from relevant State and Territory Departments.”⁴⁴

Organization, 2005) at 85; Universal Declaration of Human Rights, GA Res. 217A, UN Doc. A/810 at 71 (1948); International Covenant on Civil and Political Rights, art. 1(1), 21 UN GAOR Supp. 16, at 53, U.N. Doc. A/6316 (1966); International Covenant on Economic, Social and Cultural Rights, art. 1(1), 21 UN GAOR Supp. 16, at 49, UN Doc. A/6316 (1966).

⁴¹ *Victor Rosario Congo v. Ecuador*, Case 11. 427, Inter-Am. C.H.R., OEA/Ser.L/V/II.95 Doc. 7 rev. at 475, para. 111 (1998). For instance, the MI principles “establish standards for treatment and living conditions within psychiatric institutions, and create protections against arbitrary detention in such facilities.” Michael L. Perlin, “International Human Rights and Comparative Mental Disability Law: The Use of Institutional Psychiatry as a Means of Suppressing Political Dissent” (2006) 39 *Isr. L.R.* 69 at 83.

⁴² Helen Watchirs, *supra* note 1 at 1.

⁴³ *Ibid.*

⁴⁴ *Ibid* and Helen Watchirs, *supra* note 3 at 108.

The consultations led to the creation of the Rights Analysis Tool (RAI), which consisted of ten indicators. The ten indicators⁴⁵ include: 1) legislative objects and framework, 2) safeguards in mental health facilities, 3) determination of disorder and involuntary admission, 4) review body, 5) review process, 6) personal representative, 7) consent to general procedures, 8) consent to special procedures, 9) mental health treatment and 10) other laws.⁴⁶ The RAI was designed to measure only the formal content of legislation and not the outcomes arising from the implementation of mental health laws.

It is important to note that although the indicators were designed through qualitative methods, the application of them used a quantitative methodology measured in quadrants (“substantial, significant, partial and minimal”).⁴⁷ In order to apply the Rights Analysis Tool, there were several local, multi-disciplinary panels formed that consisted of the following members: “a consumer; a human rights expert; a lawyer familiar with mental health legislation; an NGO service provider; a clinician; an advocate; a carer; and a government official from the mental health area.”⁴⁸ The RAI was applied from 1998 to 1999 to seven jurisdictions (Tasmania, New South Wales, Victoria, Western Australia,

⁴⁵ There were originally thirteen indicators, however it was refined to include only ten. In 2000, the thirteen indicators included: 1) general and aspirational human rights, 2) human rights in mental health facilities, 3) determination of mental illness, 4) criteria for admission to a mental health facility, 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 mental health treatment, 10) consent to special procedures, 11) treatment and medication, 12) accountability, standards and monitoring and 13) general legal provisions (not usually found in mental health law), Helen Watchirs, *supra* note 1 at 5.

⁴⁶ Helen Watchirs, *supra* note 3 at 99.

⁴⁷ Helen Watchirs, *supra* note 1 at 1.

⁴⁸ *Supra* note 1.

South Australia, the Northern Territory, and the Australian Capital Territory).⁴⁹ Arising from the local panels, a National Panel⁵⁰ was formed to examine the consistency in RAI's scoring, and to identify the RAI's positive and problematic areas.⁵¹

Helen Watchirs, the leading Health and Human Rights Consultant and a member of the National Panel, argues that a value of the audit methodology is that it “uses very specific standards and makes concrete findings rather than being vague and intangible.”⁵² Since the UN human rights treaty monitoring system is often un-resourced, the audit methodology provides a mechanism for measuring the formal content of mental health laws’⁵³ compliance with international human rights obligations.⁵⁴ As the international Anti-Poverty Law Centre argues:

The emerging framework of international human rights law provides a strong foundation for deriving indicators on the legal obligations of the state. Bringing quantitative assessment⁵⁵ to this legal framework is empowering government to understand their obligations and the actions needed to meet them. It is also empowering civil society to stand up in court and provide advocacy.⁵⁶

⁴⁹ *Supra* note 1. Queensland was the only jurisdiction that did not apply the RAI because it was in the final processes of drafting its own Mental Health Bill.

⁵⁰ This included a member of the “Mental Health Review Board, a Chief Psychiatrist, a lawyer with specialist skills in mental health, an independent human rights expert, a representative from the Mental Health Council of Australia, the Royal Australian and New Zealand College of Psychiatrists, and the Australian Medical Association, and officers from the Commonwealth Health and Attorney-General’s Departments.” The member from the Human Rights and Equal Opportunity Commission did not attend these meetings. Helen Watchirs, *supra* note 1 at 4.

⁵¹ Helen Watchirs, *supra* note 1 at 1.

⁵² Helen Watchirs, *supra* note 3 at 100.

⁵³ The RAI does not assess the outcomes of laws or administrative policies.

⁵⁴ Helen Watchirs, *supra* note 3 at 102.

⁵⁵ This involves the process described earlier. Helen Watchirs, *supra* note 1; Haney Lopez, *White By Law: The Legal Construction of Race* (New York: New York University Press, 1996) at 176-177.

⁵⁶ UN Development Program, *Report on Human Rights and Development* (United Nations: Geneva, 2000) cited in Helen Watchirs, *supra* note 3 at 101.

A human rights paradigm⁵⁷ was used to inform the creation of the tool to reflect how social, individual and systemic factors affecting people with mental health disabilities. However, there are many limitations of the audit methodology. Given that the panel did not release numerical scores, there was a tension between the quantitative scores and the qualitative scores.⁵⁸

Unlike the CAT, the RAI only evaluates the extent to which formal laws comply with UN principles and does not analyze the outcomes of mental health legislation for people with mental health disabilities. In this regard, it is important to draw the distinction between human rights indicators and development indicators. The terms human rights indicators and development indicators are defined as “means of determining the extent to which a government is complying with its obligations, whereas the latter is concerned with outcomes, that is the extent to which individuals experience satisfaction of their basic needs.”⁵⁹ The use of development indicators is not endorsed by the RAI as the audit methodology only “reviews the design of a jurisdiction’s legal system in the mental health area (a form of meta-regulation) rather than measuring specific functions or

⁵⁷ “Human rights not only provides a normative framework of analysis for mental health, but also a morally powerful and legally binding foundation with international procedural, institutional and other accountability mechanisms that cannot be removed by ordinary political processes. Instead of being seen as internal domestic issues immune to domestic scrutiny, human rights are a legitimate subject on international as well as local debate.” Helen Watchirs, *supra* note 3 at 111 citing L.O. Gostin and L. Gable, “The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health” (2004) 63 Maryland Law Review 20. However, as previously described, this framework was used along with the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (1991), Adopted by General Assembly Resolution 46/119, 17 December 1991 (“MI Principles”) and Australian Government: Department of Health and Ageing, “Mental Health: Statement of Rights and Responsibilities” online: Australian Government <<http://www.mhlcwa.org.au/wp-content/uploads/2013/02/rights.pdf>>.

⁵⁸ Helen Watchirs, *supra* note 1 at 2.

⁵⁹ *Supra* note 4 at 1063.

outcomes, such as actual human rights enjoyment.”⁶⁰ Thus, dissimilar to this study, the RAI does not engage in an analysis of the broader dimensions of administrative processes and policies underlying mental health legislation. As Watchirs argues, “a further second stage could consider broader and more complex issues related to enforcement of laws, for example through surveys of tribunal caseloads, documenting experiences of vulnerable populations and comparing the equity of resource allocations.”⁶¹

In the broader debate, it is important to note that Australia’s tool was criticized by scholars because it was based on the MI Principles. Scholars such as Theresia Degener⁶² and Aaron A. Dhir⁶³ present critiques of the MI principles. These scholars argue the MI principles put forth a medical-based approach focusing on treatment instead of advancing a rights-based approach focusing on individual dignity and the right to refuse treatment. The MI principles are primarily concerned with civil rights, and generally do not include principles based on positive economic and social rights.⁶⁴ For instance, the principles give “vast discretion” to health professionals and they are “weaker on substantive limitations for coercion in deciding what is in the best interests of the patient.”⁶⁵

Advocacy groups have also criticized the consultation and drafting process underlying

⁶⁰ Helen Watchirs, *supra* note 3 at 125.

⁶¹ Helen Watchirs, *supra* note 3 at 125.

⁶² Theresia Degener, “Disabled Persons and Human Rights: The legal framework,” in Theresia Degener and Yolanda Koser-Dreese, *Disabled Persons and Human Rights* (Boston: Martinus Nijhoff Publishers, 1995) at 27. Michael Perlin also describes the MI principles in his work. Michael L. Perlin, “International Human Rights and Comparative Mental Disability Law: The Use of Institutional Psychiatry as a Means of Suppressing Political Dissent” (2006) 39 *Isr. L.R.* 69 at 84. Other discussions are given by Eric Rosenthal and Clarence J. Sundram, “International Human Rights in Mental Health Legislation” (2002) 21 *N.Y.L. Sch.J. Int’l and Comp.L* 469.

⁶³ Aaron A. Dhir, “Human Rights Treaty Drafting Through the Lens of Mental Disability” (2005) 41 *Stan J Int’l L* 181.

⁶⁴ Helen Watchirs, *supra* note 3 at 125.

⁶⁵ Theresia Degener, *supra* note 62 at 27.

the creation of the MI principles for its lack of participation by people with mental health disabilities.⁶⁶ Thus, the World Network of Users and Survivors of Psychiatry created an alternate set of principles to replace the MI principles.⁶⁷

⁶⁶ Eric Rosenthal and Clarence J. Sundram, *supra* note 62; *supra* note 63 at 189.

⁶⁷ World Network of Users and Survivors of Psychiatry, "Human Rights Position Paper of the World Network of Users and Survivors of the World Network of Users and Survivors of Psychiatry" online: World Network of Users and Survivors of Psychiatry <http://www.wnusp.net/index.php/human-rights-position-paper-of-the-world-network-of-users-and-survivors-of-psychiatry.html>.

These include: "In pursuing the goals and values outlined above, the WNUSP establishes the following principles: "Every user/survivor shall be treated with the basic respect and dignity afforded to all persons; Every user/survivor shall be free from any and all human rights abuses -- no user/survivor shall be subject to physical, sexual or emotional abuse; Every user/survivor shall be free from any and all forms of discrimination -- no user/survivor shall be subject to housing, employment, economic, educational, racial or cultural discrimination; Every user/survivor shall be granted self-determination and the ability to make informed choices -- no user/survivor shall be denied the opportunity to make educated decisions affecting their lives including full informed participation and informed consent in all mental health "treatment" matters; additionally, users/survivors shall have the opportunity to fully participate in the planning, policy development, delivery, evaluation and research of mental health services; Every user/survivor shall be granted full political, legal and civil rights -- no user/survivor shall be denied the right to participate fully in society including the rights to participate in political processes, practice one's religion, free speech and to petition their governments; Every user/survivor shall have the opportunity to organise collectively -- no user/survivor shall be denied the opportunity to assemble for mutual support and political action; Every user/survivor shall have the right to refuse any and all "treatments or procedures" -- no user/survivor shall be subjected to coerced or forced psychosurgery, sterilisation, over-medication, psychiatric drugging, chemical restraints, physical restraints, insulin shock, electroshock, or inpatient or outpatient commitment; Every user/survivor shall have the right to representation on his/her behalf -- no user/survivor shall be denied the opportunity to have an advocate or attorney to ensure the protection of one's rights; Every user/survivor shall be provided with having their basic needs met -- no user/survivor shall be subject to hunger, poverty, homelessness or a lack of adequate health care; Every user/survivor shall be fully integrated as any and all citizens within any community -- no user/survivor shall be segregated and relegated in separate housing or separate areas of communities; Every user/survivor within a hospital or mental health setting shall in addition to these principles have the following rights: unrestricted and private communication including receiving and sending unopened letters and to have outgoing letters stamped and mailed, to have access to telephones, to receive visitors of one's own choice, and to make grievances and have those grievances heard and adjudicated promptly with appeals

Although I draw from the RAI's thematic assessments and questions, there are other limitations for its applicability to this study. First, issues of culture, race, ethnicity and other intersecting factors are often not embedded within the RAI's indicators. Secondly, an analysis of the principles and certain parts of the audit focus on "protecting against abuses, rather than positive obligations of care."⁶⁸ Specifically, indicator one does not mention that treatment should be culturally appropriate. Indicator two does not mention language, translation and communication issues within mental health facilities. While indicator three does include cultural background into the determination of a mental disorder, factors such as "age, gender and disability" are excluded.⁶⁹ Indicator four does not require the review board to provide decisions chosen by the client. Indicator five does not mention mediation as being an option for the review process, and it does not describe the composition and expertise of those who will sit on the "judicial, or other independent

processes in place keep, use and sell personal possessions, participate in the development and review of one's "treatment" plan, and to be discharged or released upon one's wishes; Every user/survivor shall have the right to handle one's personal affairs -- no user/survivor shall be denied the opportunity for holding a driver's license or professional license, engaging in personal intimate relationships of one's choice, marrying, obtaining a divorce etc.; Every user/survivor shall have the right to be paid at equitable pay for any work performed -- no user/survivor shall be forced to work or be paid beneath equitable rate scales for equitable work; Every user/survivor shall have the opportunity to participate in alternative services -- no user/survivor shall be restricted in participating in voluntary self-help alternatives as well as other supports such as spirituality, meditation, acupuncture, yoga etc, and voluntary self-help alternatives shall be made available in all communities; Every user/survivor shall have the opportunity to become informed of the user/survivor movement -- no user/survivor shall be restricted in becoming educated on this movement; Every user/survivor shall have the right to confidentiality and access to any records or documents concerning one's self -- no user/survivor shall have their privacy rights violated; Every user/survivor shall be notified of their rights and these principles."

⁶⁸ Helen Watchirs, *supra* note 3 at 125. Given the theoretical underpinnings of this study, the focus on protecting against abuses needs to be combined with an emphasis to provide a positive obligation of care.

⁶⁹ *Ibid.*

and impartial body.”⁷⁰ The right to choosing and appointing a counsel in indicator six does not mention the option of having someone who speaks the same language as the person or having someone who understands his or her own culture. Within indicator seven, the questions about informed consent do not address language barriers and alternative treatment options.⁷¹

3.3 The United Kingdom’s Race Equality Impact Assessment

The United Kingdom developed the Race Equality Impact Assessment (REIA) in accordance with the duties arising from Section 71 of the *Race Relations (Amendment) Act 2000*.⁷² The United Kingdom Department of Health applied this legislative evaluative tool to various pieces of mental health legislation in 2004 and 2006 in order to assess systematically what impact certain policies and laws had on different racial groups.⁷³ The REIA was used to amend the *Mental Health Act 1983*⁷⁴ and to amend the *Mental Capacity Act 2005*.⁷⁵ The first REIA was carried out on the *Mental Health Bill 2004*,⁷⁶

⁷⁰ *Ibid* at 118.

⁷¹ *Ibid*.

⁷² *Race Relations Amendment Act 2000* (c.34). Section 2 (1) states as follows: “ Every body or other person specified in Scheduled 1A or of a description falling within that Schedule shall, in carrying out its functions, have due regard to the need – a) to eliminate unlawful racial discrimination; and b) to promote equality of opportunity and good relations between persons of different racial groups. 2) The Secretary of State may by order impose, on such persons falling within Schedule 1A as he considers appropriate, such duties as he considers appropriate for the purpose of ensuring the better performance by those persons of their duties under subsection (1).”

⁷³ Department of Health, “Race Equality Scheme” online: Department of Health <http://webarchive.nationalarchives.gov.uk/20040216034425/doh.gov.uk/race_equality/; Department of Health, *Mental Health Bill 2006: Race Equality Impact Assessment*, (London: Department of Health, 2006).

⁷⁴ *Mental Health Act 1983*, Chapter 20.

⁷⁵ *Mental Capacity Act 2005*, Chapter 9.

but was later withdrawn by the government due to criticism of its consultative process.⁷⁷

Consequently, the *Mental Health Bill* 2006 focused on amending the following parts of the *Mental Health Act* 1983:

1. Supervised treatment in the community.
2. Skill base of professionals.
3. Patient safeguards with regard to the Mental Health Review Tribunal.
4. A simplified definition of mental disorder.
5. Exclusion for drug and alcohol dependency and preserving the effects of the Act in relation to people with learning disabilities.
6. Availability of appropriate treatment.
7. Remedying ECHR incompatibility in relation to the Nearest Relative and bringing the Act in line with the Civil Partnership Act 2004.⁷⁸

⁷⁶ The REIA “work for the draft 2004 Bill contributed to the Department’s decision to adapt or not pursue the following policies. 1) adapted Supervised Community Treatment and introduced clauses in the amending Bill that mean all patients must first be detained and assessed in detention in hospital before they are placed on SCT and no one can be detained in a community setting. BME groups had suggested that there would be a lower threshold for using compulsory community treatment orders in the draft 2004 Bill and this could affect BME patients; 2) decided against a separate condition for patients at substantial risk of causing harm to another person (BME groups felt their communities would suffer from stereotyping) and instead has largely retained the current structure for criteria for detention; 3) decided against the policy that anyone should have the statutory right to request the relevant authority to consider an examination against the first four criteria for detention (initial examinations). BME groups felt that patients could be more likely to be subject to vexatious requests; 4) decided against the policy that Mental Health Tribunals could sit with fewer than three members. Instead the current MHRT with three panel members will be maintained.” Department of Health, “Mental Health Act 2006: Race Equality Impact Assessment,” online: Department of Health <http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@leg/documents/digitalasset/dh_062698.pdf>.

⁷⁷ Chinyere Inyama, “Race Relations, mental health and human rights – in the legal framework,” in Suman Fernando and Frank Keating, eds., *Mental Health in a Multi-Ethnic Society: A Multidisciplinary Handbook* (New York: Routledge, 2009) at 39.

Although it is preferable that the REIA is carried out in the development stage of a law or policy, it can also be used retroactively in order to modify or re-develop a law or policy.⁷⁹ In its consultative process in 2006, the Department of Health had seven regional events with 430 people attending, had interviews with approximately 120 involuntary and voluntary patients and consulted with stakeholders including: “the mental health alliance, the royal college of psychiatrists, refugee council and metropolitan police.”⁸⁰ Also, the Department of Health partnered with the National Black and Minority Ethnic Mental Health Network to hold consultations in four major cities in the United Kingdom including Bristol, Manchester, Birmingham and London. There were approximately two hundred “black and minority ethnic minority service users, health professionals, academics and other statutory organization representatives”⁸¹ involved in these events. The consultations involved presentations followed by workshops (lasting approximately four to six hours).⁸²

In a critique of the REIA, Chinyere Inyama suggests that the Department of Health carried out the assessment “in a desultory and negligent manner” because the views and proposals from the community groups such as the Black and Ethnic Mental Health Network (BMENW) and the Commission on Racial Equality (CRE) were

⁷⁸ Department of Health, “The Mental Health Bill 2006: Briefing Sheets on Key Policy Areas,” online: Department of Health <http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4134229>.

⁷⁹ *Ibid.*

⁸⁰ *Supra* note 73.

⁸¹ Department of Health, “Race Equality Impact Assessment – Consultation Material,” online: Department of Health <http://www.equalityhumanrights.com/uploaded_files/PSD/race_equality_impact_assessment_guidance.pdf>.

⁸² *Ibid.*

ignored.⁸³ Consequently, the Bill was passed by the Parliament and received royal assent as the *Mental Health Act 2007* with only minor changes. According to Chinyere Inyama, it appears that the *Mental Health Act 2007* did not address the racial inequities and differential outcomes experienced by various racial groups interacting with the United Kingdom's mental health legislation.⁸⁴

In regard to this study, there are useful themes that can be drawn from the proposals put forth by the community groups in their consultations for the REIA. For instance, they argued that sensitizing the psychiatric and the legal system to issues of diversity could occur through a shift from the medical model of illness towards

⁸³ *Supra* note 77 at 41.

The suggestions put forth in these proposals include:

“1. An amendment that makes it legally binding for the detaining authority to consult with such persons, community organizations and human rights bodies as have knowledge of the patient's social and cultural background. 2. Wherever the “Approved Mental Health Professional” (AMHP) is mentioned in the course of amendments of the Act, there should be a clause stating that the person should have ‘those skills that are appropriate for working in a multicultural society.’ 3. An amendment to Schedule 2 of the 1983 Act should ensure that a) the legal persons appointed by the Lord Chancellor should have experience in the race relations field; and b) the non-legal, non-medical persons appointed by the Lord Chancellor should have experience in anti-discriminatory practice. An amendment to Section 78 (Procedure of Tribunals) should state that the Tribunal, in arriving at their decision, takes account of cultural diversity and institutional racism. An amendment to Section 72 (Power of Tribunal) should enable a Tribunal to direct the detaining authority to seek additional information on the cultural background of the patient. 4. An amendment to the Act should bring in a clause that states that the judgment of the presence of ‘mental disorder’ must take account of the patient's social and cultural background. 5. An amendment should ensure that (for the purpose of sectioning) mental disorder should not be construed by ‘reason only of culturally appropriate beliefs and/or behaviours.’ 6. An amendment should make it legally binding that any treatment that is imposed on a patient should take account of the patient's culture, gender, sexuality and social background. 7. An introduction to the Act should set out principles that define human rights and anti-discriminatory practice. The principles should be modeled on those within the Scottish Mental Health Act 2003, including adherence to equality and non-discrimination” (p 41).

⁸⁴ *Supra* note 77 at 41.

addressing the underlying social factors.⁸⁵ Given that the *Mental Health Act 2007* allows mental disorder to be diagnosed broadly, factors such as race, culture, religion or sex should be considered.⁸⁶ As Suman Fernando and Frank Keating emphasize, culturally appropriate treatment, along with principles of equity and non-discrimination should also be included within the Act.⁸⁷

Through an analysis of the REIA's methodology, it appears that the REIA's questionnaires attempt to gather quantitative answers. Certain questions ask for numerical evidence, the level of adverse risk upon race equality and measurement criteria.⁸⁸ In contrast, the CAT focuses on gathering qualitative information, rather than statistical or numerical information.

3.4 International Human Rights Law

Before embarking upon an analysis of the relevant international laws applicable to ethno-racial people with mental health disabilities, I will describe the interplay between international law and domestic law within Canada's courts and the debates relevant to this discourse. For instance, international treaties that have been ratified can be incorporated into Canadian law by the incorporation of all or part of its text within a

⁸⁵ *Supra* note 77 at 41.

⁸⁶ Suman Fernando and Frank Keating, eds., *Mental Health in a Multi-Ethnic Society: A Multidisciplinary Handbook* (New York: Routledge, 2009) at 41.

⁸⁷ *Ibid* at 247-248.

⁸⁸ For instance, the supplementary question states 'to demonstrate that the amendment was fairly applied to all racial groups and promoted equality of opportunity and good race relations, what should we measure/what evidence should we look for?' Department of Health, "Amending the Mental Health Act 1983: Race Equality Impact Assessment-Questionnaire," online: Department of Health http://webarchive.nationalarchives.gov.uk/20080814090217/dh.gov.uk/en/Consultations/Closedconsultations/DH_4135812

Canadian statute.⁸⁹ However, an informal transformation or “inferred implementation”⁹⁰ of international law can occur if treaties are transformed implicitly into domestic law by enacting new legislation or amending existing legislation.⁹¹

Scholars have debated whether states should be bound by international laws and principles not directly incorporated into domestic law.⁹² The dualist approach suggests that a state should not have to comply with an international treaty unless it has been incorporated within domestic law. In contrast, a monist approach indicates that international law is automatically implemented within domestic laws, if a state has voluntarily agreed to become a party to an international treaty through ratification or accession of it.⁹³ The customary international law position is specified in the *Vienna Convention on the Law of Treaties*.⁹⁴ Accordingly, the Supreme Court in *Baker v. Canada (Minister of Citizenship and Immigration)*,⁹⁵ found that although international treaties may have no direct application unless incorporated into Canadian statutes, the “values reflected in international human rights law may help inform the contextual approach to statutory interpretation and judicial review.”⁹⁶ The universality of

⁸⁹ Jutta Brunnee and Stephen J. Toope, “A Hesitant Embrace: The Application of International Law by Canadian Courts” (2002) 40 Can YB of International Law 3 at 22 and 51.

⁹⁰ *Ibid* citing Ruth Sullivan, *Driedger on the Construction of Statutes* (Markham: Butterworths, 1994) at 330.

⁹¹ *Supra* note 89 at 23.

⁹² *Supra* note 89 at 23; Munyonzwe Hamalengwa, “Opening Statement Baker Ruling Leaves Questions Unanswered” (1999) 19:6 *The Lawyers Weekly* 1 at 1.

⁹³ John H. Currie, *Public International Law* (Toronto: Irwin Law, 2001) at 199-201.

⁹⁴ *Vienna Convention on the Law of Treaties*, 22 May 1969, 1155 U.N. T.S. 331 art. 26, Can. T.S. 1980 No. 37 (Entry into force 27 January 1980), confirming the customary international law position.

⁹⁵ [1999] 2 SCR 817, 174 DLR (4th) 193 [*Baker*].

⁹⁶ *Baker, ibid.* at paras. 69-70.

international laws and principles has also been contested.⁹⁷ In this vein, Third World Approach to International Law (TWAIL) scholars suggest that international law must be evaluated within a paradigm that deconstructs the realities of colonialism and imperialism and the lived history of Third World peoples inherent in its creation.⁹⁸ Collectively, these views have informed the analysis and development of the CAT.

There is a wide range of international human rights documents relating to ethno-racial people with mental health disabilities.⁹⁹ These include the *United Nations Convention on the Rights of Persons with Disabilities (CRPD)*¹⁰⁰ *Universal Declaration of Human Rights (UDHR)*,¹⁰¹ the *International Covenant on Civil and Political Rights (ICCPR)*,¹⁰² the *International Covenant on Economic, Social and Cultural Rights (ICESCR)*,¹⁰³ the *Convention on the Elimination of All Forms of Racial Discrimination (CERD)*,¹⁰⁴ the *Convention against Torture and Other Cruel, Inhuman or Degrading*

⁹⁷ Anthony Anghie and B.S. Chimni, “Third World Approaches to International and Individuals Responsibility in Internal Conflicts” (2003) 2:1 Chinese J I L 71.

⁹⁸ See generally Makau Mutua, “What is TWAIL?” (2000) 94 Am. Soc’y Int’l L. Proc. 31; See generally Antony Anghie, “What is TWAIL: Comment” (2000) 94 Am. Soc’y Int’l L. Proc. 39; Obiora C. Okafor, “Critical Third World Approaches to International Law (TWAIL): Theory, Methodology, or Both?” (2010) 10 International Community Law Review 37; Ruth Buchanan, “Writing Resistance into International Law” (2008) 10 International Community Law Review 445.

⁹⁹ Eric Rosenthal and Clarence J. Sundram, *supra* note 62.

¹⁰⁰ *Convention on the Rights of Persons with Disabilities*, G.A. Res. 61/106, at 25(d), U.N. Doc. A/RES/61/106 (Dec. 13, 2006) [hereinafter CRPD].

¹⁰¹ General Assembly Resolution 217A (III) of 10 December 1948.

¹⁰² G.A. Res. 2200 A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16 at 52, U.N. Doc. A/6316 (1966), entered into force Mar. 23, 1976.

¹⁰³ General Assembly Resolution 2200A (XXI) of 16 December 1966 (Entry into force: 3 January 1976).

¹⁰⁴ General Assembly Resolution 2106A (XX) 21 December 1965 (Entry into force 4 January 1969).

Treatment or Punishment,¹⁰⁵ the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW),¹⁰⁶ and *Convention on the Rights of the Child* (CROC).¹⁰⁷ Other instruments include the United Nations General Assembly on the *Declaration on the Rights of Mentally Retarded Persons* (1971),¹⁰⁸ the *Declaration on the Rights of Disabled Persons* (1975),¹⁰⁹ the *World Programme of Action Concerning Disabled Persons* (1982),¹¹⁰ the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (1991),¹¹¹ and the *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*.¹¹²

However, as Herr suggests, these international laws do not appear to have impacted litigation for the rights of people with mental health disabilities because of the lack of relevant language.¹¹³ In circumstances where they are referred to, they often are used in regard to due process and procedural requirements.¹¹⁴ The most comprehensive of these instruments include: the ICCPR,¹¹⁵ the ICESCR,¹¹⁶ and the MI Principles.¹¹⁷ As

¹⁰⁵ General Assembly Resolution 39/46, 10 December 1984 (Entry into force: 26 June 1987).

¹⁰⁶ General Assembly 34/180, 18 December 1979 (Entry into force: 3 September 1981).

¹⁰⁷ General Assembly 44/25, 20 November 1989 (Entry into force: 2 September 1990).

¹⁰⁸ General Assembly Resolution 2856 (XXVI) 20 December 1971.

¹⁰⁹ General Assembly Resolution 3447 (XXX) of 9 December 1975.

¹¹⁰ UN General Assembly Resolution 37/52, 3 December 1982.

¹¹¹ Adopted by General Assembly Resolution 46/119, 17 December 1991.

¹¹² General Assembly Resolution 48/96, 20 December 1993.

¹¹³ Stanley Herr, "From Wrongs to Rights: International Human Rights and Legal Protection," in Stanley S. Herr, Lawrence Ogalthorpe Gostin, Harold Hongju Koh (eds), *The Human Rights of Persons with Intellectual Disabilities* (Oxford: Oxford University Press, 2003).

¹¹⁴ Joaquin Zuckerberg, "International Human Rights for Mentally Ill Persons: The Ontario Experience" (2007) 30 *Int'l J L & Psychiatry* 512 at 513.

¹¹⁵ G.A. Res. 2200 A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16 at 52, UN Doc. A/6316 (1966), (Entry into force Mar. 23, 1976).

¹¹⁶ General Assembly Resolution 2200A (XXI) of 16 December 1966 (Entry into force: 3 January 1976).

previously mentioned, the RAI was created to measure compliance with the MI principles, which are based on the ICCPR and the ICESCR, along with the *Universal Declaration of Human Rights*. Other relevant conventions include the *Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention)*¹¹⁸ and the *Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities*.¹¹⁹

In a study of the rate of compliance with Ontario's mental health laws under international human rights standards, Joaquin Zuckerberg contends that the rate of compliance is high.¹²⁰ In particular, he analyzed the *Ontario Mental Health (MHA)*,¹²¹ the *Health Care Consent Act (HCCA)*,¹²² the *Personal Health Information Act (PHIPA)*¹²³ and the *Substitute Decisions Act*¹²⁴ under the MI principles and the *European Convention*. He analyzed the legal framework underlying the implementation of Ontario's civil mental health laws. This included a critique of the pre-CCB hearing, CCB hearing and post-CCB hearing processes highlighting key legal issues throughout the processes such as: detention for assessment purposes, authorized place of detention, least restrictive means, treatment, notice of rights, right to legal representation, access to information, the nature of the tribunal, the procedures used by the tribunal, onus and standard of proof, subsequent periodic reviews, publication of outcome, and right to

¹¹⁷ General Assembly Resolution 46/119 of 17 December 1991 ("MI Principles").

¹¹⁸ Amended by Protocols No. 11 and No. 14, Rome, 4.XI.1950.

¹¹⁹ AG/RES 1608 (XXIX-0/99).

¹²⁰ *Supra* note 114 at 514.

¹²¹ MHA, *supra* note 12 at s 20.

¹²² HCCA, *supra* note 13 at s 10-25.

¹²³ PHIPA, *supra* note 19.

¹²⁴ SDA, *supra* note 15.

appeal a tribunal's decision.¹²⁵ This technical analysis of Ontario's legislation will be relevant to the research for understanding and examining Ontario's mental health legislation compliance under the *MI principles* and the *European Convention*.

However, Zuckerberg's analysis is problematic because of his endorsement of the *MI principles*, which are based on the medical model of disability as previously critiqued by Theresia Degener and Aaron A. Dhir.¹²⁶ Also, issues of race, culture and ethnicity are not mentioned in Zuckerberg's article. According to Suman Fernando, problems the medical model carries for ethno-racial people with mental health disabilities may include "the muddle between social control and therapy, the abject failure of psychiatry to address the cultural variation in perceptions of illness and, most of all, in the firm conviction held by many service users that psychiatry and clinical psychology no longer provide useful bases for professional practice in mental health care."¹²⁷ Thus, for ethno-racial people with mental health disabilities, there are certain procedural, systemic and discretionary barriers during the pre-CCB hearing, CCB hearing and post-CCB hearing processes, as described earlier,¹²⁸ that are considered in the development of the CAT.

3.5 United Nations Convention on the Rights of Persons with Disabilities (CRPD)

In the development of the CAT, I have considered and incorporated relevant sections of the *United Nations Convention on the Rights of Persons with Disabilities*

¹²⁵ *Supra* note 114.

¹²⁶ Theresia Degener, *supra* note 62 at 27; Michael L. Perlin, *supra* note 62 at 84; Eric Rosenthal and Clarence J. Sundram, *supra* note 62; Aaron Dhir, *supra* note 63.

¹²⁷ Suman Fernando and Frank Keating, eds., *supra* note 86 at 35.

¹²⁸ Ruby Dhand, *Challenging Exclusion: A Critique of the Legal Barriers Faced by Ethno-Racial Psychiatric Consumer/Survivors in Ontario* (LL.M. Thesis, University of Toronto Faculty of Law, 2009) [unpublished]; Ruby Dhand, "Access to Justice for Ethno-Racial Psychiatric Consumer/Survivors in Ontario" (2011) 29 (11) Windsor YB Access Just 127-162.

(CRPD).¹²⁹ The CRPD was signed by Canada on March 30, 2007 and ratified on March 11, 2010.¹³⁰ According to Perlin and McClain, the CRPD articles that are applicable to the implementation of domestic mental health laws include, “respect of inherent dignity (Article 3a), and non-discrimination (Article 3b), freedom from torture or cruel, inhuman or degrading treatment or punishment (Article 15), freedom from exploitation, violence and abuse (Article 16), a right to protection of the integrity of the person (Article 17), equal recognition before the law (Article 12) and finally access to justice (Article 13).”¹³¹ A through examination of these articles and the CRPD’s principles will inform the CAT. In particular, Article 13 (the equal access to justice) will be used to include factors relating to the quality of counsel for ethno-racial people with mental health disabilities within the CAT.¹³²

In respect to Article 12 of the CRPD, it is important to note that Canada reserves the right to allow supported and substitute-decision making arrangements in “appropriate circumstances,” which are subject to the proper safeguards including the review by an independent tribunal.¹³³ Given the CCB’s wide jurisdiction and its use of a “color-blind”

¹²⁹ *Convention on the Rights of Persons with Disabilities*, G.A. Res. 61/106, at 25(d), U.N. Doc. A/RES/61/106 (Dec. 13, 2006) [hereinafter CRPD].

¹³⁰ United Nations Enable, “United Nations Convention on the Rights of Persons with Disabilities,” online: United Nations Enable <<http://www.un.org/disabilities/default.asp?id=17>>.

¹³¹ Michael L. Perlin and Valerie McClain, “Where Souls Are Forgotten: Cultural Competencies, Forensic Evaluations, and International Human Rights” (2009) 15:4 *Psychology, Public Policy and Law* 257 at 270; Michael L. Perlin, “A Change is Gonna Come: The Implications of the United Nations Convention on the Rights of Persons with Disabilities for the Domestic Practice of Constitutional Mental Disability Law” (2009) 29 *Northern Illinois University Law Review* 483.

¹³² Michael L. Perlin and Valerie McClain, *ibid* at 270.

¹³³ CRPD, *supra* note 129; United Nations Enable, “United Nations Convention on the Rights of Persons with Disabilities,” online: United Nations Enable

approach, this reservation may be problematic in cases involving ethno-racial people with mental health disabilities.¹³⁴

Similar to the theoretical underpinnings of this study, the CRPD appears to be endorsing the social model of disability and an intersectional approach to understanding the realities faced by persons with disabilities.¹³⁵ For instance, the preamble of the CRPD states “that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others”¹³⁶ It also recognizes “difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other

<<http://www.un.org/disabilities/default.asp?id=17>>. Also, in regard 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.

¹³⁴ Ruby Dhand, *Challenging Exclusion: A Critique of the Legal Barriers Faced by Ethno-Racial Psychiatric Consumer/Survivors in Ontario*, *supra* note 128 at 77; Ruby Dhand, “Access to Justice for Ethno-Racial Psychiatric Consumer/Survivors in Ontario,” *supra* note 128. In my previous research, respondents indicated that the Consent and Capacity Board adopted a “color-blind” approach (the omission of a racial or cultural analysis). According to Carol Aylward, “the colour-blind approach to law, ignores the fact that Blacks and Whites have not been and are not similarly situated with regard to legal doctrines, rules, principles and practices.” *Canadian Critical Race Theory: Racism and the Law* (Nova Scotia: Fernwood Publishing, 1999) at 34.

¹³⁵ See for example Theresia Degener and Gerald Quinn, “A Survey of International, Comparative and Regional Disability Law Reform” in Mary Lou Breslin and Sylvia Yee (eds), *Disability Rights Law and Policy: International and National Perspectives* (New York: Transnational Publishers, 2002) at 3.

¹³⁶ CRPD, *supra* note 129, Preamble 3).

status”¹³⁷ and the “critical need to address the negative impact of poverty on persons with disabilities.”¹³⁸

3.6 Instruments Derived From International Human Rights Law

Based on the *European Convention* and the *Convention on Human Rights and Biomedicine*,¹³⁹ the Council of Europe created a checklist to assess the principles of non-discrimination, civil and political rights, promotion of physical and mental health, protection of vulnerable persons, quality of living conditions, services and treatment, least restrictive alternatives, quality of legal framework for mental health, its implementation and monitoring, and the rights and needs to those close to people with mental health disabilities.¹⁴⁰

This instrument was created for the individual member states and other interested service providers, NGOs and patient groups. It consists of indicators, which are specific questions and measures for member states that support the delivery of the principles. The methodology used to create this tool involved extensive consultation by the Council of Europe steering committee and various stakeholders.¹⁴¹ This tool is relevant to the theoretical underpinning informing the CAT as it purports a therapeutic aim and it does

¹³⁷ CRPD, *supra* note 129, Preamble p).

¹³⁸ CRPD, *supra* note 129, Preamble t).

¹³⁹ CETS No.: 164.

¹⁴⁰ Council of Europe, “Recommendation CM/Rec (2009) 3 of the Committee of Ministers to Member States on Monitoring the Protection of Human Rights and Dignity of Persons with Mental Disorder,” online: Council of Europe <[https://wcd.coe.int/ViewDoc.jsp?Ref=CM/Rec\(2009\)3&Language=lanEnglish&Ver=original&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383](https://wcd.coe.int/ViewDoc.jsp?Ref=CM/Rec(2009)3&Language=lanEnglish&Ver=original&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383)>.

¹⁴¹ *Ibid.*

ensure that issues of age, gender, culture and equitable access are included within the indicators.¹⁴² For instance, although not directly involving the legal system, the questions under non-discrimination (principle one) encourage anti-stigma campaigns, and equitable access. Under principle four, (the protection of vulnerable persons), the indicators question whether treatment plans are culturally appropriate. Similarly, principle six includes questions about whether alternative treatment plans are available and the various types of treatment facilities.¹⁴³

In Scotland, the Scottish Recovery Index (“SRI”)¹⁴⁴ has been developed to measure government accountability within social programs. There are nineteen indicators that are broken up into eight parts including: basic needs, personalized services and choice, strengths based approach, comprehensive service, service user involvement/participation, social inclusion and community integration, advance planning and a recovery focus.¹⁴⁵ However, since this tool does not involve issues within the legal system, the majority of questions and assessments are not relevant to this study.

Drawing on the *MI Principles* and the *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*, the World Health Organization has created the *Resource Book on Mental Health, Human Rights and Legislation*.¹⁴⁶ In particular, this includes a checklist, which is based on the Ten Principles of Mental Health Law,

¹⁴² *Ibid.*

¹⁴³ *Ibid.*

¹⁴⁴ Scottish Recovery Network, “Scottish Recovery Indicator,” online: Scottish Recovery Network < <http://www.scottishrecovery.net/SRI/sri.html> >.

¹⁴⁵ *Ibid.*

¹⁴⁶ World Health Organization (WHO), *WHO Resource Book on Mental Health, Human Rights and Legislation* (Geneva: World Health Organization, 2005) at 85.

which is the WHO's interpretation of the MI Principles.¹⁴⁷ The checklist was created by the WHO staff, in collaboration with the WHO faculty for legislation.¹⁴⁸ Unlike the tool that I propose to create, the checklist only applies to legislation and does not analyze the outcomes of the legislation. However, similar to the methodology for this study, the checklist takes a qualitative approach and it is more flexible¹⁴⁹ than the narrower UN principles. The checklist emphasizes using a non-discrimination¹⁵⁰ and a community-based approach.¹⁵¹ The section that is most relevant to this study is under the *Protection of Minorities*. For instance, question two states that legislation should provide “for a review body to monitor involuntary admission and treatment of minorities and ensure non-discrimination on all matters?”¹⁵² Accordingly, the CAT will explore options for ensuring non-discrimination in the implementation of Ontario's civil mental health laws.

¹⁴⁷ World Health Organization, “Ten Basic Principles of Mental Health Law,” online: World Health Organization http://whqlibdoc.who.int/hq/1996/WHO_MNH_MND_96.9.pdf.

¹⁴⁸ *Supra* note 146 at 119.

¹⁴⁹ *Supra* note 146 at 119. The introduction states, “the format of this checklist allows flexibility and aims to encourage internal debate; it thus permits countries to make decisions based on their own unique situations.”

¹⁵⁰ *Supra* note 146 at 119.

¹⁵¹ *Supra* note 146 at 119.

¹⁵² *Supra* note 146 at 153.

CHAPTER 4

METHODOLOGY

This chapter explains the methodology used to develop the CAT and the relevant literature needed to explain the qualitative methods used in this study including the grounded theory approach, the constant comparative method and the member-checking technique. In the first section of this chapter, I examine Glaser and Strauss' grounded theory approach,¹ its historical origins and the rationale for using this approach. Secondly, I describe the participants involved in the study, the research settings and the inclusion criteria for the participant recruitment process. In the third section, I outline the ethical considerations surrounding this study, issues regarding the informed consent process and the sensitivity required to understand and accommodate the interviewing needs of people with mental health disabilities and the other participants involved.

In the fourth and fifth sections of this chapter, I explain the interview and analytical procedures involved, including a discussion of Glaser and Strauss' constant comparative method² and the use of memo-writing. Lastly, I explain how I increased the rigour of the study through an expert review of the CAT involving the qualitative

¹ Barney Glaser and Anselm Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (New York: Aldine de Gruyter, 1967). It is important to note that differences arose between Glaser and Strauss' adaptations of grounded theory in their later works. However, I use the tenets of grounded theory, as jointly described by Glaser and Strauss in this book, and I also refer to Glaser's later works, which are consistent with the original tenets of grounded theory.

² *Ibid.*

technique of member checking and adopting Lincoln and Guba's framework for "trustworthiness."³

4.1 Development of the CAT

I developed the CAT through an iterative and flexible process involving a comprehensive review of the literature⁴ and qualitative data drawn from interviews with seven members of each of the following groups: (1) ethno-racial people with mental health disabilities including in-patients and ex-patients, (2) lawyers who practice in the area of mental health law, (3) health care professionals including psychiatrists, nurses and social workers, (4) service providers such as front-line case workers at mental health agencies and (5) adjudicators, government advisors and academics. The theoretical framework and the analysis of the jurisprudence, applicable statutory provisions and legal processes literature on the existing legislative tools and applicable international laws were used to inform the qualitative data collection stage of research including the interview guide, the interview process and the data analysis procedure. Further, the jurisprudence, applicable statutory provisions and legal processes relevant to the implementation of the laws were analyzed.

My research question warranted a methodology that privileged the participants' perspectives and their experience interacting with Ontario's civil mental health laws. Therefore, I chose to use an interpretive paradigm, seeking to understand people's

³ Yvonna Lincoln and Egon. C Guba, *Naturalistic Inquiry* (Newbury Park, CA: Sage Publications, 1985) at 290.

⁴ This includes the theoretical framework consisting of the institutional racism paradigm, the social model of disability, the intersectional approach and cultural considerations on mental health law. The literature review includes an analysis of the jurisprudence, applicable statutory provisions and legal processes, the existing legislative evaluative tools for mental health legislation, and the applicable international laws.

interpretations and perceptions holistically through the theoretical underpinnings of approaches offered by grounded theory approach and symbolic interactionism.⁵

4.1.1 Grounded Theory Approach

In order to analyze the qualitative data, this study used Glaser and Strauss' grounded theory approach,⁶ along with symbolic interactionism, and tenets from the theoretical framework and literature review previously described. As a methodology, grounded theory is a “way of arriving at theory suited to its supposed uses.”⁷ Grounded theory involves systematic data collection, analysis and development of theory through precise analytical procedures. It is a rigorous qualitative methodology used to increase knowledge, provide exploratory research and discover new theories about a phenomenon under study.⁸

The hypotheses and concepts arise from the data during the course of the research, while the source of certain ideas may come from theories and models outside of the data itself.⁹ By developing a “general and abstract theory grounded in the views of the participants,”¹⁰ the researcher inductively derives a theory by systematically collecting interview data and analyzing the data using various methods to explore social

⁵ Judith Green and Niki Thorogood, “Qualitative Methodology and Health Research” in *Qualitative Methods for Health Research, 2nd Edition* (London: Sage Publishing, 2009) at 14-15.

⁶ *Supra* note 1.

⁷ *Supra* note 1 at 6.

⁸ *Supra* note 1 at 8.

⁹ *Supra* note 1.

¹⁰ Sarah Hartley and Mohammad Muhit, “Using Qualitative Research Methods for Disability Research in Majority World Countries” (2003) 14.2 *Asia Pacific Disability Rehabilitation Journal* 103 at 105.

processes.¹¹

i) Historical Origins: Symbolic Interactionism

Grounded theory was derived from symbolic interactionism. As Blumer emphasizes,¹² symbolic interactionism has three major tenets:

- 1) Human beings act towards things on the basis of the meanings that the things have for them.
- 2) The meanings of things arise out of the social interaction one has with one's fellows.
- 3) The meanings of things are handled in and modified through an interpretative process used by the person in dealing with the things he encounters.¹³

Accordingly, symbolic interactionism aims to analyze participants' interpretations of their interactions with the social world.¹⁴ In this vein, both symbolic interactionism and grounded theory recognize that "there can be multiple non-contradictory descriptive and explanatory claims about any phenomenon."¹⁵ Grounded theory builds upon symbolic interactionism by recognizing that concepts gain significance through their emergent meanings and their relationships with other concepts through an ongoing comparative procedure.¹⁶ In order to develop theory, researchers must critically assess the meanings of the participants' views and their own predispositions and biases towards the phenomenon being examined.

¹¹ *Ibid.*

¹² Herbert Blumer, *Symbolic Interactionism: Perspective and Method* (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1969) at 20.

¹³ *Ibid.*

¹⁴ *Ibid.*

¹⁵ M. Hammersley, *The Dilemma of Qualitative Method: Herbert Blumer and the Chicago Tradition* (Routledge: London, 1989) at 135.

¹⁶ *Ibid.*

ii) Rationale for Using the Grounded Theory Approach

Given its historical roots in symbolic interactionism, I chose to use the grounded theory approach in the development of the CAT because it recognizes that participants interpret variables differently based on their individual life experiences and the meanings they attach to these experiences.¹⁷ I was able to explore the phenomenon, while actively questioning my own predisposed biases, gender, culture, age and social status relative to those interviewed. Thus, I was reflexive by striving not to claim generalizations, by questioning the assumptions I have brought to the research, and my understandings of the participants' cultural backgrounds.

Grounded theory also enfranchises the study participants by ensuring that the relevant concepts, issues and ideas emerge from within the interviews and the data collection process itself.¹⁸ The participant groups have unique relationships and experiences to each other and to the phenomenon being studied. In this regard, I have drawn upon the works of previous scholars who have used critical theoretical frameworks to inform their use and development of the grounded theory approach. For instance, Maria Malagon et al. attempt to situate the grounded theory approach within tenets of critical race theory and they align the goals of both frameworks.¹⁹ They suggest that traditional research methodologies may ignore the inherent power structures between the researcher and the research participants and the complexities of the participants' lived

¹⁷ *Supra* note 5 at 14-15.

¹⁸ Jo Reichetz, "Abductor: The Logic of Discovery of Grounded Theory" in Antony Bryant and Kathy Charmaz, eds., *The SAGE Handbook of Grounded Theory* (SAGE Publications: Los Angeles, 2007) 214 at 215.

¹⁹ Maria C. Malagon, Lindsay Perez Huber and Veronica N. Velez. "Our Experiences, Our Methods: Using Grounded Theory to Inform a Critical Race Methodology" (2009-2010) 8 *Seattle J. Soc. Just.* 253 at 254.

experiences, by focusing primarily on the findings' external validity.²⁰ Accordingly, adopting a grounded theory approach in tandem with other critical theoretical frameworks has the “potential to be a tool for social change,”²¹ by being “critically sensitive.. to situate lived experience within a broader socio-political frame - both in the final research product and throughout the entire research process.”²²

As I developed the CAT, the grounded theory approach was used along with tenets of the theoretical framework (including the institutional racism paradigm, the social model of disability, intersectionality and cultural considerations in mental health law) to understand and examine the participants' perceptions of how culture and equity pertaining to ethno-racial people with mental disabilities can be incorporated into the implementation of Ontario's civil mental health laws. I was able to use the theoretical frameworks described in Chapter Two to constantly question the systemic and structural power hierarchies at play behind the legal processes and the mental health system.

4.1.2 Participants: Setting, Inclusion Criteria and Recruitment

The interviews were conducted in Toronto since the majority of CCB hearings take place in Toronto.²³ Also, there are a large number of people with mental health disabilities from various ethno-racial communities,²⁴ and the Centre for Addiction and

²⁰ *Ibid* at 253.

²¹ *Ibid* at 254.

²² *Ibid* at 253.

²³ Interview with an adjudicator, 2011.

²⁴ Statistics Canada, *Population Projections of Visible Minority Groups, Canada, Provinces and Regions 2001 to 2017*, online: Statistics Canada <<http://www.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=91-541-XIE&lang=eng>>; Centre for Addiction and Mental Health, *Research Report 2002/2003* (Toronto: Centre for Addiction and Mental Health, 2003) at 54; Mental Health Commission of Canada and CAMH, “Improving Mental Health Services for Immigrant, Refugee, Ethno-Cultural and Racialized Groups: Issues and Options for Service Improvement” (November 2009) at 4

Mental Health (CAMH) in Toronto is Canada's largest psychiatric institution.²⁵ The participant groups included (1) ethno-racial people with mental health disabilities including in-patients and ex-patients, (2) mental health lawyers, (3) health care professionals including psychiatrists, nurses and social workers, (4) service providers such as front-line case workers at mental health agencies and (5) adjudicators, government advisors and academics. I chose participants according to their function within the Consent and Capacity Board pre-hearing, hearing and post-hearing legal processes and the broader mental health system in accordance to the specific inclusion criteria.

Recruitment commenced once ethics approval was obtained from York University's Human Participants Review Sub-Committee in the Office on Research Ethics,²⁶ and CAMH's Research Ethics Board.²⁷ I interviewed thirty-five people (seven of each of the participant groups). This is an acceptable sample size to reach "data saturation," which refers to the point at which the researcher is not gathering new information from the participants or observing new themes from the data.²⁸ Creswell for

online: Mental Health Commission of Canada<http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2010/Issues_Options_FINAL_English%2012Nov09.pdf>;

²⁵ Centre for Addiction and Mental Health, "About CAMH" online: CAMH http://www.camh.net/About_CAMH/index.html; accessed 21 April 2012. The interviews were conducted primarily in Toronto and the findings of this study might have varied if there were interviews conducted in rural areas of Ontario. In light of these limitations, these findings are not conclusive statements and they are grounded in the views of the respondents.

²⁶ I received ethics approval from the York University's Human Participants Review Sub-Committee in the Office on Research Ethics on February 10, 2011.

²⁷ I received ethics approval from the CAMH Research Ethics Board on June 21, 2011.

²⁸ Ryan and Bernard suggest that data saturation depends on "1) the number and complexity of data, 2) investigator experience and fatigue and 3) the number of analysts reviewing the data." Gery W. Ryan and H. Russel Bernard, "Techniques to Identify

example, recommends interviewing between five and thirty-five participants for researchers using the grounded theory approach.²⁹

The inclusion criteria for the mental health lawyers, health care professionals, service providers, adjudicators, government advisors and academics included:

1. Licensed mental health lawyers, health care professionals, service providers adjudicators, government advisors and academics in Ontario.
2. Experience working with ethno-racial people with mental health disabilities.

The potential participants were identified through the advice of my supervisors, informal networking with my colleagues in the area of mental health law and mental health support services and subsequent “snowball sampling,” which involved requesting initial contacts to refer me to their peers working in the same area.³⁰ A purposive approach was used to select participants according to pre-determined criteria relevant to the research objectives.³¹

To gain access to the ethno-racial people with mental health disabilities (in-patients) at CAMH, I advertised the study at CAMH.³²

The inclusion criteria for in-patients being interviewed were:

Themes” (2003) 15 *Field Methods* 85 at 90. See also, Greg Guest, Arwen Bunce and Laura Johnson, “How Many Interviews Are Enough? An Experiment with Data Saturation and Variability” (2006) 18.1 *Field Methods* 59.

²⁹ John Creswell, *Qualitative Inquiry and Research Design: Choosing Among Five Traditions* (Sage: Thousand Oaks, 2008) at 67.

³⁰ Antony Bryan and Kathy Charmaz (eds), *The Sage Handbook of Grounded Theory* (London: Sage, 2007) at 605.

³¹ Greg Guest, Arwen Bunce and Laura Johnson, “How Many Interviews Are Enough? An Experiment with Data Saturation and Variability” (2006) 18.1 *Field Methods* 59 at 61

³² As per the CAMH ethics guidelines, “those who have a treating relationship with the prospective subject must not obtain consent.” Thus, psychiatrists and caseworkers were only able to notify the in-patients of the study. CAMH, “Standard Operating Procedures for Obtaining Consent for a Research Study at CAMH” online: CAMH Research Ethics <http://www.camh.net/Research/Research_ethics/protocol_forms_guidelines.html>.

- 1) Ethno-racial person with a mental health disability in Ontario.
- 2) Has been through a CCB hearing within the last three years (2007-2010).
- 3) Over the age of 18 years.
- 4) Willing to participate in the interview process.
- 5) Able to speak English.³³

I also advertised the study within mental health organizations including Across Boundaries – An Ethno-racial Mental Health Centre , Hong Fook Mental Health Association and Sound Times Support Services in Toronto to recruit ex-patients outside of CAMH. The inclusion criteria for ex-patients being interviewed were the same those for in-patients.

4.1.3 Ethical Considerations

Ethical considerations were addressed throughout the study in order to ensure that research participants understood the informed consent process and the ethical standards regarding privacy and confidentiality. Before proceeding with the recruitment process, I obtained ethics approval through both York University's Human Participants Review Sub-Committee in the Office on Research Ethics,³⁴ and CAMH's Research Ethics Board.³⁵ I also completed the Tri-Council's Tutorial Course on Research Ethics and I received a certificate of completion, which was submitted to both York University and

³³ Exclusion criteria: not considered stable by their treatment team.

³⁴ I received ethics approval from the York University's Human Participants Review Sub-Committee in the Office on Research Ethics on February 10, 2011.

³⁵ I received ethics approval from the CAMH Research Ethics Board on June 21, 2011.

CAMH.³⁶

Since this study deals, in part, with a vulnerable population in an area of differential treatment, I followed the rigorous procedures stipulated in CAMH's ethics guidelines when interviewing in-patients and ex-patients at CAMH. For instance, the Standard Operating Procedures (SOP) states that "if there is doubt about an individual's competency to provide fully informed consent, a competency assessment should be performed by a psychiatrist who is not associated with the study."³⁷ Secondly, "those who have a treating relationship with the prospective subject must not obtain consent. Instead, the patient can be asked for permission for someone without a treating relationship to approach him/her to discuss the study."³⁸ In addition, seventeen other CAMH SOPs, along with their accompanying ethics guidelines were followed throughout this study.³⁹

Prior to formally beginning each interview with each participant, I explained the purpose and objectives of my research and the informed consent process. As required by the ethics' guidelines, I presented each participant with a written consent form. I reviewed the consent form with participants and invited them to ask questions if necessary. The participants were given as much time as they needed to review the documentation before being asked to give consent and they had the option to opt out of the interview procedure at anytime before or during the interview.

³⁶ This was handed in as part of the forms to York University's Human Participants Review Sub-Committee and CAMH's Research Ethics Board. See Government of Canada, "The TCPS 2 Tutorial Course on Research Ethics (CORE)" online: <http://www.pre.ethics.gc.ca/eng/education/tutorial-didacticiel/>; accessed April 20, 2011.

³⁷ CAMH Ethics, *supra* note 32.

³⁸ CAMH Ethics, *supra* note 32.

³⁹ CAMH Ethics, *supra* note 32.

After the interview data were collected, stringent measures were taken to ensure anonymity and confidentiality of the information. For instance, the digitalized tapes and transcripts of the data were kept confidential. These data were stored on computerized files and secured by a protected password server. Regarding privacy, participants are identified in this thesis only with reference to their participant group name (i.e. ethno-racial person with a mental health disability, lawyer, health care professional, service provider, adjudicator, government advisor or academic).

4.1.4 Data Collection

i) Interview Process

I conducted interviews with the participant groups using semi-standardized interview/topic guides. These are attached as Appendices C to G. The topic guide was informed by the literature review on the existing legislative tools, the theoretical orientation underlying this study, discussions with my supervisory committee and colleagues in the area and my own personal experiences advocating on behalf of people with mental health disabilities.

The interviews were completed over a one-year period. To be flexible and responsive to individual participant's needs, the interviews took place in a location of the participant's choosing or necessity (e.g. in hospital if the participant was hospitalized). For instance, I interviewed some participants, including both ethno-racial people with mental health disabilities and health care professionals, at the Centre of Addiction and Mental Health (CAMH) in Toronto because it was accessible for them.

The interviews lasted approximately forty-five minutes to an hour long, but I accommodated the participants' needs as required. With participant consent, a digital

recording device was used so that the interviews could be transcribed and analyzed in further detail afterwards. As well, detailed notes of the interview were taken during and after the interview. Throughout the research process, I also took part in a reflexive process. In a journal, I recorded my initial thoughts, assumptions and personal feelings about the topic and my initial reactions to the interviews.

During the interviews, I strived to create a comfortable and safe environment for the participants. In this regard, I had to be flexible to accommodate the needs of the participants, often taking breaks and modifying questions if necessary. The semi-structured and open-ended approach to interviewing not only allows for some structure in presenting the topics and questions, but also enables flexibility in participants' responses.⁴⁰ As such, participants were encouraged to talk about their own experiences and perceptions regarding the questions. If participants chose to raise other issues, topics or examples, I pursued this with further questions and curiosity. For some of the participants with mental health disabilities, I often took extra caution, empathy and time and used empathy to explain the informed consent process and then ask the questions, depending on their individual comfort levels. In one case, the participant was experiencing the effects of medication and the interview had to be conducted in separate parts. Thus, I tried my best to prioritize the participants' needs during the interview process in a sensitive manner.

⁴⁰ Ruth E. Fassinger, "Paradigms, Praxis, Problems, and Promise: Grounded Theory In Counseling Psychology Research" (2005) 52 *Journal of Counseling Psychology* 156 at 160.

ii) Observations

Throughout the data collection stage, I attended weekly CCB hearings⁴¹ involving ethno-racial people with mental health disabilities. With the support of my colleagues from the Mental Health Legal Committee of Ontario,⁴² I was given access to the case materials and I was often able to observe the pre-hearing meetings between the lawyer and the client. I was also able to observe the client's interactions with health care professionals and CCB adjudicators before the hearings began. During the hearings, I examined and documented the subtle nuances of the legal proceedings and how issues of equity pertaining to ethno-racial people with mental health disabilities were addressed.

4.1.5 Analytical Procedures

The data gathering, transcription and data analysis processes occurred concurrently. The qualitative data were analyzed using the grounded theory approach⁴³ and elements of the theoretical framework described in Chapter Two. In law, the use of grounded theory enables the researcher to have an “open methodology” using a variety of theories from other disciplines, which allows the legal researcher to “move forward in addressing the needs of the population.”⁴⁴ There is an underlying assumption that legal norms and structures can be changed because reality is socially constructed.⁴⁵

In particular, the analysis of the data involved a number of stages. First, I

⁴¹ I attended approximately thirty CCB hearings.

⁴² A committee comprised of mental health lawyers advocating on behalf of people with mental health disabilities in Ontario.

⁴³ *Ibid.*

⁴⁴ Agnette Weis Bentzon, Anne Hellum, Julie Stewart, Welshman Ncube and Torben Agersnap, *Pursuing Grounded Theory in Law: South-North Experiences in Developing Women's Law* (Oslo: Mond Books, 1998) at 25.

⁴⁵ *Ibid* at 244.

personally transcribed the thirty-five interviews verbatim in order to familiarize myself and engage with the data. Although this was an extremely time consuming and challenging process, it became invaluable to the interpretation of the data afterwards. As some scholars suggest, the process of transcription itself is “a key phase of data analysis within interpretative qualitative methodology”⁴⁶ because it is an “interpretative act where meanings are created.”⁴⁷ In this respect, the transcription process enabled me to immerse myself into the interview data and fully appreciate the complexity of the data. Secondly, I continued to re-read and engage with the data and the secondary literature. As initial themes emerged, I continued to record these in my journal. This stage led to the analysis of the qualitative data using Glaser and Strauss’ constant comparative method,⁴⁸ a valuable analytical procedure within the grounded theory approach.

i) Constant Comparative Method and Analysis

While the grounded theory approach is flexible in nature, the constant comparative method consists of explicit guidelines to analyze qualitative data. These guidelines are described in Glaser and Strauss’ constant comparative method.⁴⁹ According to Glaser and Strauss, there are four steps to the constant comparative method:

1) comparing incidents applicable to each category 2) integrating categories and their properties 3) delimiting the theory and 4) writing the theory. Although this method of generating theory is a continuously growing process –each stage after a time is transformed into the next – earlier stages do remain in operation

⁴⁶ C.M. Bird, “How I Stopped Dreading and Learned to Love Transcription” (2005) 11 *Qualitative Inquiry* 226 at 227.

⁴⁷ Virginia Braun and Victoria Clarke, “Using Thematic Analysis in Psychology” (2006) 3 *Qualitative Research in Psychology* 77 at 87-88.

⁴⁸ *Supra* note 1 at 105

⁴⁹ *Supra* note 1 at 105.

simultaneously throughout the analysis and each provides continuous development to its successive stage until the analysis is terminated.⁵⁰

This method enabled me to compare and contrast ideas within one transcribed interview to another. The result of this comparison, referred to as “coding” was written in the margins of each interview. A code is defined as “the essential relationship between data and theory.”⁵¹ Glaser defines coding as “conceptualizing data by constant comparison of incident with incident, and incident with concept.”⁵² Accordingly, there are two types of analytical coding techniques within the constant comparison method. These are 1) substantive coding and 2) theoretical coding. Substantive coding occurs when the researcher conducts a line-by-line analysis of the data to identify the key themes and concepts.⁵³ These themes and concepts are then translated into short code words or phrases.⁵⁴ This process enabled me to identify and recognize the categories and sub-categories (themes) emerging from the data. There was constant re-visitation to the data so that the categories and findings were refined until I reached “theoretical saturation” of each category. Theoretical saturation occurred when there was no new data found within a category.⁵⁵ These themes are presented in Chapter Five.

In the theoretical coding phase, I further examined the saturated categories and weaved them together to develop a general hypothesis and theory about the data. As

⁵⁰ *Supra* note 1 at 105.

⁵¹ Barney Glaser, *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory* (Mill Valley, CA: Sociology Press, 1978) at 55.

⁵² Barney Glaser, *Emergence v. Forcing Basics of Grounded Theory Analysis* (Mill Valley, CA: Sociology Press, 1992) at 38.

⁵³ Hsia-Yu Chen and Jennifer RP Boor, “Using a Synthesized Technique for Grounded Theory in Nursing Research” (2009) 18 *Journal of Clinical Nursing* 2251 at 2258.

⁵⁴ *Ibid* at 2258.

⁵⁵ *Supra* note 1 at 112.

Glaser describes, “the grounded theory mandates the [theoretical codes] to formulate a conceptual theory that explains how a problem is continually processed by the participants.”⁵⁶ This evolutionary and iterative process enabled me to examine the conceptual relationships between the categories, while continuing to constantly compare the data.⁵⁷ I also responded to the meanings within the data by comparing and relating them to the tenets of the theoretical framework and the secondary literature. As Glaser recognizes, “in an emerging integration of categories and properties, [researchers] may begin to review the literature in the substantive field and relate it to their own work in many ways.”⁵⁸

ii) Reflexivity

Throughout the analytical process, I used reflexivity to situate the research within the broader social and political field, and to ensure I was not making generalizations and stereotypes within my analysis.⁵⁹ Using reflexivity within the grounded theory approach enabled me to reflect upon my own pre-disposed biases and knowledge throughout the research process. Specifically, I am South Asian and an advocate for people with mental health disabilities.

According to Hammersley and Atkinson, reflexivity suggests the following:

The orientations of researchers will be shaped by their socio-historical locations, including the values and interests that these locations confer upon them. What this represents is a rejection of the idea that social research is, or can be, carried out in some autonomous realm that is insulated from the wider society and from the particular biography of the researcher, in such a way that its findings can be unaffected by social

⁵⁶ *Supra* note 52 at 69.

⁵⁷ *Supra* note 51 at 57.

⁵⁸ *Supra* note 52 at 32.

⁵⁹ Linda Finley, “Outing” the Researcher: The Provenance, Process and Practice of Reflexivity” (2002) 12:4 *Qualitative Research* 531 at 532.

processes and personal characteristics.⁶⁰

This lens enabled me to personally reflect upon how my own pre-disposed biases, cultural context, life experiences, profession, and relationship dynamic with the participant impacted the interviews, the subsequent reporting of them and the data interpretation.⁶¹

ii) Memo Writing

Memo writing was an invaluable part of the analytical process and the development of the CAT. I was consistently journal writing and memoing the ideas that emerged from the data and their relevance to the theoretical framework and secondary literature. According to Glaser, "Memos are the theorizing write-up of ideas about substantive codes and their theoretically coded relationships as they emerge during coding, collecting and analyzing data, and during memoing."⁶² In order to facilitate the development of the CAT, I began writing memos after the initial interview process and throughout the data collection and constant comparative procedure. Subsequently, drawing from the theoretical framework and the literature, I was able to add insights into the categories that emerged from the data into the memos. For instance, I often added specific cases, legislation and theoretical insights to the emerging themes and categories within the data.⁶³ The process of memo writing made it easier for me to identify patterns and

⁶⁰ Martyn Hammersley and Paul Atkinson, *Ethnography: Theory and Practice*, 2nd edition (London: Routledge, 1995) at 16-17.

⁶¹ *Ibid.* and Douglas Macbeth, "On Reflexivity in Qualitative Research: Two Readings and a Third" (2001) 7.1 *Qualitative Inquiry* 35 at 38.

⁶² Barney Glaser, *Doing Grounded Theory: Issues and Discussion* (Mill Valley, CA: Sociology Press, 1998) at 108.

⁶³ According to Sandelowski, researchers must be rigorous and insightful when analyzing and interpreting qualitative data. She suggests, "qualitative research.. always requires moving somewhere: that researchers make something of their data." Margarete

relationships between the categories, while synthesizing and integrating the relevant materials. At times, the data also required me to question and challenge the secondary sources including legislation, case law, academic and theoretical literature. The insights and analysis within the memos formed the basis of the results and analysis of this study.⁶⁴

After the data were analyzed and the memos were complete, I sorted them according to a theoretical outline based on themes, which facilitated the writing process. In this regard, sorting was the final emergent step in grounded theory as it ensured that data were compiled with the relevant literature vis-à-vis each theme, and the thematic data were placed under the appropriate theme.

Throughout the analytical, memo writing and final writing processes, I found the following guidelines suggested by Glaser⁶⁵ particularly useful:

1. Tolerate confusion - there is no need to know *a priori* and no need to force the data.
2. Tolerate regression- researchers might get briefly 'lost' before finding their way.
3. Trust emerging data without worrying about justification - the data will provide the justification if the researcher adheres to the rigour of the method.
4. Have someone to talk to - grounded theory demands moments of isolation to get deep in data analysis and moments of consultation and discussion.

Sandelowski, "What's in a Name: Qualitative Description Revisited?" (2010) 33 *Research in Nursing and Health* 77 at 79.

⁶⁴ It is important to note that Glaser does not encourage drawing logic diagrams and/or integrative memos because "this nondimensional typology undermines the simplicity and trust in grounded theory. It does not help in grounded theory to fracture memos like this. The grounded theorist just writes memos as formulated by the emergent theory, and the memos change the way they look at each stage." Barney Glaser, *supra* note 52 at 108.

⁶⁵ Barney Glaser, *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*, *supra* note 51; Barney Glaser, *supra* note 62; Barney Glaser, *The Grounded Theory Perspective: Conceptualization Contrasted with Description* (Mill Valley, CA: Sociology Press, 1978).

5. Be open to emerging evidence that may change the way the researcher thought about the subject matter, and to act on the new evidence.
6. Be able to conceptualise to derive theory from the data.
7. Be creative - devising new ways of obtaining and handling data, combining the approach of others, or using a tested approach in a different way.⁶⁶

iii) Limitations of the Study

The limitations of this study include the sample size, the participants and the location. In regard to sample size, there were thirty-five participants interviewed and approximately nineteen participants involved in the focus groups. Thus, it is not possible to make conclusive statements from the empirical evidence and these findings are grounded in the views of the participants. The participants' were chosen because of their particular role within the Consent and Capacity Board pre-hearing, hearing and post-hearing legal processes and the broader mental health system in accordance to the specific inclusion criteria. The sample was not intended to be representative of all of Ontario's demographics, and I cannot make generalizations regarding a specific ethno-racial community. Further, I did not include Aboriginal people with mental health disabilities in the sample because it was beyond the scope of this study.⁶⁷ Lastly, it is

⁶⁶ These are drawn from Glaser's books (1978, 1998, and 2001) and written by Walter Fernandez, "Using the Glaserian Approach in Grounded Studies of Emerging Business Practices" (2004) 2:2 *Electronic Journal of Business Research Methods* 83 at 91; Barney Glaser, *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*, *supra* note 51; Barney Glaser, *Doing Grounded Theory: Issues and Discussion*, *supra* note 62; Barney Glaser, *The Grounded Theory Perspective: Conceptualization Contrasted with Description*, *ibid*.

⁶⁷ The study did not include Aboriginal people with mental health disabilities due to the lack of Aboriginal clients at CAMH accessing mental health services, the unique methodology involved in conducting a study with Aboriginal communities and the distinct ethics procedures required. The experiences of Aboriginal people with mental health disabilities interacting with Ontario's civil mental health system is an important topic for future consideration and research.

important to note that the interviews were conducted primarily in Toronto and the findings of this study might have varied if there were interviews conducted in rural areas of Ontario.

Despite these limitations, the strengths and advantages of the study should be acknowledged. The study's limited sample size enabled me to provide an in-depth analysis and portrait of the participants' perceptions and narratives. I was able to work with a wide variety of qualitative data, drawn from a number of important perspectives and lived experiences. Another strength of the study was the participants' enthusiasm to contribute to the creation of the CAT through the interview or focus group process, their level of candor and the quality of information provided vis-à-vis their particular experiences. Participants were eager to convey their experiences, stories and recommendations of how to improve legal processes and the mental health system, and this study provided them an opportunity for expressing their views.

4.1.6 Rigour

i) Expert Review of the CAT: Using the Member-Checking Technique

I increased the rigour of the study and refined the items in the CAT through an expert review involving the qualitative technique of member-checking. By shifting the verification procedure from the researchers to the participants, member-checking “consists of taking data and interpretations back to the participants in the study so that they can confirm the credibility of the information and narrative account.”⁶⁸ Although this procedure did not result in a final verification of the tool, this procedure was used to check participants' responses and the credibility of the tool. The member checking

⁶⁸ *Supra* note 67 at 127.

method fostered the “iterative process of re-examining initial findings with regards to queries brought about by the addition of further data. In this way, member checks are stimuli for critical inspections, ongoing analyses, additional interrogation of data and new understandings of topics, practices which ultimately bolster the integrity of research.”⁶⁹

Using this method, I conducted the expert review using three focus groups (in addition to the interviews) comprised of ethno-racial people with mental health disabilities, mental health lawyers and health care professionals (ie. psychiatrists, nurses and social workers.) Participants for the focus group included those who had already been interviewed in the study. It is important to note that the interviews were conducted from April 2011 to November 2011, and the focus groups were conducted from November 2011 to February 2012. I facilitated the focus groups, along with an external participant to ensure objectivity. The external participant, who was a colleague, was involved in the focus group as a note-taker and observer. Using focus group methodology,⁷⁰ I attempted to ensure homogeneity in the focus group composition by selecting participants that have shared characteristics (profession, and occupational status).⁷¹

The first focus group I conducted was for ethno-racial people with mental health disabilities. This was organized with the support of the Empowerment Council, a non-profit advocacy-oriented organization that is funded by the Centre for Addiction and Mental Health (CAMH). This focus group, which included seven participants, was held at CAMH, given its accessibility for in-patients and ex-patients. Similarly, I organized a

⁶⁹ Sarah Turner and Stephanie E. Coen, “Member checking in Human Geography: Interpreting Divergent Understandings of Performativity in a Student Space” (2008) *Royal Geographical Society* 1 at 4.

⁷⁰ Pascale Lehoux, Blake Poland and Genevieve Daudelin, “Focus Group Research and the Patient’s View” (2006) 64 *Social Science and Medicine* 2091 at 2093.

⁷¹ *Ibid.*

focus group for health care professionals including psychiatrists, nurses and social workers, with the support of Dr. Kwame McKenzie at CAMH. There were five participants who attended. Lastly, I organized a focus group for mental health lawyers. There were seven participants in this focus group and it was held at the ARCH Disability Law Centre, a community legal clinic in Ontario that specializes in advocating for people with physical and mental disabilities.

The focus group sessions were approximately two hours long. They were conducted in relaxed and comfortable settings that were most accessible for the participants. I provided refreshments for all the participants (i.e. water, coffee, tea, juice, cookies, vegetables and fruit) and I ensured that they were seated around a round table to facilitate an open dialogue. In each focus group, I began by explaining the informed consent process and I ensured all of the participants had given me their written consent to participate. I proceeded to outline the purpose of my research and research questions, the methodology, theoretical framework and literature review underlying the development of the CAT. After the initial introductions, I presented a draft of the CAT to each participant and I explained the interpretations of the themes that had emerged from the analytical process. Using a semi-structured focus group moderator guide,⁷² I presented each theme separately to ensure that participants were able to engage in the “member checking” process, as well as feel comfortable to present their views and perceptions openly. I inquired further into certain issues by raising questions and facilitating the group’s interactions. It is important to note that the moderator guide was modified to accommodate the particular needs of each focus group. For instance, given the sensitive

⁷² *Ibid.*

nature of the topic, I explained the legal concepts underlying this research in plain language in the focus group for ethno-racial people with mental health disabilities.

Throughout the focus groups, the note-taker and I took extensive notes and I used a digital recording device. Afterwards, I transcribed and analyzed the focus group data using Glaser and Strauss' grounded theory approach previously described. However, there was a distinction. When coding and analyzing the focus group data, I was aware of how the group dynamic affected the participants and I coded the interaction process between the research participants. Thus, I distinguished between the participants' opinions and I identified the specific interactions and discussions participants were having in the group settings throughout the analysis and writing process. As Smithson suggests,

Opinions stated in the groups should be viewed not as previously formed, static things which people brought to the focus group, but as constructed in social situations. Neither should these opinions be treated as "belonging" to individuals with the group, or as opinions held by the whole group, but as discourses which emerge in this context.⁷³

The results of the interviews were described and contextualized in Chapter Five. Chapter Six applies the relevant secondary sources and focus group data to the results of the interviews. This analysis created and developed the CAT.

ii) Trustworthiness

Along with the member checking technique, Lincoln and Guba's criteria were used to evaluate the "trustworthiness" of the qualitative inquiry and increase the rigour of

⁷³ Janet Smithson. *Using and Analyzing Focus Groups: Limitations and Possibilities* (2000) 3:2 International Journal of Social Research Methodology 103 at 116.

this study. ⁷⁴According to them, “trustworthiness” contains four criteria: 1) credibility, 2) transferability, 3) dependability and 4) confirmability. ⁷⁵ These criteria are fundamental to evaluating qualitative research. They have suggested a variety of methodological strategies to ensure the “trustworthiness” of qualitative research, which are given in the table below:

Lincoln and Guba’s Criteria for Evaluating Qualitative Research⁷⁶

Criteria	Methods to Ensure Trustworthiness
Credibility	Triangulation; Member-checking; Peer debriefing; Prolonged engagement in the field
Transferability	Thick description to convey the findings
Dependability	Inquiry audit
Confirmability	Audit trail; triangulation and reflexivity

Using Lincoln and Guba’s framework, I used a variety of the methodological strategies suggested to increase the rigour of this study. First, to ensure the *credibility* of the findings, I used the strategies of triangulation, member-checking, peer debriefing and prolonged engagement. Specifically, triangulation is defined as “a validity procedure where researchers search for convergence amongst multiple and different sources of information to form themes or categories in a study.”⁷⁷ To practice triangulation, I

⁷⁴ Yvonna Lincoln and Egon. C Guba, *Naturalistic Inquiry* (Newbury Park, CA: Sage Publications, 1985).

⁷⁵ *Ibid.*

⁷⁶ *Ibid.* at 290.

⁷⁷ *Supra* note 67 at 127.

collected data using multiple methods such as interviews, focus groups, observations of CCB hearings and interdisciplinary literature. During the focus groups, the participants further engaged in the member checking technique to refute and verify various parts of the interpretation and development of the CAT. This process ensured that the findings were true to their original data set and the items within the CAT were refined according to their perceptions.

Throughout the past three years of this study, I have had prolonged engagement within the research settings and with the research participants. I have actively attended CCB hearings as an observer and I have learned about the complexities of the legal process from my colleagues working in mental health law. During this time, I have also had my peers review my research design, methodology and analytical interpretations. Through my involvement and participation in courses at the University of Toronto's Centre for Critical Qualitative Health Research and Osgoode's Graduate Seminar, I was able to meet and form study groups with other graduate students, who were conducting grounded theory studies in the mental health context or working with vulnerable populations.

Secondly, to ensure the *transferability* of the findings, I used *thick description*. In this respect, I conveyed the findings of the interview and focus group data using descriptive details, quotations and narratives of the participants' perceptions. I strived to ensure that Chapters Five and Six were written in plain language and accessible to all readers. Third, in accordance with Lincoln and Guba's criterion of *dependability*, I had my supervisory committee members examine the appropriateness of the research design,

coded interview data and analysis, and I documented all of the stages of data analysis throughout the study for future external scrutiny. Lastly, to meet the criterion of *confirmability*, I actively participated in the reflexivity and self-reflection process and I clarified the biases I had brought to the study. Further, I triangulated my findings and I kept an *audit trail*, which describes the research process, the research design and the findings of the study in a transparent and simple manner.

CHAPTER 5

RESULTS

5. Introduction

This chapter describes the emergent themes, categories, sub-categories and narratives from an analysis of the qualitative data. The data are drawn from interviews with seven members of each of the following groups of respondents: (1) ethno-racial people with mental health disabilities including in-patients and ex-patients, (2) lawyers who practice in the area of mental health law, (3) health care professionals including psychiatrists, nurses and social workers, (4) adjudicators, government advisers and academics and (5) service providers such as front-line case workers at mental health agencies.¹ As described in the methodology chapter, the following results arose through an in-depth analysis of the qualitative data using the grounded theory approach.

The results are presented and examined according to each participant group and the CCB's pre-hearing, hearing and post-hearing processes. The major sections and themes include: role of practitioners, language/communication, the pre-hearing process, the CCB hearing, the post-hearing process, human rights in the hospital, access to culturally appropriate treatment and care, religious accommodation, accountability, power, admission to long term care facilities, legislative reform, research initiatives, CCB adjudicators, training and education. Within each emerging theme and subsection,

¹ The results from the 1) adjudicators, academics and government advisers and 2) service providers are presented and examined together in section 5.4, given similarity of results, responses and emerging themes within the analysis of the transcribed interviews.

respondents provided recommendations to address the differential disparities of outcome for ethno-racial people with mental health disabilities interacting with Ontario’s civil mental health laws. The underlying analysis recognizes that the debate on the causes of these inequities is complex and contested. Thus, there are similarities and differences amongst the respondents’ views and arguments. These results facilitated the creation and development of the Cultural Analysis Tool (CAT).

i) Participant Characteristics

Table 1

Participant Characteristics: Lawyers, Health Care Professionals, Service Providers, Adjudicators, Government Advisors and Academics		n
Age (yrs)		
Range		30-55
Experience Working in the Civil Mental Health System (yrs)		
Range		5-35
Background		
Ethno-Racial		13
Gender		
Male		7
Female		21

Table 2

Participant Characteristics: Ethno-Racial People with Mental Health Disabilities (In-Patients and Ex-Patients)		n
Age (yrs)		
Range		20-60
Duration of Time Institutionalized in the Civil Mental Health System (yrs)		
Range		1-25
Background		
Ethno-Racial		7
Gender		
Male		3
Female		4

The characteristics of the participants interviewed are summarized in Tables 1 and 2. The professionals (lawyers, health care professionals, service providers, adjudicators, government advisors and academics) ranged in age from thirty to fifty-five years. They have worked in the civil mental health system for approximately five to thirty-five years. Thirteen out of the twenty-eight professionals interviewed identified as being ethno-racial. In this category, there were seven males and twenty-one females who were interviewed.

In regard to ethno-racial people with mental health disabilities, the ages of the participants ranged from twenty to sixty years. The duration of the time institutionalized in the civil mental health system ranges from one to twenty-five years. Out of the seven

ethno-racial people with mental health disabilities interviewed, there were three males and four females.

5.1 ETHNO-RACIAL PEOPLE WITH MENTAL HEALTH DISABILITIES

5.1.1 Role of Practitioners

i) Recognition

Ethno-racial people with mental health disabilities suggested that all practitioners should probe further into the intersectional issues involved in their CCB cases. However, some respondents expressed a fear of disclosing intersecting aspects of their identity and their experiences of discrimination, because they did not want to inculcate stereotypes.²

Accordingly, an ethno-racial person with a mental health disability describes this problem as follows:

What may be deemed as crazy here in North America, is not necessarily deemed crazy in other cultures, it might just be that person expressing himself. And I've met someone who is from Africa and he was just crazy. But you know what, he believed in his culture, that that is revered. That is revered and you know, he would come in, and he would say things to me, he would make it known that he got ten goats and five wives, and he is being very vociferous about it, that to me is not being aggressive, that to me is not seen as aggressive behaviour or delusional behavior. That is part of his culture and instead of asking, I watched this go down with the worker who was with him. Instead of asking him: What about your culture? Trying to get to know where this is coming from, they just assumed that the person was angry, that they were aggressive and they won't calm down, and that they had to go basically. They couldn't get the service, they were saying, well – we have to leave now.³

² Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

³ Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

Thus, respondents recommended that practitioners must continue to challenge the stereotypes when identifying and addressing the barriers and intersectional issues at play.⁴

5.1.2 Language/Communication

i) Acceptance

Although all of the ethno-racial people with mental health disabilities interviewed were able to speak English, they still experienced evident language and communication barriers throughout the CCB's pre-hearing, hearing and post-hearing processes. For instance, some respondents could not understand concepts such as "rights," "treatment," "informed consent" and "CCB hearing," thereby misunderstanding the CCB's processes.⁵ Other ethno-racial people with mental health disabilities felt that their intangible qualities such as their accent, mannerisms, body language, gestures and demeanor were attributed to a perception of being less credible.⁶

Some ethno-racial people with mental health disabilities felt that language and communication barriers led to them being deemed as "non-compliant" and "incapable."⁷ Consequently, a few ethno-racial people with mental health disabilities had their privileges within the hospital taken away, and others experienced seclusion and restraint.⁸

⁴ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁵ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁶ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁷ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁸ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

To address these barriers, ethno-racial people with mental health disabilities recommended that all practitioners in the civil mental health system should understand and accept their intangible qualities and identities. An ethno-racial person with a mental health disability suggests as follows: “*My cultural way of speaking English... I don’t want to change that. My accent should be accepted.*”⁹ Other respondents suggested that there should be a greater emphasis placed on listening.¹⁰

ii) Obtaining Interpretation Services

Ethno-racial people with mental health disabilities suggested that interpreters should be available within the hospital to meet the everyday needs of clients. Also, it was recommended that service providers within the community should have on-site interpreters and case-workers from diverse backgrounds available.¹¹ An ethno-racial person with a mental health disability reflects upon this recommendation as follows:

*I think people’s solution is to stick a worker in there, thinking we have referrals; some agencies don’t even have referrals to interpreters. Some agencies didn’t even ask, do you want services from your community or are you comfortable here and how can you make. They just assume, that maybe they are comfortable with their own people. Well that is enough – if you are going to be serving a particular population or population of many different backgrounds, you should get to know and have different representations, whether if it is a non-profit, on your board, within a policy positions, within your management and also talking to the clients themselves, which doesn’t really happen so much because I find the language barrier that people just assume and they just don’t want to take the time to understand where a person is coming from.*¹²

⁹ Interview with an ethno-racial person with a mental health disability (September 15th, 2011).

¹⁰ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

¹¹ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

¹² Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

Thus, respondents recommended that interpretation services should be available and accessible within the hospital and the community.¹³

iii) Cultural Interpreters/Consultants

When questioned about whether cultural interpreters/ consultants would be beneficial, the majority of ethno-racial people with mental health disabilities believed that they needed to have cultural interpreters/consultants support and guide them through the CCB's pre-hearing, hearing and post-hearing processes.¹⁴ An ethno-racial person with a mental health disability reflects upon this as follows:

Some people, because of the language barriers, they can't articulate themselves, Some people cannot even understand what involuntary or forced treatment means and they don't know what the process is..That is the main thing, they have been brought here and they do not know what the process is because there isn't support there, a culturally appropriate support to guide them through the process of what is happening to you, what you are being held for, what your rights are and what the outcome may be.¹⁵

Some ethno-racial people with mental health disabilities also expressed the view that cultural interpreters/consultants could help create networks for them in hospital and in the community.¹⁶

¹³ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

¹⁴ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

¹⁵ Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

¹⁶ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

5.1.3 The Pre-Hearing Process

i) Rights Advice

A number of ethno-racial people with mental health disabilities did not understand the concept of rights and the process of rights advice. Questions arose such as: “What are rights? What does rights advice mean?”¹⁷ Some ethno-racial people with mental health disabilities argued that rights advice should include a discussion of the dangerous side-effects of taking psychiatric medications. Accordingly, an ethno-racial person with a mental health disability states as follows: “*No one told me about the side effects of medication. They put me on lithium. This medication could give me kidney disease. But the lawyers still couldn’t fight it.*”¹⁸ Consequently, ethno-racial people with mental health disabilities recommended that rights advice should be given in person and in writing. The written rights advice should explain the key concepts and it should be written in plain language.¹⁹

ii) Psychiatrists’ Capacity Assessments

There were varied narratives that arose as ethno-racial people with mental health disabilities discussed their experiences undergoing capacity assessments. Ethno-racial people with mental health disabilities felt that psychiatrists and other health care

¹⁷ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

¹⁸ Interview with an ethno-racial person with a mental health disability (September 15th, 2011).

¹⁹ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

professionals needed to resist the urge to pathologize their behaviors as deviant. Instead, it was recommended that there should be more questions within the assessments about their history and cultural background.²⁰ Some respondents just wanted to feel more comfortable and have their stories and narratives understood and heard during the capacity assessments.²¹ At a general level, ethno-racial people with mental health disabilities recommended that the capacity assessments should be a collaborative and holistic process. For instance, it was recommended that the capacity assessments should include a case- worker, a social worker, a family member and a service provider.²²

5.1.4 The CCB Hearing

i) Process

Ethno-racial people with mental health disabilities argued that it was an important right to be able to go before the CCB. They wanted to have their voices heard and have the opportunity to assert their rights.²³ An ethno-racial person with a mental health disability describes the importance of the CCB process as follows:

*Well, it is a reasonable thing to do, especially if you have problems that concern law. You know, about getting my rights. It is all I want, my rights. If they can understand my problems, then it is very much easier on my mind. That was all I was concerned about... you know if the judges and the other lawyers understand what I am trying to get across, and why and how.*²⁴

²⁰ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

²¹ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

²² Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

²³ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

²⁴ Interview with an ethno-racial person with a mental health disability (September 15th, 2011).

While discussing the CCB process, ethno-racial people with mental health disabilities felt that the arguments made on their behalf regarding culture, religion and other social factors were not acknowledged. A number of ethno-racial people with mental health disabilities wanted to have their unique perspectives of mental health recognized.²⁵ This is highlighted in the following narrative:

Going before the CCB was an interesting process because they didn't understand my experience from a religious context. And so they kind of super-imposed their world view on to mine and not taking that into account, I felt very affronted by the whole process. So they thought well yeah that I am this, "I am mentally ill or I have experienced an episode," and I would say, "no, my experience is based on a cultural standpoint." And so, you are not understanding me, and that is an issue for me. And so you are trying to do something to me without my consent, without even taking the time to understand my point of view and that was very disappointing. I tried the cultural argument consistently to the psychiatrist, to the teaching psychiatrist that came on board on the wing, to the hospital, to the resident psychiatrist that was there, I made it before the board, to my lawyer, to the patient advocate that came...everybody, I made these arguments to everybody. For me, the idea is not that their argument is not valid. Because, they are the protectors of society, order and all that nonsense. But at the same time, it is just an acknowledgement. If there was an acknowledgment, then it would say, it is okay, you are not totally crazy, your point of view is validated, but they didn't go there. And, so I think that has a lot to do with dominance. Dominant culture. Going before the CCB is the perpetuation of dominant cultural ideas on to those who have variant ideas.²⁶

In order to address these concerns, ethno-racial people with mental health disabilities recommended that their individual experiences must be taken into account throughout the CCB's pre-hearing, hearing and post-hearing processes.²⁷ Further, some ethno-racial people with mental health disabilities recommended that there should be free education

²⁵ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

²⁶ Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

²⁷ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

given to them about the CCB process and what to expect, since they often misunderstood the process itself.²⁸

ii) Grappling with Culture

When asked about how the CCB dealt with their cultural and religious requests in the hearings, ethno-racial people with mental health disabilities felt that the CCB did not attempt to address or accommodate such requests.²⁹ For instance, ethno-racial people with mental health disabilities suggested that their requests for culturally appropriate treatment, religious accommodation and ethno-racial service providers were often denied. Some indicated that the CCB did not probe into their cultural and social context, and their experiences of oppression and trauma in the hearing.³⁰

Accordingly, a number of ethno-racial people with mental health disabilities argue that if these types of requests and the intersectional and systemic issues are not addressed appropriately, the consequences are severe. Some people are repeatedly institutionalized.³¹ In the following narrative, an ethno-racial person with a mental health disability explains the severity of these consequences:

And also I find, I wonder though, with people who come before the board a lot, I just find that the justice system is biased, it is like that is expected behaviour of that person due to their racial background or the community they are from, and there isn't an attempt to break the cycle and help and see what is going on. So the person just becomes institutionalized, over and over again. Yes – it is a big problem because what happens is it ruins communities and then people they just give up. They don't, like I said it goes back

²⁸ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

²⁹ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

³⁰ Interview with an ethno-racial person with a mental health disability (September 15th, 2011).

³¹ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

to family dynamics and I don't think service providers what happens where the person may have immigrated here, but their parents are back wherever. Maybe it is the one mother who is supporting all their children. Those dynamics are not taken into consideration. Why are these children up by themselves home alone or why is this person...why does the eldest have to take care of all of them while the mother works? They don't see different kinds of situations. There are different types of families that immigrate here in different situations and that is not taken into consideration.³²

It was recommended that the CCB acknowledge and recognize its own institutional bias.

The CCB should use its discretion to grapple with the intersectional and systemic issues at play within these cases.³³

iii) Adversarial Environment

Ethno-racial people with mental health disabilities were uncomfortable with the concept of contesting their doctor's decision. For many, they were confused as to why they were in opposition to their doctor, whom they had bestowed trust and confidence upon. This was further complicated, given their general mistrust of the civil mental health system and the formal and adversarial nature of the hearings.³⁴

After the hearings, a number of ethno-racial people with mental health disabilities felt that their relationship with their doctors had been compromised since they were mistrustful of their doctor's authority and advice.³⁵

³² Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

³³ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

³⁴ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

³⁵ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

iv) Family Involvement

The issue of family involvement was contentious for ethno-racial people with mental health disabilities, since there were circumstances where family members were supportive, but there were other situations where ethno-racial people with mental health disabilities felt like they were in conflict with their families regarding specific treatment and care issues.³⁶ Ethno-racial people with mental health disabilities were unclear about the role that family should have in their treatment decisions and care. Specific concerns were raised regarding disclosure and the extent to which family members should be informed about their treatment, and care decisions.³⁷ An ethno-racial person with a mental health disability explains this tension as follows:

*Although support can come from the family, the stigma can also come from family, so therefore we don't want to seek support within family and we will look towards other communities to get the support.*³⁸

Some ethno-racial people with mental health disabilities also felt that their family members were biased in favor of them receiving involuntary treatment and care. These dynamics were often heightened in hearings, especially where families were biased in favor of them receiving involuntary treatment and care, and there were cultural arguments involved.³⁹ An ethno-racial person with a mental health disability explains as follows:

³⁶ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

³⁷ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

³⁸ Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

³⁹ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

I tried to make the cultural argument, even to my own family, that were privy to my experience, and they had insight to it because they saw me in an intimate context, at the end day, discounted what they were saying and hearing from me, that shows the other side to being on the other side. And I just was so pissed off by the whole experience.⁴⁰

In order to address these concerns, ethno-racial people with mental health disabilities recommended that all practitioners should be aware of the types of family dynamics involved in a particular case.⁴¹

5.1.5 Post-Hearing: Translation of Decisions

Ethno-racial people with mental health disabilities indicated that the outcomes of the decisions were not explained to them and there was a lack of written reasons available for them. For instance, it was problematic that only one of the respondents for this study received written reasons for the decisions.⁴² In light of these communication barriers, a number of ethno-racial people with mental health disabilities did not appear to understand their treatment decisions, the concept of informed consent, the right to refuse treatment, the particular treatments they were taking, the side effects of treatment and the overall outcome of their CCB hearings.⁴³ Accordingly, ethno-racial people with mental health

⁴⁰ Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

⁴¹ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁴² Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁴³ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

disabilities recommended that there should be a simple one-page summary of the CCB's written reasons available for them.⁴⁴

5.1.6 Human Rights in the Hospital

The theme of human rights in the hospitals was significant for the ethno-racial people with mental health disabilities who were interviewed. There were descriptions of rights violations involving restrictions of their liberty and autonomy through the use of restraint, the lack of food options available, the lack of space available, the lack of privileges available within and outside the hospital and the lack of monitoring of human rights abuses within the hospital and the overuse of medical labels.⁴⁵ Specifically, a number of ethno-racial people with mental health disabilities perceived the process of obtaining hospital privileges as manipulative and arbitrary because they had to prove that they were taking their medications regularly to be given days passes and other privileges.⁴⁶ Accordingly, an ethno-racial person with a mental health disability described this process to be an “affront to her dignity.”⁴⁷

She suggests as follows:

⁴⁴ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁴⁵ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁴⁶ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁴⁷ Interview with an ethno-racial person with a mental health disability (September 15th, 2011).

*I just want the freedom to smoke. To go out when I need to go out for it. And, also the freedom to bathe, go to church, do my laundry and little things around here.*⁴⁸

Ethno-racial people with mental health disabilities felt that they should have more access to the Ontario human rights system. An ethno-racial person with a mental health disability states as follows:

*Yes, I want to have access to human rights complaints system. I want to understand how to get these things...I need a lawyer to help me.*⁴⁹

Thus, it was recommended that there should be people appointed in the hospital to monitor the human rights abuses that occur within the hospitals and to support ethno-racial people with mental health disabilities to file human rights complaints.⁵⁰

i) Racism

When discussing human rights concerns within the hospitals, a common theme amongst those interviewed were their experiences of racism. It was found that ethno-racial people with mental health disabilities frequently experienced racism in their interactions with the civil mental health system including the mental health system and the legal system.⁵¹ For instance, ethno-racial people with mental health disabilities described experiences of feeling isolated, alienated and stereotyped based on racist assumptions throughout their interactions with the police and their experiences in the

⁴⁸ Interview with an ethno-racial person with a mental health disability (September 15th, 2011).

⁴⁹ Interview with an ethno-racial person with a mental health disability (September 15th, 2011).

⁵⁰ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁵¹ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

emergency department, in the psychiatrists' capacity assessments, in hospital with health care professionals and during the CCB hearings.⁵²

An ethno-racial person with a mental health disability explains her experience as follows:

For example, police or even providers, because of stereotypes, they see you and you may think you are crazy and you need the support, but they are afraid of you, and they link certain behaviours to your race such as anger, and they don't want to service you. And I find when that happens though then the person, I mean when you are a racialized you know when you are being discriminated and experiencing racism. People say 'Are you sure you are being discriminated,' people know, you have been in the body you have been in for a long time, you kind of get a wind of the experiences that you encounter, so I just find that with that the service provider doesn't necessarily genuinely engage with the person because there are those barriers, because they are not willing to understand what the person is going through, they are just going off stereotypes, they are going off behavior.⁵³

In this respect, another ethno-racial person with a mental health disability states as follows:

I believe in this particular hospital, there is a lot of injustice going on, they don't seem to regard the law and there is a lot of racism. There is no justice. This is too much for the mentally ill...they isolate them.⁵⁴

Consequently, it was suggested that all practitioners in the civil mental health system should be educated about the various cultural backgrounds, the histories and the issues pertinent to treating ethno-racial people with mental health disabilities.⁵⁵

⁵² Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁵³ Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

⁵⁴ Interview with an ethno-racial person with a mental health disability (September 15th, 2011).

⁵⁵ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

5.1.7 Access to Culturally Appropriate Treatment and Care

Respondents found it frustrating that the CCB does not have jurisdiction to consider whether treatment plans are culturally appropriate. For all of the ethno-racial people with mental health disabilities interviewed, they were not able to access culturally appropriate treatment and care.⁵⁶ This affected how their CCB cases were determined, since a number of ethno-racial people with mental health disabilities argued that they would be treatment compliant if they had more options for alternative and complementary treatments within the civil mental health system.⁵⁷ For instance, a number of ethno-racial people with mental health disabilities wanted to have more access to counseling and psychotherapy, along with alternative and complementary treatments such as meditation, yoga, homeopathy, naturopathy and light therapy.⁵⁸ Within the community, some respondents felt helpless because they were not able to access such treatment given the immense stigma. An ethno-racial person with a mental health disabilities states as follows: *“No, I don’t want to go to my community. There is shame.”*⁵⁹

To increase access to culturally appropriate treatment and care, ethno-racial people with mental health disabilities recommend that psychiatric hospitals continue to have more peer support groups. This includes recreational art programming that caters to

⁵⁶ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁵⁷ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁵⁸ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁵⁹ Interview with an ethno-racial person with a mental health disability (September 15th, 2011).

different interests.⁶⁰ Secondly, service providers need to have more interpreters and people from diverse communities available to support ethno-racial people with mental health disabilities.⁶¹

5.1.8 Religious Accommodation

When questioned about religious accommodation, ethno-racial people with mental health disabilities identified problems with the lack of access to spiritual services and the inability to practice their religions freely within the hospitals or within their community.⁶² In this respect, one ethno-racial person with a mental health disability felt dismayed that the CCB would not grant him the right to practice his religion. He argued that the CCB did not understand the notion of religious rights or his right to have religious accommodation. He described his experience before the CCB as follows:⁶³

*I was doing serious religious practices at the time that cause an experience that was not understood within this cultural context by the CCB and within the hospital. It was Hinduism at the time. And it was more of a mystical approach to it. But, if I were some place else, it would have been understood. The practices include— meditation, insight, stuff like that, diet. It was a violation of my religious rights. I mean what are you doing? What are you guys doing here? I am practicing my religion.*⁶⁴

In this regard, ethno-racial people with mental health disabilities recommended that they should have more access to spirituality services within the hospital and the CCB

⁶⁰ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁶¹ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁶² Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁶³ Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

⁶⁴ Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

should be more willing to grant such accommodation requests.⁶⁵

5.1.9 Social Supports

During the interviews, ethno-racial people with mental health disabilities identified barriers to accessing social supports including adequate housing, community supports, and ethno-specific supports. For instance, a number of the ethno-racial people with mental health disabilities interviewed were often living in poverty when released into the community, given the lack of appropriate housing and community supports.⁶⁶

The recommendations that were made to address these barriers included: increasing the awareness about the current initiatives and resources, focusing on inclusion and ensuring that ethno-racial communities are speaking to each other and creating networks. The following questions were raised: What are the specific supports that ethno-racial communities need? How can such services be mainstreamed?⁶⁷ In this respect, an ethno-racial person with a mental health disability reflects upon these recommendations as follows:

I wonder why also, ethno-racial communities are not talking to each other. There is discrimination that happens in that dynamic too. I find because it is not being discussed, it is more issues with the mainstream and how that interaction happens, how that oppression happens. They don't necessarily address ethno-racial communities interacting with each other, in those oppressions that happen. They need to talk to each other, and refer and try to understand each other languages. Coming together to try to find, in the mainstream, in the grand scheme, having the supports. I just find it is not being addressed because it is a top down process and at the top are people who have no idea about what is happening in the community, and they are not interested in finding out, because our health care system is turning into a big business. So it is more – how

⁶⁵ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁶⁶ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁶⁷ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

can you make it more mainstream? How can we make it more blanket and more uniform? And with that, there are problems. With that type of policy, whom are you really serving? Who are the people that are really to be coming to you? They are going to be people that are marginalized, and most likely from a racialized community.⁶⁸ Resources – I think there are a lot of resources. The issue is really knowledge of the people. The people need to have knowledge that the resources exist. It is question of them understanding that there are resources out there to help them. A lot of people don't even know about the patient psychiatric advocates office, the CCB or that they can say no to their doctor for that matter. It is all about awareness.⁶⁹

Further, it was recommended that the provincial government should improve access to social supports for ethno-racial people with mental health disabilities.⁷⁰

5.1.10 Power

During the CCB's pre-hearing, hearing and post-hearing processes, ethno-racial people with mental health disabilities expressed the view that they felt powerless in the system. They recommended that more ethno-racial people with mental health disabilities should be appointed to positions in power within the CCB, the hospital and community agencies.⁷¹ An ethno-racial person with a mental health disability argues as follows:

It is not just enough to hire a worker, say – a Somali worker in your agency. I think there needs to be a plan for having more of us at the table.. at the CCB, more faces and voices at the table in planning positions and policy positions because that, as much as we say that, I don't see that happening.⁷²

Accordingly, respondents warn that tokenism should be avoided when placing ethno-

⁶⁸ Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

⁶⁹ Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

⁷⁰ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁷¹ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁷² Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

racial people with mental health disabilities in positions of powers.⁷³

5.1.11 Education

In regard to education, ethno-racial people with mental health disabilities suggested that more education was needed to challenge the institutional racism within the civil mental health system.⁷⁴ Specific recommendations were made to ensure that ethno-racial people with mental health disabilities are given free education about the CCB's process. It was also recommended that researchers monitor the human rights abuses within the hospital and work to create change within the institutions.⁷⁵

5.1.12 Legislative Reform

It was recommended that the principles of inclusion, respect and cultural diversity should be included within Ontario's mental health legislation. Ethno-racial people with mental health disabilities recommended that the law should include factors of race, class, culture, ethnicity and other social factors within the definition of mental disorder.⁷⁶ In regard to the CCB's specific discretionary powers, an ethno-racial person with a mental health disability recommends as follows:

*The CCB should acknowledge the variant experiences. And see that as relevant to the experience and there is not just one way of looking at it. There are many ways of looking at it.*⁷⁷

⁷³ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁷⁴ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁷⁵ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁷⁶ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁷⁷ Interview with an ethno-racial person with a mental health disability (May 17th, 2011).

Thus, the CCB should be required to inquire into and examine the intersectional and cultural arguments made on behalf of ethno-racial people with mental health disabilities.⁷⁸

5. 2 Mental Health Lawyers

5.2.1 Role of Counsel

i) Recognition

Respondents concluded that lawyers often have their own limitations in recognizing and being alive to the cultural and intersectional issues arising from a client's case. As one lawyer described, "lawyers can be equally guilty" for not being aware of the intersecting cultural and equity issues within a case. She states as follows:

*I may not always see that there is an issue. I think that as lawyers practicing in this area and representing people in a hospital, we have our own limitations. So that may be one barrier, one big problem actually. Some people may be more sensitive than others. And some people will listen to their clients more than others. Depending on whether it is an issue the client himself or herself has raised, depending on what is needed, because I might not see the issue, unless someone points it out. Obviously if it is a language issue, that is going to be more obvious. But if it is more of a cultural issue, I might not necessarily identify it. So, maybe it just comes down to listening to clients. Just being aware that cultural issues can be an issue.*⁷⁹

Thus, respondents recommended that lawyers should attempt to identify the intersectional issues relevant to their ethno-racial clients throughout the CCB's pre-hearing, hearing and post-hearing processes.⁸⁰

⁷⁸ Data derived from interviews conducted with ethno-racial people with mental health disabilities from April 2011 to November 2011.

⁷⁹ Interview with a lawyer (July 6th, 2011).

⁸⁰ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

ii) Accessing and Presenting Cultural Evidence

Lawyers expressed the view that mental health cases were “massively magnified” when other intersectional grounds such as race, culture, ethnic background, gender and class were added.⁸¹ The lack of resources available to mental health lawyers makes it challenging for them to present cultural evidence. For instance, lawyers felt that the ten hours available on Legal Aid Ontario’s standard legal aid certificate was not nearly enough time for them to “review the client’s file or review the record or even meet the client; never mind go to the next step.”⁸² The resource issue is further complicated since there is a strict seven day deadline within which the hearing must occur. Consequently, lawyers suggested it was challenging for them to identify the cultural and equity issues within a case and prepare the appropriate “cultural evidence” within this period. Respondents felt that all lawyers needed to be more critical when embarking on a CCB case to ensure that all of the factors were considered.⁸³

When presenting cultural evidence, the respondents agreed that there must be an appropriate evidentiary basis for presenting the evidence. Lawyers should ensure they have all of the information to “prove the evidence is relevant and having an effect.”⁸⁴ The lawyers interviewed explained that cultural evidence might have a positive or detrimental impact on the client’s case. For example, in the following narrative, a lawyer describes how cultural evidence was later misinterpreted and misunderstood during a hearing.⁸⁵

⁸¹ Interview with a lawyer (May 24th, 2011).

⁸² Interview with a lawyer (April 28th, 2011).

⁸³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

⁸⁴ Interview with a lawyer (May 16th, 2011).

⁸⁵ Interview with a lawyer (May 16th, 2011).

*One of my very first involuntary status clients - he was a guy that didn't speak English at all and he spoke Cantonese only. And they had brought somebody in to assess him who had cultural knowledge and insight. The person was basically saying, 'listen this guy is sharpening a bamboo stick – an extra dangerous weapon, but in Chinese culture – it will penetrate the body and it will release energy from the body at the same time.' That is an example where they did have somebody giving cultural insights. But, then I brought this up in the hearing, and it was to my client's detriment. They interpreted the information in the hearing – saying that he was being extra dangerous.*⁸⁶

Overall, lawyers believed that cultural evidence must be presented in an appropriate and sensitive manner or they would be at risk of being perceived as “judgmental and racist.”⁸⁷

In this regard, patient-side lawyers also expressed discomfort presenting cultural evidence since they were often conflicted with paternal instincts to act in what they believed to be the client's best interests rather than in accordance with the client's instructions.⁸⁸

In order to address these issues, respondents indicated that all mental health lawyers should have access to people who provide cultural resources and a cultural resource centre.⁸⁹ A lawyer described this recommendation as follows:

*Someone is needed to help provide cultural insights into the various perceptions of mental illness. This 'cultural resource person' does not necessarily have to be a health care professional. Access to such a resource and resource centre would help to see where the client is coming from and it would make things a little easier to have insight into the culture's approach of mental illness or the regions' view/country's view to mental health issues and the legal system.*⁹⁰

⁸⁶ Interview with a lawyer (May 16th, 2011).

⁸⁷ *Ibid.*

⁸⁸ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

⁸⁹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

⁹⁰ Interview with a lawyer (April 27th, 2011).

Accordingly, lawyers recommend that a cultural resource centre is created, which is accessible to all practitioners and ethno-racial people with mental health disabilities.⁹¹

5.2.2 Language/Communication

i) Obtaining Interpretation Services for the Pre-hearing

Lawyers suggest that the LAO process of obtaining an interpreter for clients is inefficient and unreliable.⁹² It is often very difficult to obtain an interpreter within seven days of when the hearing is expected to take place. When the notification arrives from a rights adviser, lawyers must indicate to LAO that an interpreter is needed. Thereafter, LAO will only release the names of five interpreters to the lawyers at one time, instead of giving them access to the entire contact list for interpreters in Ontario.⁹³ In the following narrative, a lawyer describes these procedural inefficiencies in context:

In the mental context, the majority of our clients will be funded through legal aid. I think legal aid has to be more responsive in terms of the interpreter issue. This is a real pet peeve for me. Once we know we need an interpreter, they make us write to them or call them. And they say they have a list of interpreters that accept legal aid rates. They then read out five names at a time. Those interpreters are never available and we can never get in touch with them. You have to seek pre-approval of that disbursement according to their legal aid tariff. It is never fast enough because the CCB hearings must commence within seven days. So, we need the interpreters right away. The rights adviser will call us with a language problem and we have to get the interpreter within a day or two. We can never get the pre-approval for someone at legal aid rates for somebody that legal aid wants within the seven-day period. So we end up arguing with LAO. We have to argue with them and beg them to pay for them after the fact. The board provides an interpreter for an hour for our use before the hearing begins, which may be suitable for some

⁹¹ Data derived from interviews conducted with lawyers from April 2011 to November 2011. It is important to note that there is an on-line cultural resource centre available at CAMH.

⁹² Data derived from interviews conducted with lawyers from April 2011 to November 2011.

⁹³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

*lawyers that do CCB hearings if they don't do any prep before the hearing begins, before the hearing day, but our firm doesn't do that.*⁹⁴

Lawyers explain that LAO will only pay approximately \$50.00 for two hours of interpretation services, while most interpreters in Toronto will charge at least \$75.00 at a three-hour minimum. Further, LAO's "internal interpreter lists" (through the Ministry of Attorney General) are outdated and many of the interpreters are no longer working in the area. Thus, a few law firms choose to pay out of pocket in order to obtain interpretation services during the CCB's pre-hearing processes.⁹⁵ For others, lawyers go without interpreters during the pre-hearing and post-hearing processes, to the detriment of the client. Although some lawyers are able to use the CCB's interpreter for a few minutes before the hearing, this is not perceived to be a viable solution for those who want to meet with the client and appropriately prepare for the hearing beforehand. Some lawyers suggested that the rights advisers' lists should specify the particular language abilities of each Legal Aid Ontario lawyer to ensure clients can have access to lawyers who speak their language.⁹⁶

ii) Accommodation

Respondents indicated that lawyers should always be aware of their duty to accommodate clients as per the *Ontario Human Rights Code*⁹⁷ when addressing language issues. Accordingly, despite the lack of resources available for accessing interpreters, the majority of lawyers felt that lawyers should always opt to pay for interpreters out of their

⁹⁴ Interview with a lawyer on July 6th, 2011.

⁹⁵ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

⁹⁶ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

⁹⁷ *Human Rights Code*, RSO 1990, c H 19, s 8 (1) [HRC].

own disbursements in light of the significant communication barriers at stake for the clients.⁹⁸ A lawyer explained these challenges as follows:

*If LAO or the CCB cannot get us interpreters, I think we should be paying for it. You are required to accommodate your client until undue hardship. And I think hiring an interpreter doesn't create undue hardship. But, many lawyers just won't do it. You need to meet with the client before the hearing to prepare appropriately and you need an interpreter to do it. The Patient Psychiatric Advocate Office (PPAO) currently pays for its own interpreters for rights advisers, so lawyers must do the same.*⁹⁹

A few lawyers suggested that accommodation needs should be flagged at the outset of the hearing. In this regard, rights advisers are expected to ensure that the CCB is aware of any accommodation issues during their initial meetings.¹⁰⁰ This may include *“whether the client needs accommodation for a disability or for a translator, the need for cultural competence, or if he or she would like to give instructions when a friend is present, or a spouse, or the comfort levels of clients to sit through hearings etc.”*¹⁰¹

Further, lawyers felt frustrated that clients had to ask their lawyer to ensure the treatment team or the physicians were using interpreters for clients that spoke little to no English.¹⁰² As one lawyer describes, *“I find interpreters aren't brought in, mostly until I get involved, until I start advocating or asking questions – like ‘this person doesn't speak English – and how did you even meet or speak with them?’”*¹⁰³ In this vein, the physician-

⁹⁸ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

⁹⁹ Interview with a lawyer (July 6th, 2011).

¹⁰⁰ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁰¹ Interview with a lawyer (May 24th, 2011).

¹⁰² Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁰³ Interview with a lawyer (May 16th, 2011).

side lawyers felt that when health care professionals used interpreters, this should be charted in the hospital record to prevent later complaints against them.¹⁰⁴

iii) Quality of Interpretation

Lawyers felt the quality of interpretation services during the CCB pre-hearing, hearing and post-hearing processes could be improved.¹⁰⁵ In the following narrative, a lawyer questions whether simultaneous translation was actually occurring.

*There can be a range of concerns around interpretation. Sometimes it is in the actual hearing, whether one or many parties, either parties or members of the board express a concern regarding quality of interpretation. I certainly experience that myself where there may have been concerns about whether simultaneous translation is actually happening. Of course, it is challenging if no one other than the translator and the patient applicant has knowledge of the language. But in cases where one of us does have knowledge about the language, then those issues can be raised.*¹⁰⁶

For instance, lawyers described cases where the interpreters had internalized the client's stories and this was reflected in their translations during the hearing process.

Complications further arose where family members were also testifying, and there were familial conflicts that were translated, thereby interfering with the hearing process. As such, lawyers felt that the interpreter rules needed to be fully explained by the CCB at the outset of the hearing.¹⁰⁷

In cases where cultural evidence was at play, lawyers felt that interpreters were not able to appropriately contextualize the translation or understand the cultural nuances

¹⁰⁴ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁰⁵ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁰⁶ Interview with a lawyer (June 9th, 2011).

¹⁰⁷ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

involved.¹⁰⁸ As one lawyer describes, “*The interpreters were often not able to understand the cultural meaning of something within the context, and it added complications through the hearings, which was heightened because of the client’s mental disability.*”¹⁰⁹ Thus, lawyers recommended that there should be national standards created for qualifying interpreters to work in the mental health context.¹¹⁰

iv) Cultural Interpreters/Consultants

Lawyers suggested that all practitioners should have access to cultural interpreters or cultural consultants to understand the everyday needs of clients, and to help educate those on the front-line about what is culturally relevant. Such consultants should be familiar with both the cultural norms within a particular culture and have the relevant expertise working with people with mental health disabilities.¹¹¹

Accordingly, a lawyer reflects upon this as follows:

If a psychiatric nurse on a unit has a client who is from a particular culture, and they don’t understand what the basis of the culture is, and what may need to be accommodated, they need to be able to call someone and say, ‘my patient client is from X culture, what do I need to do? What do I need to be mindful of? What can I do to make them feel better if we are talking about the mental health context?’¹¹²

Since treatment-staff often have to rely on staff members from a particular ethnicity to understand a client’s accommodation needs, lawyers suggested that cultural

¹⁰⁸ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁰⁹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹¹⁰ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹¹¹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹¹² Interview with a lawyer (April 28th, 2011).

consultants and interpreters could help bridge this gap.¹¹³ However, as it may be impossible to attain cultural interpreters to address the everyday needs of clients, lawyers suggested that there be lists made of the languages that the treatment staff speak in order to accommodate these needs. Some lawyers also suggested that treatment teams could attempt to be more interdisciplinary by working collaboratively with both ethicists and lawyers.¹¹⁴

5.2.3 The Pre-Hearing Process

i) Police Action

Given the communication and cultural barriers at play, lawyers pointed out the dangers of having ethno-racial clients transported to psychiatric facilities in police custody.¹¹⁵ In such cases, lawyers felt that police should always act in accordance with the specific criteria within the *Mental Health Act*,¹¹⁶ be alive and sensitive to the language and communication barriers in these cases and avoid the use of force.¹¹⁷ A lawyer grapples with these issues as follows:

For a lot of cultures, the idea that you call the police to address a mental health crisis, that you throw someone in handcuffs and throw them in the back of a police car and detain them involuntarily – it is very foreign to a lot of cultures, where the approach to mental health crisis is to maintain people in the community and to protect them through a

¹¹³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹¹⁴ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹¹⁵ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹¹⁶ Police may have authority to take a person to the psychiatric facility if the circumstances are warranted as per the act and there is not enough time to obtain a judicial warrant. For example, see *Mental Health Act*, RSO 1990, c M 7, ss 16 and 17 [MHA].

¹¹⁷ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

*strong support network of family and friends and that is just not accorded any deference.*¹¹⁸

Thus, lawyers recommended that police officers should undergo cultural sensitivity training in collaborations with service providers working with ethno-racial people with mental health disabilities.¹¹⁹

ii) Rights Advice

Lawyers generally agree that rights advisers are under enormous pressure to complete the rights advice process as per s. 15 of the MHA within 24 hours¹²⁰ and this is often intensified for ethno-racial clients. In this regard, lawyers suggested that rights

¹¹⁸ Interview with a lawyer (April 28th, 2011).

¹¹⁹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹²⁰ MHA, *supra* note 39 at s 15, Reg. 741. A rights adviser must give “rights advice to a person who is an involuntary psychiatric patient, a person who is found incapable of making decisions about their psychiatric treatment or management of her property, a person who is an informal patient between the ages of twelve and fifteen and a person who is notified of an “intent to issue or renew a CTO.” D’Arcy Hiltz and Anita Szigeti, *A Guide to Consent and Capacity Law in Ontario* (Markham: Lexis Nexis Canada Inc., 2013) at 318.

15. (1) If a person who has been admitted to a psychiatric facility as a patient is 14 years old or older and if the person’s attending physician proposes treatment of a mental disorder of the person and finds that the person is incapable with respect to the treatment within the meaning of the *Health Care Consent Act, 1996*, the attending physician shall ensure that, (a) the person is promptly given a written notice indicating that he or she has been found by the attending physician to be incapable with respect to the treatment; and (b) a rights adviser is promptly notified of the finding of incapacity. O. Reg. 103/96, s. 3. (2) A rights adviser who is notified of a finding of incapacity shall promptly meet with the person who has been found incapable and shall explain to the person the significance of the finding and the right to apply to the Board under the *Health Care Consent Act, 1996* for a review of the finding. O. Reg. 103/96, s. 3. (3) Subsection (2) does not apply if the person who has been found incapable refuses to meet with the rights adviser. O. Reg. 103/96, s. 3. (4) At the request of the person who has been found incapable, the rights adviser shall assist him or her in applying to the Board under the *Health Care Consent Act, 1996* for a review of the finding and in obtaining legal services. O. Reg. 103/96, s. 3. (5) This section does not apply if, (a) the person has a guardian of the person appointed under the *Substitute Decisions Act, 1992* who has authority to give or refuse consent to the treatment; (b) the person has an attorney under a power of attorney

advisers must balance their responsibilities, which include explaining the importance of the medical finding of incapacity and the option to make an application to the CCB to review the finding,¹²¹ with accommodating requests such as those regarding disability, translation and communication services.¹²² However, lawyers felt that rights advisers could not become advocates for clients.¹²³

A lawyer expressed this view as follows:

*A line must be drawn between rights advice and advocacy because otherwise rights advisers will get pulled into all of this stuff. It is really common for people to say – ‘can you contact my family for me?’ Well – if that becomes the rights advisers’ job, then it is no longer the job of the facility that houses this person.*¹²⁴

Although rights advisers do flag the client’s accommodation needs for the CCB before the hearing, lawyers interviewed felt that these requests were often ignored.¹²⁵

Accordingly, a lawyer describes this challenge as follows:

for personal care given under the *Substitute Decisions Act, 1992*, the power of attorney contains a provision waiving the person’s right to apply to the Board for a review of the finding of incapacity and the provision is effective under subsection 50 (1) of the *Substitute Decisions Act, 1992*; (c) the person is in a coma, is unconscious, is semi-conscious or is unable to communicate comprehensibly despite reasonable efforts to understand the person; or (d) the attending physician is of the opinion that there is an emergency within the meaning of subsection 25 (1) of the *Health Care Consent Act, 1996*. O. Reg. 103/96, s. 3. (6) If a rights adviser has met with a person who was admitted to a psychiatric facility and was found incapable with respect to a treatment of a mental disorder, and if the rights adviser has provided the person with the explanation required by subsection (2), this section does not apply to any subsequent finding of incapacity made in respect of the person during his or her stay in the facility pursuant to that admission, whether the subsequent finding is made in relation to the same treatment or a different treatment. MHA, *supra* note 39 at s. 15, Reg. 741.

¹²¹ *Ibid.*

¹²² Interview with a lawyer (May 24th, 2011).

¹²³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹²⁴ Interview with a lawyer (May 24th, 2011).

¹²⁵ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

*Rights advisers actually have a procedure where they flag for the CCB if there is an accommodation need that comes up. They put it directly on the cover of the application that goes to the CCB – whether the client needs accommodation for disability or translator, cultural competence, or if they only like to give instructions when a friend is present, or a spouse or whatever like that – they try and flag at the outset of the process to the extent they can. And what does the CCB do with it? Nothing.*¹²⁶

In this respect, it is recommended that the CCB should have a policy to ensure accommodation requests identified by rights advisers are addressed.¹²⁷

iii) Forms

Respondents indicated that all of the forms such as the Application by Physician for Psychiatric Assessment, the Order for Examination under Section 16, the Certificate of Involuntary Admission and Certificate of Renewal¹²⁸ were not available in languages other than English.¹²⁹ As a result, lawyers felt that clients were not able to fully comprehend the circumstances warranting their involuntary status, their treatment and the CCB process, regardless of whether interpreters were present initially.¹³⁰ A lawyer describes this observation as follows:

*When there are liberty issues involved, there is an obligation to translate all the forms. It is an unfortunate situation. Think about it. You are sitting in this psychiatric facility – you are probably already in crisis – that is why you ended up there and you don't understand why you are there... For some of my clients, their mental capacity is enhanced by being able to communicate in their own language and being able to read the documents in their own language. I have seen this in many cases.*¹³¹

¹²⁶ Interview with a lawyer (May 24th, 2011).

¹²⁷ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹²⁸ For example, there are fifty forms under the MHA, *supra* note 39. Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹²⁹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹³⁰ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹³¹ Interview with a lawyer (July 6th, 2011).

A few lawyers suggested that rights advice should also be offered in written form and translated in the client's language of choice.¹³² Further, some lawyers explained that it was extremely challenging for them to have documentary evidence translated in the client's language of choice before the hearing.¹³³

iv) Psychiatrists' Capacity Assessments

Lawyers felt that the psychiatrists' capacity assessments prior to CCB hearings did not appropriately recognize clients' cultural background, class, social history, ethnicity, cultural standards of normality vs. abnormality and other socio-cultural factors. In particular, lawyers suggested that health care professionals must acknowledge alternative cultural explanations of mental health disability and how psychological distress may be expressed differently amongst cultures regardless of the medical model.¹³⁴

¹³² Currently, rights advice is offered in orally and not in written form.

¹³³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹³⁴ Data derived from interviews conducted with lawyers from April 2011 to November 2011. Sections 15 (1) and 15 (1.1) in the *Mental Health Act*, RSO 1990, c M7 set out the criteria regarding when a physician may make an application for a psychiatric assessment of a person. Under these sections, psychiatric assessments take place within a psychiatric facility. They can last for a maximum of 72 hours. A person held for a 72-hour assessment under a Form 1 is legally called a "detainee and not a patient." See *R v Webers*, 95 CCC (3d) 334, 25 WCB (2d) 305. Specifically, s. 15 (1) Application for Psychiatric Assessment reads as follows: "where a physician examines a person and has reasonable cause to believe that the person, a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself; b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or c) has shown or is showing a lack of competence to care for himself or herself, and in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in d) serious bodily harm to the person; e) serious bodily harm to another person; or f) serious physical impairment of the person, the physician may make application in the prescribed form for a psychiatric assessment of the person." MHA, supra note 39.

One lawyer reflected upon this as follows:

People have to be educated to even ask the questions and not use the one size fits all approach. But there is really none of that in the system. The overriding problem is clients with mental health disabilities are treated despite lip service to the contrary – they are treated as biochemical dilemmas solved biochemically and pathologized. So what dosage of antipsychotic drug will only beat the symptoms? That is all anybody cares about. It is all psychiatrists care about. Sometimes the occasional social worker will be helpful with meeting some educational or vocational goals. But culture is really seen as a luxury. Before we get there – we have to address their psychosis, their mood ability, we have to get them on the right medications, give them the ECT and then we will worry about something to do, finding them housing. It is like cultural components don't enter into the equation until the eleventh hour – until everything else is settled- the problem is – you can't settle the other things without taking cultural and heritage issues into play.¹³⁵

However, some lawyers felt that psychiatrists and other health care professionals were grappling with these issues in the diagnostic process to the best of their abilities, given the time constraints and lack of resources.¹³⁶ For instance, a lawyer representing the doctor explained that *“I certainly have evidence of health care professionals trying to sort through what is experiential vs. what might be delusional vs. what is shaping certain perceptions of things on the client's side – you see the doctors and other health care professionals grappling with that.”*¹³⁷ Accordingly, a few lawyers suggested that the culture within psychiatric institutions had to change in order to ensure that health care professionals have the time and resources to address these issues within their capacity assessments.¹³⁸

Lawyers agreed that language and communication barriers affected a client's ability to be found incapable vs. capable. In addition, lawyers suggested that interpreters

¹³⁵ Interview with a lawyer (April 28th, 2011).

¹³⁶ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹³⁷ Interview with a lawyer (May 26th, 2011).

¹³⁸ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

were needed every time a client is assessed for capacity since there cannot be an assumption that one's mental condition will stay the same. Similarly, lawyers felt that psychiatrists should always have interpreters available for clients regardless of whether they appeared to have some knowledge of English and the inevitable resource constraints.¹³⁹

Lawyers also feel that it is problematic if psychiatrists do not try and obtain collateral information from the ethno-racial client's family regarding the client's case.¹⁴⁰

A lawyer states as follows:

*I think the biggest problem is the psychiatrists don't want to do too much than what they are capable of billing OHIP for.. They won't go speak to the family to get collateral information, they will often rely on the patient denying consent for that, which I don't think, and often that is the case. I think a lot of psychiatrists don't want to inform themselves and take the extra time to get collateral information, because they will not get paid for it, because they don't have the time.*¹⁴¹

Lawyers generally felt that cases were more efficient before the CCB when the health care professionals did not dispute a client's cultural, racial and spiritual perspective vis-à-vis their mental health disability. One lawyer reflects as follows:

*Instead of denigrating the family and client's perspective about what they had termed 'spiritual possession' in a CCB treatment capacity case,' the doctor was very adept at sitting down with them and accepting their views, along with suggesting the kind of medication that could assist the client and why. This proved to be quite effective.*¹⁴²

In sum, lawyers recommended that health care professionals should acknowledge and understand the varied conceptions of mental health disability and diverse approaches to

¹³⁹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁴⁰ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁴¹ Interview with a lawyer (April 28th, 2011).

¹⁴² Interview with a lawyer (May 26th, 2011).

addressing mental health disability amongst ethno-racial people with mental health disabilities.¹⁴³

5.2.4 The CCB Hearing

i) Language/Communication

As per s. 18 of the CCB's rules of practice, lawyers felt that the CCB was consistent in its practice of providing interpreters to clients who need them during the hearing process.¹⁴⁴ However, as previously explained, the quality of interpretation during the hearing was questioned.¹⁴⁵

ii) Grappling with Culture

The majority of lawyers interviewed explained that the CCB often ignored the cultural and other social factors at play in various cases, the client's cultural context and history including experiences of oppression and trauma and the presentation of cultural evidence.¹⁴⁶ A lawyer recounts as follows:

They say they want to hear it, they say they are open to it, that is what they do now – they pay lip service to 'oh well we are becoming culturally sensitive, these issues are pertinent and we want to hear,' so you go through a lot of trouble to present the issues during the hearing and spend many hours preparing the evidence, and then it falls on completely deaf ears because the bottom line is – the doctor says a person is certifiable and there is

¹⁴³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁴⁴ Section 18 of the CCB's Rules of Practice indicates that the Board is responsible for arranging an interpreter for the hearing at its own expense. As per s. 18.2, "If a health practitioner, legal counsel, helping professional or rights adviser is of the opinion that a party or a party's witness requires an interpreter at the hearing, that person shall notify the Board office at the earliest possible opportunity." Consent and Capacity Board, "CCB Rules of Practice," online: Consent and Capacity Board <http://www.ccboard.on.ca/scripts/english/legal/rulesofpractice.asp>.

¹⁴⁵ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁴⁶ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

*a concern for risk of harm and nobody is prepared to on the strength of a cultural angle to the case. Regardless to how strong it is, they simply...they don't give it due weight or accord it real relevance – so there is almost no point.*¹⁴⁷

Specifically, in *S.K. (Re)*,¹⁴⁸ the client (S.K.) was Iranian and she spoke a specific derivation of Farsi. S.K. had been a sexual assault victim, and there was a lot of support for the client to be cared for at home by her family with various social supports in the community. S.K.'s mother and a counselor from the Canadian Centre for Victims of Torture (who had a long standing relationship with S.K. and her family) presented cultural evidence suggesting how the use of seclusion and restraint was retraumatizing for S.K., given her history of sexual assault. During their testimonies, both of them separately recommended that S.K. be given a “multicultural and cross-cultural treatment plan.”¹⁴⁹ However, according to a number of lawyers who commented on this case during the interviews, the CCB Board members discounted this evidence during the hearing, failed to appropriately analyze the cultural context of the case in their analysis and therefore rejected the recommendations for culturally appropriate treatment and care for S.K. in their final decision, which confirmed her Certificate of Renewal (for involuntary admission).¹⁵⁰ This was a stark example of how the cultural aspects of a case were not explored. A number of lawyers shared similar anecdotes and cases.¹⁵¹

¹⁴⁷ Interview with a lawyer (April 28th, 2011).

¹⁴⁸ *S.K. (Re)*, 2010 CanLII 11151 (ON CCB), TO-07-1551.

¹⁴⁹ *Ibid.*

¹⁵⁰ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁵¹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

iii) Prevalence of the Medical Model

All of the lawyers indicated that the medical model of disability was predominant in the CCB's processes. In this regard, patient-side lawyers felt that the process itself was institutionally biased against their clients since deference is consistently given to medical expertise, thereby making it easy to discredit clients¹⁵² who may be "perfectly capable."¹⁵³

A lawyer reflects upon this as follows:

In treatment incapacity and involuntary admissions cases, I almost never win. It doesn't matter what you do – nothing you can do usually can overturn the doctor's decision; unless your client is a medical practitioner, how do you prove that your client understands? The standard is just so high that unless your client is a medical practitioner, you couldn't put things in those terms. They are always going to be found 'oh well you don't really understand or appreciate' it is just easy, even though there is all this evidence otherwise showing that they are perfectly capable– if you screen them with the same standard – they wouldn't pass either –so I found them so easy to discredit the client by stating 'you just don't know what you are doing.' You are forced in a battle with a medical expert.¹⁵⁴

For example, a lawyer described a case in which the client was a Pakistani woman, who was being controlled and abused by her husband. Accordingly, every time the client resisted her family's control, her family would call the doctor and have her detained. Despite her other symptoms of trauma and fear, CCB adjudicators perceived this "resistance of control" as indicia of mental illness. The lawyer explained that the CCB adjudicators appeared to have no understanding of the other cultural, gender-based and intersectional issues at play within the case. As a result of the predominance of the

¹⁵² Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁵³ Interview with a lawyer (April 27th, 2011).

¹⁵⁴ Interview with a lawyer (April 27th, 2011).

medical model, these arguments were not accepted or assessed during the hearing process. Thus, the client was involuntarily detained for four months.¹⁵⁵ Similarly, another lawyer described a case where the treatment team interpreted a Farsi speaking client as acting “nonsensically” since she would use body language to ask simple questions such as “*I want to go to the bathroom or I want to eat – or just I want to get out.*”¹⁵⁶ Instead of addressing the communication issues at play, this behavior and agitation was perceived as increased mental distress.¹⁵⁷ Thus, when addressing such cases, lawyers felt that CCB adjudicators should be aware that there might be a non-mental health illness related explanations for an ethno-racial client’s reaction.¹⁵⁸

The predominance of the medical model is further evident in cases where lawyers have advocated on behalf of ethno-racial clients who would rather use alternative and complementary therapies such as homeopathy, naturopathy, light therapy and other culturally derived therapies instead of psychiatric medications. Since the CCB does not have jurisdiction to consider the type of medications being proposed,¹⁵⁹ lawyers felt this

¹⁵⁵ Interview with a lawyer (April 27th, 2011).

¹⁵⁶ Interview with a lawyer (July 6th, 2011).

¹⁵⁷ Interview with a lawyer (July 6th, 2011).

¹⁵⁸ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁵⁹ In such cases, the CCB’s role is to determine whether the person is capable or not of consenting to the treatment. However, as Anita Szigeti and D’Arcy Hiltz recognize, “while in law, acquiescence to treatment does not mean the person is capable, just as refusal of treatment should not be equated with incapacity, the reality is that assessments of capacity must take into account the individual’s ultimate decision about the treatment. In practice, many physicians do not question the capacity of a patient who agrees with their treatment recommendation. In one sense, it is not unreasonable for a physician to presume that his or her patient’s compliance with the recommended treatment plan is a capable decision. However, it is clearly problematic if a physician suddenly decides to declare a patient incapable because the individual refuses to continue to take medication rather than because of any change in his or her condition. Appellate courts have difficulty confirming a finding of incapacity made under these circumstances.” D’Arcy Hiltz and Anita Szigeti, *A*

was frustrating for their clients who wanted more culturally appropriate treatment options available to them.¹⁶⁰

In order to address these issues, a few lawyers suggested the CCB should adopt an “intersubjective model” which acknowledged the culturally based issues within a case.

*I think that culture, ethnicity and race certainly, all become aggravating factors for the client and I don't think those things are taken into consideration by the treatment team and the CCB. I think if they stopped to listen and to look at the situation intersubjectively rather than through the medical model – they would have a better outcome.*¹⁶¹

To achieve such a model, lawyers suggested CCB board members would need to learn analytical techniques to probe into these issues, and develop their own cultural analysis. CCB Board members need to have a positive attitude to the process of embracing cultural sensitivity.¹⁶² As one lawyer suggests, “*It may not take an expertise, but it does require a certain amount of sympathy, empathy and willingness to probe deeper into these issues.*”¹⁶³

iv) Adversarial Environment

Lawyers felt that the adversarial nature of CCB hearings could be detrimental for the therapeutic relationship between clients and physicians.¹⁶⁴ According to a physician-side lawyer:

Guide to Consent and Capacity Law in Ontario (Markham: Lexis Nexis Canada Inc., 2013) at 545; *Khan v. St. Thomas Psychiatric Hospital* (1992) 7 OR (3d) 303, par. 312 e.; *Boimier v Saminath*, [2003] O.T.C. 644 (ON S.C.).

¹⁶⁰ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁶¹ Interview with a lawyer (May 24th, 2011).

¹⁶² Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁶³ Interview with a lawyer (April 27th, 2011).

¹⁶⁴ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

*The board is not intended to be an adversarial environment and the board's rules of practice speak to how it is not. You know, to the extent – that they cannot be adversarial, that is in everyone's interest. But, the reality is that at a certain point, it is still litigation, and when things do proceed, the adversarialness can be very challenging for the therapeutic relationship, so when there is an added dimension and another layer of complexity, it is more complicated.*¹⁶⁵

Although clients are not obligated to appear at the hearings, testify or present evidence, a number of lawyers indicated that their clients often chose to participate in the hearing not expecting to be in an adversarial environment. As a result, lawyers suggested their ethno-racial clients often had greater mistrust of their own physician, and the broader mental health and legal systems after the hearings.¹⁶⁶ Thus, some lawyers suggest that the “best outcomes” are often from the hearings that do not proceed, since the concerns are addressed outside of an adversarial environment and in the context of the physician-patient therapeutic relationship.¹⁶⁷ However, other lawyers suggest that without the process, no appropriate resolution or equitable outcome is possible.¹⁶⁸

In order to reduce the adversarial nature of the hearings and ensure the best outcomes for the clients, lawyers felt that there should be consistent efforts to maintain civility and mutual respect amongst counsel in both sides of the hearing process.¹⁶⁹

v) Family Involvement

Patient-side lawyers felt that it was difficult to deal with the cultural conflicts within the families of their ethno-racial clients, and the amount of deference family

¹⁶⁵ Interview with a lawyer (June 9th, 2011).

¹⁶⁶ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁶⁷ Interview with lawyers (June 9th, 2011) and (May 26th, 2011).

¹⁶⁸ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁶⁹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

members receive during the hearing. In some circumstances, conflicts occur between the ethno-racial clients and their families as a result of the reverence given to psychiatrists and the broader mental health system by the families of ethno-racial clients. For instance, a few patient-side lawyers felt that family members of their ethno-racial clients supported the notion that their loved ones should stay in hospital for treatment instead of returning home,¹⁷⁰ where they would likely be exposed to “stigma and shame” within their communities.¹⁷¹ A lawyer describes this view as follows:

*I often feel that parents hate you. They want nothing to do with the idea that the child should be released or have the right to choose. There is often heavy interference on that side, especially when culture, stigma and shame are involved. I can understand why adjudicators often give the family a lot of leeway and let them babble on and just give them a lot of time to talk in the hearings. I found they were very generous with letting them give their information and very restrictive sometimes with the cross examination – you know – I found the families were given a little too much sway. Again, it is one of the difficult ones, obviously the mother is going to be the one person that really has an understanding, but having the motherly impulse to protect is not necessarily talking about someone to protect someone. The mother may not argue that they are going to let their child make their own decisions – it is challenging because the protective element is coming in.*¹⁷²

Subsequently, a number of lawyers interviewed suggested that the CCB take a holistic approach when addressing these familial conflicts, gathering as much collateral information as possible from family members, but always having a “patient-centred model.” Ethno-racial people with mental health disabilities should understand their treatment decisions and be involved in their own recovery process as much as possible.¹⁷³

¹⁷⁰ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁷¹ Interview with a lawyer (April 27th, 2011).

¹⁷² Interview with a lawyer (April 27th, 2011).

¹⁷³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

vi) Jurisdiction/ Discretion

The majority of lawyers indicated that the CCB has artificially restricted and narrowed its own jurisdiction.¹⁷⁴ In this regard, a lawyer argues as follows:

*The CCB's rationale is that their jurisdiction is very narrow – but in my opinion, the Board has artificially restricted and narrowed its own jurisdiction beyond where it needed to do. So I think for example that s. 41 (2)[MHA] that discretion to rescind an involuntary certificate even where the criteria are met, that could be exercised in cases where the cultural component to the case is strong for the fact that the individual – that is culturally consistent with the individual's history and background and thereby would be being cared for in a less restrictive environment.*¹⁷⁵

Lawyers feel that the CCB does have the discretion to consider culturally relevant considerations and probe further into these issues. For example, CCB board members have discretion to take culture, race, gender, class and other social factors into account when considering s. 41 (2) of the MHA (the criteria to confirm or rescind an involuntary admission certificate),¹⁷⁶ s. 1 of the MHA (the criteria of what constitutes a mental disorder)¹⁷⁷ and s. 39.1 (1) of the MHA (the criteria for issuing or renewing a Community

¹⁷⁴ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁷⁵ Interview with a lawyer (April 28th, 2011).

¹⁷⁶ MHA, *supra* note 39 states as follows:

“The Board by order may confirm the patient’s status as an involuntary patient if the Board determines that the prerequisites set out in this Act for admission as an involuntary patient were met at the time of the hearing of the application.” MHA, *supra* note 39.

¹⁷⁷ Section 1, MHA, *supra* note 39 states as follows:

“mental disorder” means any disease or disability of the mind; (“trouble mental”);” Section 15, MHA, *supra* note 39 states as follows: “15.(1) Where a physician examines a person and has reasonable cause to believe that the person, (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself; (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or (c) has shown or is showing a lack of competence to care for himself or herself, and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in, (d) serious bodily harm to the person; (e) serious bodily harm to

Treatment Order).¹⁷⁸ In this vein, for the CCB to consider cultural and other factors appropriately, lawyers suggested that its time frame for considering applications to review a client's community treatment order (s. 39.1 of the MHA) be extended from the seven-day period.¹⁷⁹

I inquired into whether or not the CCB should have jurisdiction over treatment. In response, lawyers were cautious and conflicted about endorsing a "Mazzei approach." In *Mazzei v. British Columbia*¹⁸⁰ the Supreme Court held that NCR (not criminally responsible) review boards do not have the power to prescribe treatment, but they should require the Directors of psychiatric facilities to "undertake assertive efforts to enroll the accused in a culturally appropriate treatment program"¹⁸¹ that is responsive to an accused's culture and heritage.¹⁸² Since the ORB is a NCR review board, which

another person; or (f) serious physical impairment of the person, the physician may make application in the prescribed form for a psychiatric assessment of the person."

¹⁷⁸ MHA, *supra* note 39 at s 39 (1) states as follows:

39.1(1) "A person who is subject to a community treatment order, or any person on his or her behalf, may apply to the Board in the approved form to inquire into whether or not the criteria for issuing or renewing a community treatment order set out in subsection 33.1 (4) are met;" MHA, *supra* note 39 at s 33 (4) states as follows:

"The physician shall promptly examine the person to determine whether, (a) the physician should make an application for a psychiatric assessment of the person under section 15; (b) the physician should issue another community treatment order where the person, or his or her substitute decision-maker, consents to the community treatment plan; or (c) the person should be released without being subject to a community treatment order."

¹⁷⁹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁸⁰ *Mazzei v. British Columbia*, 2006 SCC 7, [2006] 1 SCR 326.

¹⁸¹ *Ibid.* at para. 61.

¹⁸² *Ibid.* at para 65. It should be noted that NCR review boards adjudicate issues arising from forensic mental health laws. But, they do have some similarities with boards such as the CCB.

adjudicates issues arising from forensic mental health laws, its jurisdiction is distinct from that of the CCB.¹⁸³

However, some lawyers argued that the spirit of the *Mazzei* decision should be implemented in the civil mental health law context. They felt that the CCB should encourage and direct the hospitals or service provider to provide culturally appropriate treatment programs for ethno-racial people with mental health disabilities.¹⁸⁴

In contrast, other lawyers argued that the CCB should not be given any powers involving treatment, given the CCB's institutional bias against their clients.¹⁸⁵ In the following narrative, a lawyer grapples with these issues:

*I don't know – the ORB's jurisdiction is quite different. They have a broader jurisdiction, as we see from Conway, over the accused that continues over the long haul. So it is not quite the same thing. And yet it would be good. But you have to be mindful that you want to give a mental health civil tribunal, like the CCB, no offense, too much power, too much ability to direct care because for our clients – it would inevitably get worse. You would get psychiatrists members, which you already get and you have absolutely no jurisdiction to do this, getting in there in reviewing the treatment that is being provided and then making suggestions. And which is never in the interests of the person. So I would be afraid to give them more power that way. There is the tension in a sense there. On the one hand, you would want broader jurisdiction to allow tribunals to be more involved and have more power to do more to help the individual at the centre of the controversy. But that power can so easily be abused. So on the other hand, maybe it is best that their jurisdiction is as narrow as it is. As with everything else, it depends on the people who are the actual decision makers. And how they would interpret any particular jurisdiction, statutory available.*¹⁸⁶

¹⁸³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁸⁴ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁸⁵ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁸⁶ Interview with a lawyer (April 28th, 2011).

Thus, there appeared to be no consensus amongst lawyers about how the CCB should address the specific treatment concerns of ethno-racial people with mental health disabilities.¹⁸⁷

5.2.5 Post-Hearing: Translation of Decisions

Lawyers argue that it was problematic that the CCB's written decisions and reasons are only given in English, and not translated for those who do not speak English. Lawyers felt that this was a significant communication barrier for ethno-racial people with mental health disabilities who did not speak English, because they were not able to comprehend the result of their hearing (whether this included treatment, involuntary admission, community treatment etc.).¹⁸⁸ A few lawyers felt obligated to ensure their clients understood the CCB's processes and they paid for the decisions to be translated at their own expense.¹⁸⁹ A lawyer reflects upon this as follows:

*How can it be up to the litigant to take the decision and take on the expense of getting it translated? I mean it is part of due process. Someone should be in charge of translating the decision. This is the tribunal's responsibility.*¹⁹⁰

Thus, in order to address this issue of due process, lawyers recommended that the CCB must translate its decisions for those who did not speak English and this requirement should be included in the CCB's Rules of Practice.¹⁹¹

¹⁸⁷ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁸⁸ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁸⁹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁹⁰ Interview with a lawyer (July 6th, 2011).

5.2.6 Human Rights in the Hospital

Lawyers indicated that key barriers to care for ethno-racial people with mental health disabilities included: the institutional racism within the mental health and legal systems, the lack of culturally specific clinical support, the lack of access to the broader human rights system, culturally appropriate treatment options and psycho-social supports and the stigma of having a mental health disability.¹⁹² For instance, one lawyer reflects as follows:

*I think human rights are really invisible in the hospitals. Clients really don't have access to the human rights system – sure they can call the Human Rights Legal Support Centre and I think the HRLSC would do their best to help them/ accommodate – but I think a lot of clients don't have access to a phone – **it is a privilege to access a phone** – even though under the mental health act – you are supposed to have an unadulterated right to communicate with your lawyer etc....¹⁹³*

Despite the ruling in *Tranchemontagne v. Ontario (Director, Disability Support Program)*,¹⁹⁴ lawyers point out that there are only four cases where the CCB has considered human rights issues.¹⁹⁵ Accordingly, a number of lawyers suggested that CCB lawyers be trained to recognize human rights issues such as those related to racism, discrimination, harassment, accommodation issues and the increased use of seclusion and restraint and help them make human rights complaints regarding these systemic

¹⁹¹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁹² Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁹³ Interview with a lawyer (May 24th, 2011).

¹⁹⁴ 2006 SCC 14, [2006] 1 SCR 513 at para 32. In this case, the SCC confirmed that administrative tribunals do have jurisdiction to consider legal issues as per the human rights codes and tribunals must use their discretion to consider relevant code related legal issues.

¹⁹⁵ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

problems.¹⁹⁶ It was also recommended that patient advocates, staff and case-workers trained in the human rights system should be in regular contact with ethno-racial people with mental health disabilities with the support of organizations such as the CAMH Empowerment Council, the Human Rights Legal Support Centre and ethno-specific mental health organizations including Across Boundaries, Hong Fook Mental Health Association and the Ethno-Racial People with Disabilities Coalition of Ontario.¹⁹⁷ In the following narrative, a lawyer explains the importance of addressing these systemic challenges appropriately:

For one client, when her mental illness manifested, she would revert back to her Native language of Mandarin, so she starts speaking Mandarin and the treatment team thinks she is putting on a show for them – “oh you are faking, you are just trying to jerk us around.” And again, the patient advocate was able to get the family members involved. “No – she can’t speak English when she is really ill.” There again – the advocate will raise the human rights paradigm – will certainly offer the client, “do you want us to help you to the tribunal, and we will connect them to resources like the Human Rights Legal Support Centre.” They are trying to advocate their way, because they also see the systemic issue in this, that one incidence of discrimination – discreet or vocalized happens throughout the mental health system all the time.¹⁹⁸

Thus, lawyers recommended that more funding should be available for clients to make human rights complaints in the mental health context to the Human Rights Tribunal.¹⁹⁹

5.2.7 Access to Culturally Appropriate Treatment and Care

Lawyers felt that there were many barriers for their ethno-racial clients to obtain

¹⁹⁶ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁹⁷ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

¹⁹⁸ Interview with a lawyer (May 24th, 2011).

¹⁹⁹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

culturally appropriate treatment and care through the CCB's processes and within the broader mental health system. Since complaints of this nature are often not accommodated, a number of lawyers suggested that the lack of culturally appropriate treatment and care indirectly contributed to their client's mental health disability and overall well-being.²⁰⁰ A lawyer reflects upon this as follows:

*We cannot keep failing our clients. If you discharge them to someplace where they are not surrounded by people who are familiar to them – or have access to programs who are culturally appropriate for them, they are not going to do very well. Sometimes, the biggest problem with ethno-racial clients is that they are not particularly engaged with their own diagnosis, treatment, rehab and rehabilitation. You have to find culturally appropriate programs or people who understand what they are going through – who are able to find ways of engaging them in their own recovery. You can't just shrug your shoulders and say you can't help the person.*²⁰¹

It is challenging for ethno-racial people with mental health disabilities and their families to advocate for access to culturally appropriate treatment without support from their treatment team, patient advocates, case workers and lawyers. Thus, lawyers need to be aware of ethno-specific service providers and organizations that provide culturally specific treatment and care.²⁰² Further, some lawyers argued that a “collaborative care” approach should be available for the clients. This type of approach would ensure that advocates and service providers from ethno-specific mental health organizations could be involved in the treatment teams' weekly meetings.²⁰³ Consequently, it was suggested that

²⁰⁰ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²⁰¹ Interview with a lawyer (April 28th, 2011).

²⁰² Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²⁰³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

outpatient teams, who often have years of expertise and experience, could help make connections with ethno-specific service providers and organizations in the community.²⁰⁴

In this respect, there continues to be barriers for ethno-racial people with mental health disabilities to access culturally appropriate mental treatment and care given the lack of ethno-specific mental health organizations available and the scarcity of resources to create new ones.²⁰⁵ In the following narrative, a lawyer reflects upon these challenges:

*I come to it from the perspective of knowing that the resources are scarce. I think the issue is you know, if you had all the money in the world – well wouldn't it be wonderful to have everything perfectly translated, and culturally appropriate services and treatment available on the spot – unfortunately we don't live in that perfect world and the reality of health care in general and mental health care in particular is that – it is always scarce resources and you are always in the business of having to establish priorities, and that makes it very difficult to do all the things you know – would and could be and should be done, and I think that is always the challenge from the hospital's perspective is knowing the range of things that the various communities need is how do you make sure to have the highest impact for the largest number of people while at the same time making sure individuals who have certain unique needs are not left behind and that their unique needs are met. I think the reality is that it is difficult in the current economic environment, in the current public sector environment to meet all those needs. Unfortunately there is no funding for things that have to happen – and that is entirely appropriate.*²⁰⁶

Consequently, in light of the restraints on resources, lawyers suggest that all practitioners should continue to question whether current and available in-patient and out-patient mental health services are being delivered in a culturally appropriate manner.²⁰⁷

²⁰⁴ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²⁰⁵ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²⁰⁶ Interview with a lawyer (June 9th, 2011).

²⁰⁷ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

5.2.8 Religious Accommodation

Lawyers indicate that the issues surrounding religious accommodation are complex and multi-faceted since health care professionals may perceive increased levels of religious observance as indicia of mental disability. For instance, it is challenging for health care professionals to accommodate religious observation in psychiatric facilities because a reasonable amount of space and privacy is often required.²⁰⁸ In the following narrative, a lawyer describes the types of barriers ethno-racial people with mental health disabilities face when attempting to have religious requests appropriately accommodated:

I had another Farsi speaking Iranian mother – also the SDM for a daughter who was being held in an isolation room. They had put her in an isolation room. They were Muslim. They followed the Muslim faith. I think they were pretty traditional and conservative. They had placed her daughter in a small isolation room. And the way the nurses monitored her was through a camera. So there was a camera in the room and it was attached to cameras and video screens in the nursing stations. Because they were supposed to be doing constant observation or whatever. The toilet was also in that room. There was just a bed and toilet was not in a separate room. There was a toilet and a bed. So, the family were horrified that she was having to pee and do everything else (dealing with menstrual issues) in full view of male and female staff which you know – I think is a problem generally – if you are a woman or a man. In that case, it was particularly troubling because of all the religious and cultural stuff and the hospital was not sensitive to that at all. The security issue was the overriding issue until I pointed out to them in that case – that in itself affecting her – she herself (the woman being detained) was reacting negatively to this means of being isolated. That in itself was contributing to her anger.²⁰⁹

As a number of lawyers explain, increased levels of religious observance are often pathologized within psychiatric facilities since there is a lot of “grey between cultural, religious and pathological issues.”²¹⁰ Lawyers indicate that they are often arguing with the health care professionals and the CCB more broadly about the following questions:

What is a legitimately held religious belief vs. what is a delusion? What is something

²⁰⁸ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²⁰⁹ Interview with a lawyer (July 6th, 2011).

²¹⁰ Interview with a lawyer (April 28th, 2011).

non-conventional in terms of religion? Does the law recognize a particular ritual or practice as part of a religion, and how can it be proven that a violation is occurring? ²¹¹

A lawyer describes these issues as follows:

The biggest problem when it comes to religion is that psychiatrists will say – “religious preoccupation” is a big hallmark of symptoms of schizophrenia particularly. Clients who really insist on their right to practice their religion being accommodated in a psychiatric facility will see those requests are missed because the psychiatrist or the physician will determine that as just a symptom – the person isn’t really as observant as they say they are – that is just because they are symptomatic and acutely psychotic that they want to do all of these things. This isn’t really fair – even if it is – it is still religious observance – regardless of what is at the basis of it – I think it should be accommodated.²¹²

Overall, lawyers felt that it is therapeutic for ethno-racial people with mental health disabilities to explore religious ideas and engage in religious observance. Thus, lawyers felt that religious accommodation requests should not be inappropriately pathologized and these requests should be accommodated.²¹³ To address these challenges, lawyers argue that they should try to support ethno-racial clients by bringing forth religious accommodation requests before the CCB, filing complaints to the Ontario Human Rights Tribunal or involving patient advocates through the Psychiatric Patient Advocate Office.²¹⁴

²¹¹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²¹² Interview with a lawyer (April 28th, 2011).

²¹³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²¹⁴ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

5.2.9 Admission to Long Term Care Facilities

When deciding cases involving admission to long term care facilities, lawyers recommend that the CCB recognize how ethno-racial people with mental health disabilities are more comfortable and happy in a cultural environment with others from similar cultural backgrounds.²¹⁵ A number of lawyers felt that there was a lack of appropriate rights advice given in long term care facilities for older ethno-racial clients or their substitute decision makers. Thus, recommendations were made to ensure that ethno-racial people with mental health disabilities have access to appropriate rights advice (particularly in respect of the right to refuse treatment and medications), advocacy services and support when making appeals to the CCB.²¹⁶

5.2.10 Legislative Reform

Lawyers argue that legislative reform is needed to ensure that cultural background, class, social history, ethnicity, cultural standards of normality vs. abnormality and other socio-cultural factors are considered appropriately in CCB cases. Since the CCB considers itself a “creature of statute,”²¹⁷ lawyers suggest that the CCB is extremely reluctant to stray away from what is explicitly stated within the statutes.²¹⁸ Thus, lawyers felt that including cultural and other factors within key sections of the

²¹⁵ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²¹⁶ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²¹⁷ Interview with a lawyer (April 28th, 2011).

²¹⁸ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

statutes would require the CCB to examine and address these issues.²¹⁹ A lawyer

contextualizes this argument as follows:

There is nothing preventing legislatures from stipulating that a review of involuntary committal or financial capacity, or treatment capacity or CTO should take cultural factors into account. There is nothing preventing legislature from including in the criteria to be met before you can be formed for involuntary detention for instance, that the board shall be satisfied that a less intrusive treatment or care modality in the community is not available. We don't have anything as part of our test and that you know, a suitable model of care, treatment or supervision in the community with cultural factors taken into account. Sort of the same language as in the CTO sections, but in a different context. For example, language could say: 'Shall include culturally appropriate services.' Or for the CTO reviews – there is nothing that would prevent legislature from amending, adding two words to what is a community treatment plan instead of just saying – 'it is a plan of care, treatment or supervision in the community that is less intrusive than hospitalization.' Perhaps it could say – 'given the person's background, heritage, and ethnicity, a culturally appropriate plan of care.' There is nothing that would prevent legislature from including those words. If those words were included, then the board would be obliged to ensure that any community care plan is culturally appropriate – and tailored to the needs of the individual in the individual fashion.²²⁰

Lawyers further point out that there is a precedent for including this type of language in mental health statutes. For instance, as per s. 21 (2) (a) of the *Health Care Consent Act*,²²¹ (the substitute decision maker's (SDM) test of best interests in decision-making), the SDM is required to take 1) "the values and beliefs" into account, which were held by the incapable person when capable and the SDM believes he or she would still act on if capable and 2) "any wishes" expressed by the incapable person while capable and with respect to treatment.²²² Lawyers argued that these sections enabled substitute decision

²¹⁹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²²⁰ Interview with a lawyer (April 28th, 2011).

²²¹ *Health Care and Consent Act*, SO 1996, c 2, s 21 (1) (2) and s 59 (1) (2) [HCCA].

²²² HCCA, *supra* note 144 at s 21 (1) (2). Specifically, the principles for giving or refusing consent under s. 21 (1) and (2) include:

"A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles: 1. If the person knows of a wish

makers to take the incapable person's prior religious, cultural and other values/beliefs into account when making decisions for giving or refusing consent to a treatment or a personal assistance service.²²³

Lawyers recommended that mental health statutes should not be vague when incorporating criteria for considerations of culture, gender, class and other socio-cultural factors, along with human rights considerations. The statutes and legislation must be detailed and specific in order to address these issues and to ensure that clients can

applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish. 2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests."

Best interests

"(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration, (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable; (b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and (c) the following factors: 1. Whether the treatment is likely to, i. improve the incapable person's condition or well-being, ii. prevent the incapable person's condition or well-being from deteriorating, or iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate. 2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment. 3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her. 4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed."

²²³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

activate their rights.²²⁴ Some lawyers also suggested that there should be “purpose statements” for the key sections.²²⁵ One lawyer reflects upon this as follows:

So if you don't have specific legislation, you really short circuit patient rights – because they don't get it. I think yes, the more detailed you can be the better – I think. Even stuff like, in the Mental Health Act, s. 25, clients have a right to speak with their lawyer, communicate with them – that is routinely broken – because the facilities say “well – the legislation doesn't say cell phones” - the legislation is frozen in the 80s so they are thinking that people are communicating with their lawyer by a letter – not that the lawyer wants to come see them at the facility or call them on their phone or whatever. So – you know. There again – if it is not explicit – yes – patients have a right to use cell phone - it doesn't get done.²²⁶

However, lawyers suggest that regardless of how detailed and specific the statutes become, there still needs to be ongoing efforts by lawyers to continue systemic advocacy on these issues. A few lawyers also indicate that legislative reform may not be a viable or effective solution.²²⁷ Legislators may not be interested in a “patient/client/consumer – centred approach” to legislative reform.²²⁸ Instead, it was suggested that there should be a focus on mainstreaming cultural and other issues throughout the CCB's pre-hearing, hearing and post-hearing processes.²²⁹ A lawyer argues as follows:

I think that it is always important for these considerations to be mainstreamed. I don't know frankly that the legislation, I may have concerns about the legislation in other areas, but I don't know whether legislative reform is always the route that has the impact desired, to the extent these and issues are ghettoized, but rather mainstreamed into all aspects of the care from stage one arriving in the ER for example, to community treatment, that if those considerations are relevant at all stages that that is most helpful. The language of the legislation, there are lots of challenges with it, I think to be candid I

²²⁴ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²²⁵ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²²⁶ Interview with a lawyer (May 24th, 2011).

²²⁷ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²²⁸ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²²⁹ Interview with a lawyer (June 9th, 2011).

*just don't know where the opportunities would lie, and whether that would be of assistance. The reality is that legislation is a blunt instrument, like the rest of law. In practice, it is a blunt instrument.*²³⁰

Thus, some lawyers recommended that there should be ongoing systemic advocacy on behalf of ethno-racial people with mental health disabilities, along with legislative reform.²³¹

5.2.11 Research Initiatives

Lawyers suggest that further research is needed to understand and explore the inequities faced by ethno-racial people with mental health disabilities appearing before the CCB. In particular, lawyers recommended that pilot studies implementing frameworks such as the CAT should be conducted to ensure such barriers are better understood.²³² Some lawyers suggested that there should be research conducted on how ethnopharmacology (research which suggests that people from various ethnic and racial backgrounds may respond differently to psychiatric medication) should affect diagnosis, involuntary medication, and treatment plans.²³³ It is also recommended that researchers should compare how other countries' approach mental health disability in the civil context, and analyze how mental health disability is perceived amongst various ethno-racial communities. A recurring theme amongst lawyers interviewed was that research should inspire and direct systemic advocacy on behalf of ethno-racial people with mental

²³⁰ Interview with a lawyer (June 9th, 2011).

²³¹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²³² Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²³³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

health disabilities.²³⁴

In this context, a lawyer reflects upon this as follows:

*I think research is extraordinarily important, and that research is done with strong methodology and all these things, that you know that it is received and understood okay, and how can we make it better. I think the reality is that we don't know, so it is an important area – and the extent that researchers are committed to making sure that our ethno-racial clients have the best experience possible at a time in their lives that is usually pretty awful. This is why research is important.*²³⁵

Given the dearth of research available, lawyers recommended that more funding should be available for research to conduct studies on the experiences of ethno-racial people with mental health disabilities in Ontario's civil mental health system.²³⁶

5.2.12 CCB Adjudicators

Lawyers suggest that the CCB needs to build “diversity” into its membership. There is no policy to ensure that CCB adjudicators are reflective of Ontario's diverse population.²³⁷ Thus, lawyers recommended that the CCB should actively recruit adjudicators from diverse communities and those who have a “history of understanding” the colliding intersections of culture, race, mental health disability and other identities.²³⁸

A lawyer reflects upon this recommendation as follows:

I think it is important to have representatives from racialized communities as members of the board. For my clients are from racialized communities – it does help them and they comment when they see someone from their community on the panel. . Similarly, the

²³⁴ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²³⁵ Interview with a lawyer (June 9th, 2011).

²³⁶ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²³⁷ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²³⁸ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

*clients want consumer/survivors on the panel, so they will comment on that during the hearing. As with everything else, just the fact that someone is black and just the fact that someone is survivor, it has to be more than that; it has to be someone with a “history of understanding,” or someone who is prepared to be educated of how their own race or culture links with issues mental disorder or mental illness and how we treat that. And, the other big huge cultural difference is whether police are used to enforce mental health laws or whether detention is appropriate for people in mental health crises. The other big contentious issue that is very dependent on race and culture is the approach to psychiatric medications.*²³⁹

Consequently, it appears that lawyers suggest that CCB adjudicators do not necessarily have to be from ethno-racial communities, if they are culturally sensitive, competent and able to question their own bias and privilege when addressing such cases.²⁴⁰ In this regard, lawyers emphasized that the recruitment process should be improved to ensure that members are highly qualified, and genuinely interested in taking equity concerns seriously.²⁴¹

5.2.13 Training

Lawyers suggested that CCB adjudicators and all mental health practitioners should undergo sustained and ongoing “cultural sensitivity, diversity, anti-racism or anti-oppression” training.²⁴² Since various models of training exist, lawyers were torn on which approach would be appropriate. However, there was a consensus that training should be accessible for all practitioners and the current training programs should be

²³⁹ Interview with a lawyer (April 28th, 2011).

²⁴⁰ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²⁴¹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²⁴² Data derived from interviews conducted with lawyers from April 2011 to November 2011.

improved.²⁴³

For instance, lawyers indicated how the rights-advice training program was amended to ensure that intersectional, cultural and human rights considerations were at the forefront through a problem/scenario based approach.²⁴⁴ A number of lawyers noted that it was problematic that rights advisers received five days of full training whereas CCB adjudicators only received two days of training (which often does not address cultural considerations). Consequently, it was recommended that the CCB training program be improved and expanded to include mandatory training regarding cultural and intersectional issues.²⁴⁵ Similarly, lawyers felt they needed training to recognize when a cultural, or intersectional issue was relevant to a particular case, and how cultural evidence should be appropriately included within their arguments before the CCB. It was recommended that Legal Aid Ontario (LAO) should provide financial support for funding such training. Training should include guest speakers from ethno-racial communities and Ontario service providers specializing in this area.²⁴⁶

²⁴³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²⁴⁴ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²⁴⁵ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁴⁶ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

5.3 HEALTH CARE PROFESSIONALS

5.3.1 Role of Health Care Professionals

i) Recognition

Health care professionals suggest that the cultural and intersectional issues affecting ethno-racial people with mental health disabilities significantly add to their level of isolation, distress and disempowerment within the civil mental health system. In this regard, a number of health care professionals question the extent to which these issues are recognized and addressed by their fellow colleagues.²⁴⁷ For instance, a health care professional explains the significance of recognizing these issues as follows:

*I think it was very clear that culture plays a huge role, in the quality of health care people receive in health care. That has to do with the extent to which they will disclose issues, how we interpret symptoms, how they share or not share with providers. Sometimes in the mainstream system, ethno-racial clients may be describing a different context, but it may be interpreted by someone from a very different context. So I think being aware of all of that is extremely important for all health care professionals. There is a need to recognize the role culture plays in how we provide services – in communication and assessment, like the whole shebang when it comes to clinical care processes. And there isn't a right or wrong. It isn't that one approach is right and the other is wrong.*²⁴⁸

Accordingly, respondents argued that health care professionals should be trained to acknowledge and examine the relevant cultural factors within an ethno-racial client's case.²⁴⁹

²⁴⁷ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁴⁸ Interview with a health care professional (September 8th, 2011).

²⁴⁹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

5.3.2 Language/ Communication

i) CAMH Interpretation Services

CAMH interpretation services are provided to all CAMH clients and their families free of charge, and there are interpretation and translation services available for written materials in approximately fifty languages. However, respondents indicate that these services have not been used to translate documents for CCB hearings.²⁵⁰ In the following narrative, a health care professional describes how CAMH's interpretation services are administered:

We have a coordinator... the staff member, clinician, physician or nurse will send a request to the coordinator. And we have about 40 contract interpreters, which are not CAMH employees. But, they are qualified freelance interpreters who signed contracts with CAMH. They do meet all of the qualification requirements for I don't know how many languages. And they provide interpretation services for CAMH clients and their families on site. If they are not available, then we contact interpretation agencies, it is usually there are three non-profit in Toronto – either Riverdale or Access Alliance or sometimes CIAS. There is a list of non-profit agencies and it will always be non-profit agencies, like Access Alliance is a community health centre, so one of their services is they also provide community interpreters who are qualified to meet our criteria. And, then we pay the agency.²⁵¹

Overall, health care professionals suggest that interpretation services at psychiatric hospitals are accessible and effective. However, since all interpreters have to be scheduled in advance, there are often no interpreters available to meet the everyday needs of clients, the needs of clients in the emergency department and clients who speak rare languages.²⁵² A health care professional argues as follows:

²⁵⁰ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁵¹ Interview with a health care professional (September 12th, 2011).

²⁵² Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

*It has to be booked in advance, so you can't just call up and say, 'can you have an interpreter come up right now,' so you need scheduled appointments. I think it is a big barrier. Getting everyday needs met can be really challenging when there is a language barrier because of clients coming up and asking something, and often struggling to make themselves understood.*²⁵³

Further, a number of health care professionals indicate that psychiatrists will not use interpreters during capacity assessments if ethno-racial clients appear to have some knowledge of English, since the capacity assessment can take twice as long with an interpreter involved.²⁵⁴ As one psychiatrist indicates, “we don't make enough use of interpreters, either language interpreters or cultural interpreters.”²⁵⁵ Consequently, health care professionals suggest there are higher risks of misdiagnosis, misunderstandings and mismanagement in such circumstances.²⁵⁶

Specifically, a health care professional articulates these issues as follows:

*People don't come to the hospital because they are healthy and feeling great. They come because they are feeling stressed. So what does that do to people's abilities to express themselves adequately and what does that do to the word choice? And we rely heavily on how people express themselves – the words they use. So I think this is where we have to be conscious of – to what extent? And it is not easy, I don't have a clear flow path for you to say – if this, then that. But we must recognize that some of this behavior is not necessarily being evasive, or being lying, or trying to be deliberately misleading but it is a clear language, communication barrier, because of the lack of interpretation services being used.*²⁵⁷

²⁵³ Interview with a health care professional (September 14th, 2011).

²⁵⁴ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁵⁵ Interview with a health care professional (October 4, th 2011).

²⁵⁶ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁵⁷ Interview with a health care professional (September 8, th 2011).

Accordingly, respondents argue that health care professionals should be aware of the impact that communication barriers may have on their ethno-racial clients' diagnosis and treatment.²⁵⁸

ii) Quality of Interpretation

In spite of when interpretation services are used, health care professionals argue that ethno-racial people with mental health disabilities continue to face evident language and communication barriers, because the standard of care they are receiving is diminished.²⁵⁹ A health care professional reflects upon this as follows:

*That being said, there is no question that if someone doesn't speak English and has a difficult time communicating, the standard of care they get is diminished simply because we function in English. Although I can function in French, the communication barriers are not only with me, but also with nursing staff, who are with patients on a regular basis. We aren't at the point of getting translators everyday for example.*²⁶⁰

Respondents also questioned the quality of interpretation services in regard to whether simultaneous translation was occurring, and whether cultural practices and nuances were appropriately interpreted during psychiatrists' capacity assessments.²⁶¹ Accordingly, a health care professional argued that psychiatric hospitals must implement "linguistic competence strategies," which have been developed by Health Equity Offices. Such a strategy is described as follows:

There is a whole linguistic competence strategy, which includes strengthening cultural interpretation services, building internal capacity, ensuring compliance and qualification

²⁵⁸ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁵⁹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁶⁰ Interview with a health care professional (September 14th, 2011).

²⁶¹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

*of the interpreters. We are revising the new confidentiality aspect (we had an initial one but we are revising the old one) and adding some new requirements. We need to look into the insurance issue for interpreters, develop translation guidelines and guidelines to ensure that client documents are appropriately translated. Also, we need to ensure/protect privacy for the clients.*²⁶²

A number of other recommendations were also made to improve the quality of interpretation services. For instance, some health care professionals suggested that there should be guidelines implemented to ensure that every client gets access to interpretation services within 24 hours of admission.²⁶³ Further, health care professionals suggested that there should be guidelines implemented to ensure that those who need interpretation services for their “everyday needs” should receive interpretation services at least twice a week.²⁶⁴ Lastly, it is also recommended that there be specific standards implemented to certify that all interpreters are well-qualified and trained in understanding the mental health and cultural context in which they are practicing.²⁶⁵ One health care professional suggests that there should be national standards implemented in Canada to ensure that there are culturally and linguistically appropriate interpretation services available for ethno-racial people with mental health disabilities, similar to the national standards used in the United States.²⁶⁶

²⁶² Interview with a health care professional (September 12,th 2011).

²⁶³ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁶⁴ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁶⁵ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁶⁶ Interview with a health care professional (September 8,th 2011).

iii) Cultural Interpreters/Consultants

There are currently no “cultural interpreters” available since there is no formal training for cultural interpreters offered in Canada.²⁶⁷ When questioned about whether cultural interpreters or consultants should be used, health care professionals were divided in their views regarding the appropriateness of developing cultural interpretation/consultant services.²⁶⁸ In the following narrative, a health care professional explains why this is such a challenging issue for many health care professionals:

*It is a tough one. I don't know if there are right answers anyway. I think for the course, particularly it is very clear that it is a linguistic interpretation that people do, as opposed to a cultural interpretation. My general approach is that the linguistic interpretation is most important. The cultural component of it is something that can be offered for consideration. In the health care context, and I think it might be similar in the legal context, is that the interpreters' job is to do the best they can linguistically. And if they think that there is a cultural component – maybe if they phrased it a different way, or if they asked five other questions about context, they would get more, to share that information with whomever they are interpreting for. So, they are the lawyer's voice or they are the health care professional's voice, whether it is the nurse or the doctor.*²⁶⁹

Consequently, some health care professionals warn that there is a danger of perceiving people who act as cultural interpreters / consultants to be the “experts of the culture.”²⁷⁰ However, those in favor of using cultural interpreters/ consultants suggest that cultural interpreters/consultants may offer another possibility of thinking about a cultural issue, understanding the ethno-racial client's cultural norms and contextualizing the interpretation. In this vein, cultural interpreters/consultants can act as knowledgeable facilitators to help educate health care professionals about the ethno-racial client's

²⁶⁷ Interview with a health care professional (September 12,th 2011).

²⁶⁸ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁶⁹ Interview with a health care professional (September 8,th 2011).

²⁷⁰ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

cultural background enabling health care professionals to ask relevant or varied questions, while providing a cultural context for the ethno-racial client's answers.²⁷¹

Thus, some health care professionals argue that cultural interpreters/consultants may help ensure health care professionals, and in particular, psychiatrists avoid misdiagnosis and miscommunicating with ethno-racial people with mental health disabilities.²⁷²

The following key questions should be asked when considering whether to use cultural interpreters/ consultants: Is the interpreter appropriately giving the client a voice? Does the interpreter understand the client's cultural background and cultural context? Can a question be rephrased since it has a different interpretation in another culture? Does a word or phrase have a different interpretation in the client's culture?²⁷³

5.3.3 The Pre-Hearing Process

i) Police Action

Health care professionals argue that it is problematic how police are often charged with transporting ethno-racial clients to psychiatric facilities.²⁷⁴ Respondents suggest that security guards often use "excessive force" when there appears to be a need to de-escalate an ethno-racial client. This was perceived as being a significant equity concern. Some health care professionals also felt that there was inequity of how ethno-racial people with

²⁷¹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁷² Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁷³ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁷⁴ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

mental health disabilities were treated when in police custody.²⁷⁵ Health care professionals expressed the view that the procedures appeared arbitrary and inconsistent as some ethno-racial people with mental health disabilities were brought to the hospital and others were charged and arrested.²⁷⁶ Thus, a number of health care professionals recommended that a study be conducted to examine the likelihood of police bringing an ethno-racial person with a mental health disability into the hospital vs. jail for the same complaint.²⁷⁷ A health care professional reflects upon this recommendation as follows:

*It would be nice to do a study on this issue. I think sometimes with the police, the impression is that they tend to take mercy on women and white people and bring them to hospital for care. If somebody is a man, black and tall, they bring him into the jail. They find a way to charge them - a stupid reason to charge them. I think that would be my main recommendation in terms of research within the legal system. I think there is inequity of how people are charged vs. brought to the psychiatric hospitals.*²⁷⁸

ii) Rights Advice

Health care professionals felt that rights advice in Toronto hospitals was provided appropriately and effectively.²⁷⁹ However, they questioned whether ethno-racial people with mental health disabilities actually understood the concept of “rights” and their legal rights in general. For instance, respondents argue that ethno-racial clients often understand the concept of involuntary admission because they are being held against their

²⁷⁵ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁷⁶ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁷⁷ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁷⁸ Interview with a health care professional (October 4,th 2011).

²⁷⁹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

will.²⁸⁰ In contrast, they do not understand the different types of treatments, the names of the treatments they are taking, and the concepts of informed consent and treatment capacity and incapacity in respect of the management of property.²⁸¹ A health care professional describes these issues in the following narrative:

*Only some ethno-racial people understand their rights. I think around involuntarily admission – most people understand that if they want to go, and they are being told not to, no matter how unwell they might be at the time, I think those people can understand... “You know, I am being helped and I don’t want to be here, someone is telling me that and I can’t go.” So it is pretty easy for most folks to understand. They may not agree, but I think they can understand what is happening around capacity and treatment. Around finances, that might be something that some people have a harder time understanding. Because that is less tangible. It is like someone else is doing stuff in the background and it is not necessarily impacting them everyday. Treatment – a lot of time is not tangible, they call it “medication time”...and they come up to take their cup of medication, and they take it – and no one really says, “this is clozapine, this is risperidone.” But for something, like ECT, that would be more tangible. ‘He is making me do this and I am not consenting to this,’ but other medication and treatment decisions I think are not understood. So, it is whether it is impacting somebody.*²⁸²

Thus, health care professionals recommended that rights advisers should improve their approach when giving rights advice to ensure they use plain-language, cross-cultural communication methods and specific examples to explain the legal concepts. Some health care professionals even suggested using fact sheets, which should be translated for those who do not speak English.²⁸³

²⁸⁰ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁸¹ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²⁸² Interview with a health care professional (September 15th 2011).

²⁸³ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

iii) Psychiatrists' Capacity Assessments

Health care professionals argue that the psychiatrists' capacity assessments do not often appreciate and recognize the lived experiences of ethno-racial people with mental health disabilities, their cultural background, social history and cultural standards of normality vs. abnormality.²⁸⁴ A number of health care professionals indicated problems with the diagnostic approaches and tools used for ethno-racial people with mental health disabilities. For instance, health care professionals pointed out the problems involved with using the "mental status examination."²⁸⁵ Health care professionals are required to use this exam in every interaction with clients, whether for assessments, diagnosis or general care. In this respect, the "mental status examination" is deficit based since the categories for assessment are based on deficit. Health care professionals suggest that this tool is problematic for assessing and diagnosing ethno-racial people with mental health disabilities since all of the categories may be influenced by cultural norms, cultural practices and expressions, along with language/communication barriers.²⁸⁶ A health care professional argues as follows:

It is expected for all of us to use the mental status exam – so essentially there are seven or eight categories. Appearance, motor, speech, thought process, perception, intellect and sight...etc. But essentially you are making this judgment about somebody in the here and now. And the expectation in our program is that everybody does it in every note and interaction with this client. But I don't do it because I think it is deficit based and it is not how I practice. We should have some parallel tool where you look at what are people's values, beliefs, or a recovery-based tool where you could assess somebody in the here and now rather than having it be totally deficit based. With the mental health status exam, they talk about making judgments about somebody's facial expression – whether

²⁸⁴ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁸⁵ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁸⁶ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

*they are calm, tense, stressed, but all of this is around judgment and you are not asking someone about what the meaning is.*²⁸⁷

Thus, health care professionals recommended using recovery based tools and models for assessments and diagnosis that broadly attempt to grapple with how mental health disability is conceptualized in various cultures.²⁸⁸ In this respect, health care professionals recognize that the *recovery model* is based on facilitating community integration and respecting each individual's journey and culture. However, a number of health care professionals argue that the predominance of the medical model in the practice of psychiatry has prevented the goals of the *recovery model* to be fully realized.²⁸⁹

Respondents suggest that the predominance of the medical model in psychiatrists' capacity assessments is especially problematic for ethno-racial people with mental health disabilities since non-violent, "culturally normal" behaviors are predominantly pathologized.²⁹⁰ Further, health care professionals indicate that the predominance of the medical model (exemplified by the pathology of certain cultural behaviors as per the DSM) prevents some psychiatrists from considering culturally appropriate treatment options for their ethno-racial clients.²⁹¹ A health care professional argues as follows:

We had a client who is from Ethiopia originally and he is not on the unit anymore, but he has been through a lot. He wouldn't talk about it as much, but he went through trauma

²⁸⁷ Interview with a health care professional (September 15th, 2011).

²⁸⁸ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁸⁹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁹⁰ Interview with a health care professional (September 15th, 2011); Data derived from interviews conducted with lawyers from April 2011 to November 2011.

²⁹¹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

*experience. While in Ethiopia, he was in prison. Also, there was a language barrier and also, his mental health condition made it hard for him to communicate. But, he would wear some of the sheets and robe, and drape them around himself. That was talked about in clinical meetings and pathologized within the capacity assessments. I wonder if that might be the type of dress he wore back home. That is a concern because so many behaviours in the mental health setting are pathologized. We need to ensure that practices which are normal for people, they are based on their culture or whatever are not pathologized. It is something I try to pay attention to...and I think it can happen from time to time, you know, it is just considering everything. When people are in the hospital, this is my personal take – it seems like everything that they do is scrutinized. So to ensure that you are not framing something, which is normal for them and not harmful in any way, as a mental health problem, or as a symptom, is really important.*²⁹²

In order to avoid pathologizing certain behaviors, health care professionals argued that psychiatrists should explore alternative cultural explanations of mental health in their assessments, and the broader context of an ethno-racial client's lived experience of mental health disability. This may include understanding an ethno-racial client's experience of trauma and his or her own understanding of their mental health disability.²⁹³

A few health care professionals recommended that psychiatrists should make use of the DSM –IV and the forthcoming DSM V's cultural formulation guidelines for capacity assessments, diagnosis and general care.²⁹⁴ Respondents suggest that such guidelines ensure that clinicians are consistently questioning the institutional culture of the hospital and the broader mental health system, their own cultural biases, along with

²⁹² Interview with a health care professional (September 15th, 2011).

²⁹³ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁹⁴ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

how an ethno-racial client's cultural background impacts his or her perceptions, behaviors, actions and expectations of treatment.²⁹⁵

5.3.4 The CCB Hearing

i) Process

Health care professionals perceived the CCB hearings to be inaccessible and too formal for ethno-racial people with mental health disabilities. Given the significant use of legalese and medical jargon within the adversarial environment, health care professionals argue that the CCB process itself is not understood by ethno-racial people with mental health disabilities because they may often have no idea what is happening throughout the hearing and post-hearing processes.²⁹⁶ Accordingly, a health care professional states, *“The language used during the CCB hearing is so formalized, that a lot of our patients don't have a clue what is going on.”*²⁹⁷

ii) Grappling with Culture

Health care professionals questioned the extent to which CCB adjudicators understood and recognized the evident cultural and intersectional issues within a case.²⁹⁸ The following questions arose: Is the ethno-racial client able to have his or her story properly told? Is there recognition of the individual's identity and his or her strengths and weaknesses? Why does the CCB not probe into the cultural evidence and issues

²⁹⁵ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

²⁹⁶ This does not consider the language or communication barriers, which ethno-racial people with mental health disabilities may be facing.

²⁹⁷ Interview with a health care professional (October 4th, 2011).

²⁹⁸ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

involved? How can health care professionals help facilitate a discussion and analysis of the cultural and intersectional issues involved during the CCB hearings? Should health care professionals include a detailed summary of the ethno-racial client's cultural background and cultural context in their submissions to the CCB?²⁹⁹

Some health care professionals suggest that the extent to which these questions can be addressed is highly dependent on the lawyer advocating on behalf of the ethno-racial client. The process of accessing a lawyer appears quite arbitrary, since all clients are expected to choose a lawyer from the list of lawyers given to them by rights advisers.³⁰⁰ A health care professional describes this as a “significant barrier” as follows:

*The CCB process is highly dependent on the lawyer who is given to the individual when they are applying to the CCB Board. Your level of defense will depend on who is defending you. That is an issue that is not insignificant. If there were one barrier with respect to equity in terms, it would be the inadequate legal representation that individuals get simply by chance because of the lawyer that they picked out of the hat.*³⁰¹

Consequently, a number of health care professionals recommended that the process of accessing and obtaining legal representation before the CCB must be improved for ethno-racial people with mental health disabilities.³⁰²

iii) Adversarial Environment

Health care professionals argued that the adversarial environment in CCB hearings compromised the “well-being” of ethno-racial people with mental health

²⁹⁹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁰⁰ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁰¹ Interview with a health care professional (September 14th, 2011).

³⁰² Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

disabilities, along with the therapeutic relationship between clients and psychiatrists. Specifically, some health care professionals suggested that the entire CCB hearing process was based on a non-client centred approach where the legal technicalities, and adversarial semantics of the process disregarded the comfort levels and communication barriers involved for ethno-racial people with mental health disabilities.³⁰³ In this respect, health care professionals themselves felt targeted within the adversarial environment because they were seen as “*the bad guys, the awful oppressors who want to lock people up.*”³⁰⁴ In the following narrative, a health care professional describes these challenges and her perceptions of the negative outcomes that may occur for clients who continually appear before the CCB:

I find it challenging. I think sometimes people pick a part of law and really ignore the bigger picture. We are not here to make the clients' lives miserable and lock them up. And when it comes to a CCB hearing, I mean we want people to be able to return to the community and do that, but a lot of the times they don't. They come back and they have years and years of that. And so, we don't take the hearings lightly or frivolously. The CCB hearings are a hell of a lot of work; they are a lot of research and a lot of time. But, sometimes we think if you don't have some parameters around you, you are going to be very unsafe and you are going to do very badly. We will see you back here within months and I think sometimes that gets really watered down. And I have seen that get really watered down, where I have had lawyers sometimes pick on something that really isn't relevant, that really has nothing to do with client welfare, but it is like a technical point and they are lawyers. I think sometimes it becomes a very expensive non-client kind of approach and I really worry about that. I think clients should have the right to express their own point of view and why they want to do their own thing. But the evidence that we gather and the things that we present are not frivolous, and sometimes it feels like that – we feel targeted like we just decided to be mean. We would love more people out of here. Our emergency is backed up and there is tremendous bed pressure. If we possibly can make somebody capable, we will. But, on this particular floor, people are so ill that sometimes, we have to challenge that.

I think it depends on the lawyer. But I have seen clients who have been declared capable just because the semantics of the process are such, and go out, leave the hospital and

³⁰³ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁰⁴ Interview with a health care professional (September 19th, 2011).

*they are placed in such risk. They are often homeless, starving and all these kinds of things, because they were found capable on a little technicality and I think that it is just wrong. Then it turns into the clients' rights vs. their well-being. You can kind of predict what is going to happen if they go off their medication. They have the right to do that, but wow, we really worry about them. We have known them for five years, and everytime they go off their medications, this is what happens. I have had people come in with amputations, because they didn't wear shoes in the winter, because they can't live properly and look after themselves. And I think that is not right.*³⁰⁵

In order to address these challenges, the majority of health care professionals argued that the entire CCB hearing process should be reformed. It was recommended that a new model for CCB hearings should be considered, which ensures an open dialogue between all parties (before and after the hearings), and mandatory mediation.³⁰⁶

iv) Family Involvement

The theme of family involvement was significant for health care professionals. They suggest that it is extremely important to have families involved in the CCB cases, given that many clients do not have family support or contact with their families.³⁰⁷ Other health care professionals also mention how important it is for all practitioners to facilitate effective communication methods with substitute decision makers, who are making significant decisions on behalf of ethno-racial people with mental health disabilities.³⁰⁸ Thus, health care professionals felt that ethno-racial people with mental health disabilities

³⁰⁵ Interview with a health care professional (September 19th, 2011).

³⁰⁶ Interview with a health care professional (September 19th, 2011).

³⁰⁷ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁰⁸ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

should have as much contact as possible with their families and all practitioners should help facilitate familial involvement.³⁰⁹

However, there were varied views about how to facilitate familial involvement.³¹⁰ Accordingly, health care professionals argue that these issues are problematic for ethno-racial people with mental health disabilities, since there is a western perception of how family should be involved within the civil mental health system.³¹¹ A health practitioner describes this as follows:

I feel like the conversations about the family and the family involvement is all framed as very problematic within these processes. These perceptions always come from a “western idea” of how family should be involved and I think that is actually backing up a big piece in terms of family involvement. So, I end up being the one corresponding with family. This it is not what would be expected from a Western perspective – where it is seen as a fraud. They think: “How can we get rid of these people? These families are getting the way of everything.” That is what I find can be a challenge when trying to get family involved.³¹²

In contrast to these western notions of familial involvement, health care professionals indicate that some families come from “collectivist cultures” where there is “no differentiation between the patient and the family.”³¹³ Family members often have an expectation that “everything should be shared with families.”³¹⁴ Thus, a number of health

³⁰⁹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³¹⁰ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³¹¹ Interview with a health care professional (September 15th, 2011).

³¹² Interview with a health care professional (September 15th, 2011).

³¹³ Interview with a health care professional (September 8th, 2011); Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³¹⁴ Interview with a health care professional (September 8th, 2011); Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

care professionals also struggle with underlying confidentiality issues and the boundaries around disclosure.³¹⁵

In order to address these issues, health care professionals agree that all practitioners must consider the stigma that families may be facing when attempting to support their loved ones in navigating the mental health and legal systems, along with the fact that they may be living in poverty, thereby making them inaccessible by mainstream methods of communication (such as phone). Consequently, practitioners must consider using alternative and effective methods of communication for creating a dialogue with the families of ethno-racial people with mental health disabilities.³¹⁶ Health care professionals also recommended that communication tools, which could be used to address the boundaries around disclosure with the families of ethno-racial people with mental health disabilities, should be examined, evaluated and implemented.³¹⁷

5.3.5 Post-Hearing: Translation of Decisions

Health care professionals argued that the CCB's written decisions and reasons should be translated for those who do not speak English. It was also pointed out that even when the written decisions and reasons were presented in English, the excessive use of legalese in the CCB's decisions and reasons was inappropriate and unreadable.³¹⁸ As a result, ethno-racial people with mental health disabilities often struggle with

³¹⁵ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³¹⁶ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³¹⁷ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³¹⁸ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

understanding the legal outcomes and consequences of their CCB hearing. Accordingly, health care professionals recommend the CCB should create a one-page summary in plain-language (in the clients' language of choice) of the legal decision and reasons.³¹⁹

5.3.6 Human Rights in the Hospital

Health care professionals described a multitude of evident human rights issues for ethno-racial people with mental health disabilities. In this regard, the key barriers included: the language/communication barriers, the lack of culturally specific clinical support and services, the lack of legal support for addressing refugee/ immigration issues, the lack of access to ACT (assertive community treatment) and the increased use of seclusion and restraint for ethno-racial people with mental health disabilities.³²⁰ Underlying these barriers were systemic issues of racism, poverty and discrimination. For instance, health care professionals argued that the lack of culturally appropriate food options (aside from Halaal and Kosher) and the lack of physical space available (since men and women have to share space and bathrooms at psychiatric hospitals) were examples of systemic barriers.³²¹

In order to address these issues, health care professionals argue that there needs to be continuous systemic advocacy in these areas through organizations such as the Empowerment Council, the Psychiatric Patient Advocate Office and the CAMH Health

³¹⁹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³²⁰ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³²¹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

Equity Office. More funding and resources are needed to sustain these organizations and ensure systemic change.³²²

In particular, a health care professional recommended that psychiatric hospitals must strive to continue developing and implementing health equity initiatives to address these barriers. Recent developments include the Health Equity Impact Assessment (HEIA), created by the Ministry of Health and Long Term Care, Toronto Central Local Health Integration Network (LHIN) and CAMH.³²³ This tool is used for considering how to address the “unintended health impacts that a certain policy, plan and program” has upon vulnerable populations. Specifically, the HEIA’s five steps encourage health care professionals to “1) identify the problem, 2) consider the potential impacts, 3) consider mitigation strategies, 4) consider monitoring strategies and 5) dissemination strategies.”³²⁴ However, as expressed by a number of respondents, this tool has not been implemented or evaluated, and it may not deal with issues identified within this study.³²⁵ Thus, respondents recommend that there should be a rigorous evaluation of the HEIA conducted in the next few years.³²⁶

³²² Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³²³ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³²⁴ Interview with a health care professional (September 12th, 2011).

³²⁵ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³²⁶ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

5.3.7 Access to Culturally Appropriate Treatment and Care

Health care professionals recognized the significance of ensuring that ethno-racial people with mental health disabilities have access to culturally appropriate treatment and care.³²⁷ However, the overall consensus was that alternative and complementary therapies such as homeopathy, naturopathy, light therapy and other culturally derived therapies should only be used as adjective or adjunct treatments.³²⁸ It is emphasized that only medical treatments, which have been scientifically proven to be effective through solid evidence, should be prescribed and recommended. These guidelines are imperative in light of the ethical obligations that psychiatrists have towards their clients and the medical profession in general.³²⁹

A health care professional reflects upon this issue as follows:

As I will tell my patients, my responsibility as your physician is to make recommendations based on what science tells me to recommend. And I say, look, “if voo-doo was scientifically studied and proven to work, I would recommend voo-doo to you. There are so many treatments out there, and so many people who have a vested interest in you getting their treatment that it is so much for you to grasp and me to grasp. And it would be, unsafe of me and not fulfilling my role as a doctor, my ethical obligation to recommend things for you that are not scientifically proven for me or where there is not a good amount evidence that it is effective.” So I work with a population where there is a clear mental condition or a clear organic condition that manifests through mental disorders –schizophrenia, severe bipolar disorder. There are clear treatment recommendations for those disorders. I am certainly happy to consider adjective or adjunct treatments, but the reality is that for those treatments, psycho-pharmacological are the major cornerstone and if people want to move forward in their recovery, with other forms of treatment, that is fine with me. But, my strongest recommendation would

³²⁷ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³²⁸ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³²⁹ CAMH uses the term “client” to refer to its patients. Thus, this language is used in this section of the results.

*be not an either or, but you need this, and if you want to look at other things, we can consider them only in addition.*³³⁰

Thus, in order to facilitate improved access to culturally appropriate treatment and care, health care professionals suggested that there should be a focus on improving access to culturally appropriate services and organizations, which specialize in providing aspects of culturally appropriate treatment and care.³³¹ For instance, according to one health care professional, they have the following types of ethno-specific services at psychiatric hospitals:

*In terms of population specific programs, we have Aboriginal services, we have a SuPasee – Substance Abuse Program for Caribbean Youth, we have Rainbow Services and we do have a women’s program – women and mental health. Also, we have addiction programs – some of them are time limited and some of them are ongoing. There is also a partnership with the Portuguese Mental Health and Addiction Services in the Toronto General Hospitals, so we work together to provide programming for clients. There is also a specific addictions cycle for Afro Caribbean clients.*³³²

However, despite such resources at psychiatric hospitals for in-patients, health care professionals argue that there are not enough services that enable “people with mental health disabilities to make sense of their mental health difficulties in their own way and based on their own experiences” in the community.³³³ Health care professionals found it frustrating to find case-workers and social workers who would support ethno-racial people with mental health disabilities in their integration into the community. In this respect, some health care professionals suggested that relationships should transcend

³³⁰ Interview with a health care professional (September 14th, 2011).

³³¹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³³² Interview with a health care professional (September 12th, 2011).

³³³ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

culture. Accordingly, ethno-racial people with mental health disabilities should be open to working with well-trained case-workers and social workers who are outside of their culture.³³⁴ Also, health care professionals recommended that members of in-patient and out-patient treatment teams should be from diverse backgrounds, and have varied language capacities.³³⁵

Among the health care professionals interviewed, a common theme was that there should be more education, training and awareness about the stigma and shame experienced by ethno-racial people with mental health disabilities in the civil mental health system. Health care professionals suggested that more funding be available for ethno-specific mental health organizations such as Across Boundaries and Hong Fook Mental Health Association.³³⁶ Aside from access to services and placements within these organizations, health care professionals argue that there should be other initiatives to ensure that ethno-racial people with mental health disabilities can participate in cultural activities and social gatherings within their communities.³³⁷

In this respect, health care professionals need to continue challenging the stigma, shame and attitudes regarding mental health disability within various cultures. For instance, in order to address this issue, some health care professionals suggested that there should be more recreational programming available to ensure that ethno-racial people with mental health disabilities felt included and understood in their path to

³³⁴ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³³⁵ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³³⁶ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³³⁷ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

recovery. These programs should cater to varied interests and be offered in diverse languages.³³⁸ A health care professional reflects upon this recommendation as follows:

*I think having more, in terms of recreation programming, would make sense. It is important that we cater to all sorts of different kinds of interests. I do an art group. There is another social worker on the floor. We both speak French but nothing else, so the groups we offer are in English so we could have an interpreter but we haven't had to do that yet. But it would be nicer to have someone else who spoke another language to be able to offer a recreational group. There are lots of other pieces. I think too, that awareness is important and this is probably part of the whole recovery paradigm. Awareness of everyone's experience of mental illness is their own and their path to recovery. They should define their experience themselves rather than having it defined within the constraints of what is normal and what is not normal.*³³⁹

Some health care professionals recommended that objective measures should be created, which ensure consistency and transparency when matching ethno-racial people with mental health disabilities to culturally appropriate mental health services.³⁴⁰ One health care professional argues as follows:

*Right now as it stands, the process is quite subjective and according to clinician preference and clinician biases. And of course during their stay, it would be nice to provide education to staff on these objective measures to make sure that we don't have outcomes like increased rates of seclusion and restraint for ethno-racial clients.*³⁴¹

Since the wait lists for accessing culturally appropriate services is approximately two years, this is especially problematic when attempting to find culturally appropriate housing arrangements for ethno-racial people with mental health disabilities. Thus, it was

³³⁸ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³³⁹ Interview with a health care professional (September 15th, 2011).

³⁴⁰ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁴¹ Interview with a health care professional (October 4th, 2011).

recommended that health care professionals should make referrals immediately once they have identified that a culturally appropriate housing arrangement is needed.³⁴²

5.3.8 Religious Accommodation

Given the lack of resources within psychiatric hospitals, health care professionals felt that accommodating religious observation could be challenging.³⁴³ The following questions were raised: To what extent should we accommodate? Where do we draw the line? How do we know when a certain practice or belief is based on a religion? What if the religion is not a mainstream one? How can we appropriately monitor those who are praying for most of the day?³⁴⁴

In this respect, a health care professional describes these issues as follows:

*We have had people who have had delusional beliefs. One fellow believed that his religion was to stand for days and weeks and months so that he would have edema. So, he would tie himself up with a rope so he would sleep standing up and he found on the internet, some obscure religion that supported that. That was really tricky and in the end, we had to say, the self-harm and the risk was too high for us to accommodate him, as he would fall asleep with a rope and it could choke him.*³⁴⁵

Thus, the majority of health care professionals felt that the religious observation requests made by ethno-racial people with mental health disabilities were often not accommodated. Some respondents also expressed the view that although the CCB appeared to be sensitive towards these issues, this did not impact whether or not the

³⁴² Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁴³ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁴⁴ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁴⁵ Interview with a social worker (September 19th, 2011).

accommodation requests were made.³⁴⁶ For instance, the spirituality and religious care services are limited in psychiatric hospitals because they often only offer specific workshops and services for those from Catholic, Anglican, Jewish, Aboriginal or Muslim faiths, and many of the requests for religious observation are not accommodated through these services.³⁴⁷ Thus, recommendations were made to expand spirituality and religious services in psychiatric hospitals to cater to individuals from other religions and to increase participation and inclusivity.³⁴⁸

5.3.9 Accountability

A number of health care professionals emphasized the importance of creating accountability mechanisms for health care professionals to use in the implementation of Ontario's mental health laws. Health care professionals argue that all practitioners need to have required standards of practice and they need to be accountable to these standards and guidelines.³⁴⁹ A health care professional emphasizes this point as follows:

*People need to recognize that by not paying attention to these issues, they are actually not providing a good standard of care or practice. When people start to see that there are equity standards and guidelines in place, that is the motivation to change. Most people go into their profession because they want to be good at their profession. There is a commitment to the principles, to the values of what that profession is all about. So I have learned that you got to hit at the very core.*³⁵⁰

³⁴⁶ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁴⁷ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁴⁸ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁴⁹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁵⁰ Interview with a health care professional (September 8th, 2011).

In this respect, a number of health care professionals recommend that there should be national standards created to ensure that they are providing culturally competent care. These standards and guidelines could then serve as an educational tool, for facilitating an open dialogue, discussion and understanding of these issues.³⁵¹

5.3.10 Power

Health care professionals argue that there is a vast power imbalance between themselves and their ethno-racial clients interacting with Ontario's civil mental health laws. Accordingly, respondents suggested that this contributed to the differential treatment experienced by ethno-racial people with mental health disabilities.³⁵² A health care professional reflects upon this as follows:

I personally don't think that cultural competence goes far enough. I mean what we are dealing with are issues of power. They don't arise necessarily only because of color, they arise because there is such a divide between the provider and the patient interaction. Given that dynamic, there is often an insurmountable power relationship that has made into the language we use, for example, we talk about case managers, where people are cases and we are managing them. To me, that is unacceptable and this is how embedded this is into what we do.³⁵³

In order to address the power imbalance, health care professionals recommend that language, which is used in everyday interactions with ethno-racial people with mental health disabilities, should be revised to reflect the principles of equity.³⁵⁴ For instance, one health care professional suggests that a term such as "case manager" is

³⁵¹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁵² Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁵³ Interview with a health care professional (October 4th, 2011).

³⁵⁴ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

problematic. She questioned: “Do people really like to be managed?”³⁵⁵ Other health care professionals recommended that ethno-racial people with mental health disabilities should be integrated into the decision-making bodies such as the CCB in roles that are not merely “advisory.”³⁵⁶

5.3.11 Research Initiatives

Given the dearth of ethno-racial statistics available, health care professionals suggest that more research is needed to obtain data on the number of ethno-racial people with mental health disabilities entering psychiatric hospitals and those appearing before the CCB.³⁵⁷ This data can “create a sense of urgency” for the CCB to change and to ensure equity in its processes.³⁵⁸ Although health care professionals have begun identifying ethno-racial clients through intake systems within psychiatric hospitals (such as the “ADT”), this information is not relevant to the CCB, and it is not available to the public and external researchers. Thus, it was recommended that a similar system, which is accessible to researchers and practitioners, should be created to track how many ethno-racial clients appear before the CCB.³⁵⁹

In a similar vein, health care professionals argue that there should be specific equity indicators and frameworks created for them to use when interacting with Ontario’s mental health laws. Further, research should be conducted on examining various

³⁵⁵ Interview with a health care professional (October 4th, 2011).

³⁵⁶ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁵⁷ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁵⁸ Interview with a health care practitioner (October 4th, 2011).

³⁵⁹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

approaches that can be used to ensure that all ethno-racial people with mental health disabilities understand their rights vis a vis Ontario's mental health legislation.³⁶⁰ Lastly, health care professionals recommended that a longitudinal study should be conducted to examine the efficacy of using alternative, culturally appropriate treatment plans for ethno-racial people with mental health disabilities.³⁶¹

5.3.12 Training

CAMH currently has a mandatory one-day training on diversity and health equity for all staff, volunteers, students and managers. However, this training is not ongoing and it is not mandatory for physicians.³⁶² Thus, health care professionals advised that there should be ongoing and consistent training on cultural competency, which is available for all health care professionals, staff, lawyers and other practitioners involved. Some health care professionals recommended that separate training and educational modules should be created for each stakeholder group in order to understand the core values of each group.³⁶³ One health care professional explains this recommendation as follows:

When I work on training with different groups, I try to understand what their professional culture is, and I try to understand what is most important to their professional culture, then I talk to those values. You can't make people understand, without having people looking at themselves and understand the whole notion of culture, and who they are as cultural beings. Lawyers have a culture. Everyone has a culture, both their personal and also their professional. So if it is the police, what is their professional culture and help them see where their professional culture could be consistent, whether it is could be at

³⁶⁰ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁶¹ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁶² Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁶³ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

odds with, so the police – are about the individual, the perpetrated, but there are lot of families.. In a way there is a need to unpack the legal culture a little bit, and I realize lawyers are very different. So it is that generic – what is most important? What is in common? What is most important no matter what kind of lawyer? Then you assess those core values to talk about the need for cultural competence to those core values. I think for health care professionals or psychiatrists or any physicians, the core values – are everybody talks about it being really client centered. We talk about most of us regardless of it of who we are will talk about most effective care for patient. We have learned that the right care will not be what I think you need. There is no point of me giving expert advice if you are not going to follow it, so we have learned that the core values become yes – we have learned to understand that effectiveness is shared, it is not just about that I am going to tell you what to do, but it is to the extent that you trust and you think I am a credible clinician, and the ability to follow through, so that is a key piece of it.³⁶⁴

Health care professionals were torn as to which training approach (diversity, cultural competence, anti-oppression or anti-racism) was appropriate. Specifically, a number of respondents suggested that the cultural competence approach did not recognize the inherent power imbalances between the health care professional and the patient. Thus, they recommended using an anti-oppression or anti-racism lens.³⁶⁵

In addition, some health care professionals recommended using experiential learning exercises in order to depoliticize and desensitize the training workshops. Experiential learning exercises ensure that people are comfortable discussing particular case scenarios.³⁶⁶ A health care professional reflects upon the use of experiential learning as follows:

Try to make it less sensitive. Take away the politics of it, because people are afraid to talk openly about what they feel because it is probably not the right thing to say. When you use examples that people can relate to that are not political, that are not sensitive, it is about not just about race or ethnicity, it is about who you are as a human being and common examples that you can relate to. Then they go – ‘I get it, right.’ So a lot of it is demystifying and depoliticizing culture. So we can relate at a human level, and a

³⁶⁴ Interview with a health care professional (September 8th, 2011).

³⁶⁵ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁶⁶ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

*personal level. The more people can relate themselves, to these kinds of issues of equity, diversity, marginalization, exclusion, power, privilege, communication, misunderstanding etc. etc., the easier it becomes for them to get it. I use a lot of those strategies in the work that I do.*³⁶⁷

It was also suggested that community advisory panels, comprised of ethno-racial people with mental health disabilities, service providers and experienced lawyers, should be involved in facilitating and conducting training workshops for health care professionals.³⁶⁸

5.3.13 Education

Health care professionals found it problematic that classes on cultural sensitivity/cultural competence or health equity were not part of the mainstream medical education curriculum. The following questions were raised: Why are such courses not part of the core curriculum in Canada? How will health care professionals recognize the importance of these issues if there are no quality assurance mechanisms in place? A health care professional argued as follows:

*I think a big part of training and education is helping people recognize that providing culturally competent care focusing on health equity is not a nice to do, it is a must to do. So how can anybody say they are providing even good quality care if it is culturally unsafe for somebody.*³⁶⁹

Accordingly, respondents recommended that there should be a mandatory class on cultural competence/cultural sensitivity or health equity in Canadian medical schools. In a similar vein, health care professionals suggested that cultural sensitivity/ cultural

³⁶⁷ Interview with a health care professional (September 8th, 2011).

³⁶⁸ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁶⁹ Interview with a health care professional (September 8th, 2011).

competence or health equity requirements should be embedded within the continuous medical education requirements for health care professionals.³⁷⁰ For instance, one health care professional argued that Canada should adopt a similar approach as it is practised in the United States. In the United States, a number of states require health care professionals to adhere to cultural competency as a requirement for continuous medical education and recertification.³⁷¹

5.4 ADJUDICATORS, GOVERNMENT ADVISERS, ACADEMICS AND SERVICE PROVIDERS³⁷²

5.4.1 Role of Practitioners

i) Recognition

Respondents argued that practitioners interacting with Ontario's civil mental health system should recognize and acknowledge how structural and systemic racism affects the lived experiences of ethno-racial people with mental health disabilities.³⁷³ An academic reflects upon this recommendation as follows:

How do you draw a line between or maybe not draw a line between, but make sure you recognize both issues of structural and systemic racism that impact people's lives and how those intersect with and are part of, but also separate from cultural practices and other kind of things that we might associate with ideas like ethnicity and religion, which are – those two concepts don't necessarily map on to each other. In terms of people's actual lives, the intersection of cultural practices that they adhere to and the larger hegemonic societies like disapproval of or whatever, those things I think become really complicated and in mental health, a lot of people..asserting that problem was the cause

³⁷⁰ Data derived from interviews conducted with health care professionals from April 2011 to November 2011.

³⁷¹ Interview with a health care professional (September 8th, 2011).

³⁷² The results from the 1) adjudicators, academics and government advisers and 2) service providers are presented and examined together in section 5.4, given similarity of results, responses and emerging themes within the analysis of the transcribed interviews.

³⁷³ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

*of the mental health problem.*³⁷⁴

Similarly, service providers emphasize the impact that poverty may have on the experiences of ethno-racial people with mental health disabilities.³⁷⁵ Other respondents such as government advisers suggested that lawyers should be trained to understand how post-traumatic stress disorder (PTSD) might affect their ethno-racial clients. For instance, PTSD can impact one's memory, thereby influencing the way testimony and evidence is presented in a hearing.³⁷⁶ In order to address these intersections, all of the respondents recommended that practitioners (in particular – adjudicators) should learn to be active listeners, sensitive and self-educators. To raise awareness about the intersectional issues affecting ethno-racial people with mental health disabilities, adjudicators should talk amongst themselves and participate in peer-learning.³⁷⁷ An adjudicator explains this as follows:

Again, “cultural competency” – is a whole big buzzword. People throw it around and not many know what it is. And that is to be able to understand your space in dealing somebody who is different than you in culture and race, understanding people, knowing how to listen to them, asking questions about them to be informed and how to apply that information to the case scenario or the their factual model that you have been given. And you know, it is like receiving information, learning how to actively listen about somebody's culture for him or her to tell you about it, for you to admit what you don't know. No matter how knowledgeable how you are, you can never know everyone's culture. Having that dialogue with the person. Not making assumptions, but asking the person to educate me about this, and knowing how to be sensitive to things that are different from you and different from Western culture and using that information in an objective way to come to a decision about that person's life. I talk about cultural matters, human rights matters, lots of things with my colleagues so that they will be aware that these are things that are necessary, and even imperative in an adjudicative setting, so I

³⁷⁴ Interview with an academic (July 20th, 2011).

³⁷⁵ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

³⁷⁶ Interview with a government adviser (June 3rd, 2011).

³⁷⁷ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

*find that there is a willingness on their part to learn.*³⁷⁸

Accordingly, during a hearing, respondents recommend that questions regarding cultural factors should be asked, generalizations should be avoided and a dialogue should be created.³⁷⁹

5.4.2 Language/ Communication

i) Varied Conceptions of Mental Health Disability

Respondents identified the communication barriers which ethno-racial people with mental health disabilities experience as a result of stigma and varied conceptions of mental health disability.³⁸⁰ For instance, a service provider pointed out that certain words might not exist for certain concepts, especially in mental health.³⁸¹ Accordingly, ethno-racial people with mental health disabilities may describe their mental disability differently from health care professionals.³⁸² A government adviser describes these challenges as follows:

We have had clients who have been diagnosed with schizophrenia who, the way that they explain their disability is that ‘they have had a negative experience and it has made go temporarily, it has been torturing them temporarily and it is stress.’ So, we should not use the language of psychiatry or survivor; especially with newcomers and immigrants who don’t know the language or don’t even have a concept of what does it mean to experience mental health issues. I think we just couch in the sense of “staying healthy,” things that you do to stay health, not just physical health – not just worrying about your

³⁷⁸ Interview with an adjudicator (May 18th, 2011).

³⁷⁹ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

³⁸⁰ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

³⁸¹ Interview with a service provider (May 17th, 2011).

³⁸² Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

*physical body, you have to think about your emotions and your mind, and how you feel. I think that is the language that I have used.*³⁸³

Thus, all practitioners must be reflective about the cultural conceptions surrounding mental health and they should try to be sensitive when using language to convey certain diagnoses.³⁸⁴

ii) Communication Barriers

Given funding constraints, a few service providers found it challenging to obtain interpretation services within psychiatric hospitals and the community.³⁸⁵ When interpretation services were provided to ethno-racial people with mental health disabilities, some service providers felt that interpreters did not mention the resources and advocacy groups available to support them. This was a further barrier for service providers from various mental health agencies, because they were not able to provide the necessary support for ethno-racial people with mental health disabilities.³⁸⁶ Thus, service providers recommend that interpreters are educated about and be made aware of the resources available for ethno-racial people with mental health disabilities. Similarly, interpreters should receive training on culture, discrimination, prejudice and sanism within the mental health context.³⁸⁷

³⁸³ Interview with a government adviser (June 3rd, 2011).

³⁸⁴ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

³⁸⁵ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

³⁸⁶ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

³⁸⁷ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

iii) Cultural Interpreters/Consultants

When discussing whether or not to use cultural interpreters/consultants, respondents were divided in their views. Specifically, a number of adjudicators, government advisers, academics and service providers recommended that cultural interpreters/consultants should be used for ethno-racial people with mental health disabilities throughout the pre-hearing, hearing and post-hearing processes. Recommendations were made to create such a position through the human rights or ombudsmen office.³⁸⁸

In contrast, some respondents identified the risks with using cultural interpreters/consultants. For instance, one adjudicator argued that it was difficult to hire people who were competent. She argues:

*I know in immigration and refugee hearings, there are a lot of cultural consultants, called 'CSick' or 'CM' – they are all consultants and they come from all walks of life, a lot of them are people from cultural backgrounds etc. And but I don't find they add anything to the equation really. A lot of them are sadly incompetent. And for me to get where I want to get the evidence I need, I have to jump in and ask questions actively...ask questions.*³⁸⁹

Thus, instead of relying upon cultural interpreters/consultants, some respondents recommended that adjudicators should be actively inquiring into cultural and intersectional issues throughout the hearing.³⁹⁰

³⁸⁸ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

³⁸⁹ Interview with an adjudicator (May 18th, 2011).

³⁹⁰ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

5.4.3 The Pre-Hearing Process

i) Rights Advice

Respondents felt that the rights advice process was fairly effective at providing specific rights information vis a vis Ontario's civil mental health laws. However, respondents identified barriers that ethno-racial people with mental health disabilities have with accessing other types of rights information and resources.³⁹¹ For instance, a service provider explains these challenges as follows:

There is general inaccess to rights information and subsequent barriers to accessing resources. In terms of rights, ensuring that piece is happening. For example, when clients come in to CAMH they are supposed to be given the client bill of rights and within it they are supposed to get a Bill of Client Rights and presumably in accessible language and help if they want. The rights advisers are not supposed to give them out. The hospital staff of every unit, each particular program is supposed to give them out. The CAMH Client Relations Office, which is also the complaints office started to check in to see if this was actually happening, and it wasn't happening everywhere. There are barriers to having some information out. On top of that, some people don't get info in a language they require and they don't have a staff person there to help navigate the system.³⁹²

In sum, respondents recommend that mechanisms be put in place to ensure that every client receives a Bill of Client Rights in the language of their choice. Similarly, it is recommended that treatment staff should ensure ethno-racial people with mental health disabilities are aware of their rights and the resources available to them in the hospitals and community.³⁹³

³⁹¹ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

³⁹² Interview with a service provider (May 20th, 2011).

³⁹³ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

ii) Psychiatrists Capacity Assessments

Adjudicators, government advisers, academics and service providers questioned whether the psychiatrists' capacity assessments appropriately addressed the importance of culture, race, ethnicity, socio-economic status, gender and other social factors.³⁹⁴ The following questions arose: Are ethno-racial people with mental health disabilities being under-diagnosed or over-diagnosed as a result of stereotypes and cultural misunderstandings? Are interpreters being used, where necessary, during the capacity assessments?³⁹⁵ Accordingly, an adjudicator made the following observations:

Another root to disproportionate for members of ethno-racial communities coming before the CCB may be through...I don't what the right lingo for it is, maybe selection bias. Another way maybe that doctors are more likely to label behavior by members of racial and ethnic communities as ill or as being captured under the MHA if there are a member of a racial or ethnic community then they would if that person were Caucasian for example or Canadian born. So, there may be some bias in the way doctors apply the legislative criteria and that may result. Bias may be applied unconsciously. So, there are a number of ways that it may happen but I think it does happen.³⁹⁶

In order to address such barriers, respondents recommended that psychiatrists should acknowledge how ethno-racial people with mental health disabilities have been historically pathologized as a result of institutional and systemic racism and colonialism.³⁹⁷ In this regard, there should be a focus on creating a positive therapeutic

³⁹⁴ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

³⁹⁵ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

³⁹⁶ Interview with an adjudicator (June 8th, 2011).

³⁹⁷ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

relationship between the psychiatrist and the ethno-racial client.³⁹⁸ For instance, an academic argues as follows:

*Will we stop thinking about psychiatry and analyzing it critically if we are focused on how to make people of color feel better about the therapeutic relationship for instance? And how to make sure that psychiatrists remember that culture makes a difference. How do get them to remember that context makes a difference, historical, political, social, all of those things? And that they are working in this context. And not outside of it.*³⁹⁹

In a similar vein, a service provider recommends that psychiatrists understand and grapple with how ethno-racial people with mental health disabilities resist psychiatry and how this resistance may be misinterpreted as indicia of a mental health disability.⁴⁰⁰

5.4.4 The CCB Hearing

i) Process

Respondents suggested that there was a disproportionate number of ethno-racial people with mental health disabilities that appeared before the CCB.⁴⁰¹ Some felt that this was because of socio-economic status, and inherent biases.⁴⁰² Accordingly, an adjudicator argues as follows:

I find that there is in my experience there is a disproportionate representation of members of ethnic and racial communities in front of the CCB, so if I sit on ten hearings, if you, you know – I don't what the percentage of Caucasian Canadians as compared to members of cultural and racial communities, but I think there is much higher representation of cultural and racial and ethnic communities in front of our board than you'd expect relative to their percentage of the population. And, as a sitting member of

³⁹⁸ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

³⁹⁹ Interview with an academic (July 18th, 2011).

⁴⁰⁰ Interview with a service provider (May 20th, 2011).

⁴⁰¹ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁰² Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

*the board there is nothing I can do with that. But, as a human being, I think it is very interesting. As a thinking person, I find that interesting and concerning because I wonder if I don't know how to explain it. I haven't done any research into it, so it may be that immigrants to this country for example, go through jarring and dislocating experiences that make them more predisposed to end up in the mental health system. Or, it may be that the route from being a racial or ethnic community member to ending up in the civil mental health system is via another route which is poverty because I think there is also a disproportionate representation of poor people before our board and so there is a link between mental health issues in my view between mental health issues that result in findings of incapacity and civil commitment and socio-economic status. Another root to may be through selection bias.*⁴⁰³

Given this reality, respondents raised the following questions: Is there enough time to address issues relating to cultural evidence and other intersecting factors within a CCB hearing? What are approaches that adjudicators can use when addressing relevant issues for ethno-racial people with mental health disabilities?⁴⁰⁴

In this respect, one adjudicator recommended using a tri-partite approach including: cultural competencies, human rights and ethics.⁴⁰⁵ Using this approach, adjudicators must learn to be sensitive, active listeners, and aware. They should consistently be engaged in assessing cultural information and cultural evidence, within an ethical and rights oriented paradigm.⁴⁰⁶

ii) Grappling with Culture

When describing their experiences grappling with culture within CCB hearings, some respondents felt that patient-side lawyers could address cultural concerns within a

⁴⁰³ Interview with an adjudicator (June 8th, 2011).

⁴⁰⁴ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁰⁵ Interview with an adjudicator (May 18th, 2011).

⁴⁰⁶ Interview with an adjudicator (May 18th, 2011).

CCB hearing.⁴⁰⁷ Specifically, adjudicators suggested that patient-side lawyers have the opportunity to grapple with culture during cross-examination of the physician. During cross-examinations, patient-side counsel may question the physician's assumptions and cultural biases. This may impact whether or not cultural information and cultural evidence are accepted and addressed.⁴⁰⁸ In the following narrative, an adjudicator describes how this may occur:

*Sometimes I've seen a good patient's counsel conduct cross-examinations that ask the medical practitioner or evaluator to question some of their assumptions and to look at the patient applicant in a more culturally sensitive way. So, you sometimes for example, I can think of one hearing that I sat on recently where the applicant.. it was a Form A for admission to a long –term care facility and the evaluator was a social worker who had a finding of incapacity to make the admissions decision. The applicant was an elderly, Italian woman, who was born in Italy and had little education and worked in a factory all of her life, and she was unwilling to consider information about long term care because her belief was that she was mother of children and her children should take care of her. So, the evaluator said – well, she won't even consider this information, so she is incapable of making decisions relative to her care. And the patient's counsel, said 'wait a minute' this is an elderly woman, not educated woman and somebody who was raised in Europe in a family-oriented culture. Could it simply be that she has a cultural overlay and tells her that long term care is only for people who don't have families to care for them in their old and really their families should care for elderly people in their old age. And what can we understand about capacity given her family and the history of the place where she came from. I have seen a number of cross-examinations, which tend to do that with greater or lesser of success. In that case, we ended up holding the finding of incapacity but not on that issue. I was very alive to those issues and I really questioned whether the patient applicant was capable of understanding the information, whether she was capable of appreciating the risks and benefits given the place that she came from and her cultural tool set and I came to conclusion that I was satisfied by the medical evidence that she was suffering from Alzheimer's and that she had no insight into her condition. But, I tried to be cultural sensitive and the cultural overlay formed part of my decision.*⁴⁰⁹

The majority of respondents felt that CCB adjudicators should probe into cultural

⁴⁰⁷ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁰⁸ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁰⁹ Interview with an adjudicator (June 8th, 2011).

and other intersectional factors. However, there were contrasting views on the extent to which such factors should influence the adjudicators' discretionary decision-making powers.⁴¹⁰ For instance, some adjudicators argued that they were uncomfortable applying varying standards to cases involving ethno-racial people with mental health disability versus other people with mental health disabilities.⁴¹¹ Accordingly, an adjudicator reflects upon these challenges as follows:

As an adjudicator, I don't want to apply a different standard when I am looking at the MHA. I don't want to apply the legislation differently if I have the 55-year-old woman than I would to a 23-year-old black male of Jamaican descent. But, what I am trying to assess is, how at risk are they of provoking police retaliation. I know police will respond to those two figures differently. It becomes a bit complicated to figure out how to do that in a fair and equitable way. I can think of one case, where the issues get really complicated, as you know. It was a very sad one, where the applicant was a young black man and he was challenging involuntarily detention that he was challenging under the MHA and the question was whether... I think he was schizophrenic, and the question was whether he would provoke retaliation because he did all of these bizarre and possibly potentially inflammatory behaviors in the community, whether he was going to provoke retaliation on himself by being a young black male doing these weird things in the community. He had been provoking interaction with the police and the question was: was he going to wind up getting himself shot by behaving in these ways? And, the question is, 'well you're a young black male, how did the police react to you? And the community?' And, it is complicated in the sense that we know that police behave differently, we know that Native people are over represented in the justice system and jails and we know that black people are over –represented in the justice system and in jail. Some of that is because of the way that we are policed. So, as an adjudicator in a hearing, I am trying to decide whether this person is at risk of provoking police retaliation on him. How do you know with the fact that I know that police are going to be trigger-happy likely, with a 22-year-old black male than they will with a 55-year-old white female.⁴¹²

However, some respondents argued that the issue should not be about whether to create varied standards for ethno-racial people with mental health disabilities. Instead, there

⁴¹⁰ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴¹¹ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴¹² Interview with an adjudicator (June 8th, 2011).

should be a focus to ensure that ethno-racial people with mental health disabilities have a similar quality of experience when appearing before the CCB and when they are within Ontario's civil mental health system.⁴¹³

As such, a service provider reflects upon this suggestion as follows:

*It is not about creating varying standards for people, it is about providing access – it is not about special treatment. It is the same argument you make about accommodating disabilities. So, in order for their argument to hold water, they would have to prove that these individuals have the same access, not just that they get to the door – but that they have the same quality of experience.*⁴¹⁴

Despite these unresolved tensions, respondents advised that adjudicators could not ignore culture and other intersecting factors.⁴¹⁵ Thus, one adjudicator recommended using an inductive/ deductive approach when evaluating cultural evidence. This approach involves a continuous analysis of the cultural evidence within the context of systemic racism. Adjudicators should engage with cultural evidence by asking relevant questions and active listening.⁴¹⁶ Another adjudicator recommended that adjudicators should not be judgmental in cases involving ethno-racial people with mental health disabilities.⁴¹⁷ As such, she reflects upon this recommendation as follows:

We must listen really carefully and not bring self- sort of cultural baggage or the thinking 'that is not the way I was raised.' You kind of have to learn that from the beginning with any of these boards, basically not to be judgmental. You see people, and you read accounts of people's lives which are widely divergent and so you learn to just accept that this is what happened in this person's life, this is where they came from, this is where they were raised and if the quality or the accuracy of the information is there

⁴¹³ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴¹⁴ Interview with a service provider (May 17th, 2011).

⁴¹⁵ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴¹⁶ Interview with an adjudicator (May 18th, 2011).

⁴¹⁷ Interview with an adjudicator (June 13th, 2011).

*before you, you accept it and then you go on to apply the criteria of the MHA to it. So, I am not saying it is racially neutral, if racialization or cultural values factor into the event that brought the person into the event or to us or factor into the reality, then all the things we have to look after which are their needs, safety of the public, reintegration, then it is very front and centre. These boards are inquisitorial. We can seek out and we should seek out more information, and if we have a little suggestion that is relevant we should go farther and dig farther. That is what is directed by the legislation. If you are doing your job properly, you will find out more about that context if it is important to the person and it almost always will be.*⁴¹⁸

In sum, respondents argue that adjudicators should actively seek out relevant cultural information and cultural evidence in CCB hearings. There should be an emphasis placed on creating a dialogue about these issues and ongoing learning on a case-by-case basis.⁴¹⁹

iii) Prevalence of the Medical Model

Respondents indicated that the prevalence of the medical model within the CCB's processes was problematic.⁴²⁰ For instance, an adjudicator pointed out that the success rates for those coming before the CCB for treatment capacity applications and involuntary admission hearings were between approximately 5-10%.⁴²¹ Thus, it is extremely challenging for adjudicators to question the physician's authority, given their inherent power within the CCB and the mental health system.⁴²² Accordingly, an adjudicator highlights these challenges as follows:

You know it remains an abiding sort of feeling on the Board that we are there to kind of rubberstamp the doctors. And that is totally problematic. I mean it is not isolated to your issues around ethno-racial communities, but it is problematic across the Board. And it

⁴¹⁸ Interview with an adjudicator (June 13th, 2011).

⁴¹⁹ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011

⁴²⁰ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴²¹ Interview with an adjudicator (June 8th, 2011).

⁴²² Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

*shouldn't be that... You know it is not enough that the doctor thinks so right? I think it is hard to get a good quality of justice for our applicants.*⁴²³

In order to challenge the prevalence of the medical model, respondents suggested CCB adjudicators should identify and analyze the diverse social realities, which marginalize ethno-racial people with mental health disabilities within their decisions.⁴²⁴

iv) Applying an Intersectional Approach

Respondents recommended that the CCB should adopt an intersectional approach when adjudicating cases involving ethno-racial people with mental health disabilities.⁴²⁵

For instance, a number of academics suggested that the mechanics of discrimination were often left out of the actual cases, and the intersectional approach had not been appropriately applied or understood.⁴²⁶ As such, an academic reflects upon this observation as follows:

The CCB and the courts haven't actually done intersectionality, and this is one of the problems. This may lead to a much longer discussion about intersectionality and the full scope of that kind of insight, which I have no doubts about it being an incredibly important insight, but the way that it is getting translated I think often into litigation, is precisely what people warned about it in the beginning. That this isn't just gender plus race, this isn't just...and I think that for the most part, when you see intersectionality discussed in case law, any recognition of intersectionality is a kind of recognition that seems to say like "and of course this is even worse for women," or "and of course this is even worse for racial minorities," it is that this is not an important insight, it is just that this is not a full recognition of what intersectionality is, what insight actually provides us with, some of that is because of the cases that are getting brought. The cases that are getting brought, it may be that that is how intersectionality actually operates in those cases. It is just worse for, let's say, mental health, schizophrenia, treatment and

⁴²³ Interview with an adjudicator (June 8th, 2011).

⁴²⁴ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴²⁵ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴²⁶ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

*movement between criminal and civil systems, we might be able to say it is worse for minority men, but the real insight of intersectionality is that these splintered up locations can change the nature of the discrimination that you are facing, not its extent, but its nature.*⁴²⁷

Some respondents also worried that adjudicators have no knowledge about how to appropriately apply an intersectional approach. Thus, it was recommended that CCB adjudicators should be trained to understand how intersectionality could be applied to Ontario's civil mental health laws.⁴²⁸ An adjudicator reflects upon this recommendation as follows:

*We need to have processes, we need to be genuine, we need to be committed, and we need to have a plan. We need to have a strategic plan on how we are going to deal with every kind of discrimination. You can't just do it to appease someone. You really have to be committed. Whether it is an intersectional approach that you are dealing with, you have to have a strategic plan and you have to be committed.*⁴²⁹

Accordingly, respondents recommend that academics and service providers should be involved in training adjudicators on how to apply an intersectional approach to the CCB. There should be a strategic plan created to ensure that intersectionality is built into the CCB's training mandate.⁴³⁰

5.4.5 Post-Hearing

When making recommendations for the post-hearing process, respondents argued that there were limited resources for ethno-racial people with mental health disabilities to challenge the adjudicator's decisions. Thus, there should be more resources available for ethno-racial people to make appeals and to make complaints to the Ontario Human

⁴²⁷ Interview with an academic (July 20th, 2011).

⁴²⁸ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴²⁹ Interview with an adjudicator (May 18th, 2011).

⁴³⁰ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

Rights Tribunal.⁴³¹ Similarly, respondents recommended that ethno-racial people with mental health disabilities should have access to legal advice/resources on their immigration status, given the negative impact involuntary admission to a psychiatric hospital may have on their immigration process.⁴³²

5.4.6 Human Rights in the Hospital

i) Racism

Respondents recommended that there should be more cultural programming within psychiatric hospitals. They advise that it would be ideal to have treatment staff from diverse communities available for ethno-racial people with mental health disabilities.⁴³³ A number of academics felt that the issue of racism should be explicitly named and identified.⁴³⁴ For instance, an academic explained that in the mental health context, the issue of racism, both systemic and structural, was often framed in terms of cultural difference.⁴³⁵ She states as follows:

*The problem is not cultural difference. The problem is racism, injustice, inequality.... That is thing..that is the question we have to ask. It hasn't meant that they have noticed injustice. What they have noticed is difference. Difference not dominance. And difference, slips very easily in hierarchy because different from whom and pretty soon you are in a different level, different from whom, who is being sensitive to who..*⁴³⁶

⁴³¹ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴³² Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴³³ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴³⁴ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴³⁵ Interview with an academic (July 15th, 2011).

⁴³⁶ Interview with an academic (July 15th, 2011).

Thus, it was recommended that all practitioners should recognize and identify the racism experienced by ethno-racial people with mental health disabilities.⁴³⁷

5.4.7 Access to Culturally Appropriate Treatment and Care

Respondents recognized the challenges for ethno-racial people with mental health disabilities to access culturally appropriate treatment and care. Since recommending treatment is beyond the CCB's jurisdiction, adjudicators are unable to grapple with these issues within the CCB's processes.⁴³⁸ However, some adjudicators felt that they should be able to challenge this throughout the hearing and post-hearing processes. For instance, an adjudicator reflects upon this as follows:

I mean we have typically taken the approach that what the treatment is beyond our jurisdiction. We have typically taken the view that that is doctor's purview. While we are empowered to look at whether the patient is capable of consenting to a particular treatment and we acknowledge that capacity to consent is treatment specific, so somebody might be capable of consenting to their anxiety because of sleeplessness, but not psychosis. We have typically taken the position that because we are not the clinician or the treatment team, it is not to us to say that have you considered this or that, what about this treatment, or is this treatment appropriate, and the same is true about community treatment. What the Community Treatment Plan says is a hot issue right now for the Board. That is a hot issue for the Board – is whether we should be going into the CTP – saying well what is the treatment plan itself. Do you approve the plan itself? The Board typically takes the position that is beyond our purview.

What I will do even, if I see that something like that is beyond my jurisdiction, I will often include, if I am writing reasons, include a piece of obiter so I will say, while this is beyond my jurisdiction under the MHA, and HCCA as the case may be or the SDA, as a matter of obiter, I would encourage the physician to consider X, Y or Z, so basically I am saying, I don't have the legal right to tell you what to do, but as an intelligent third party observer it seems to me that you might want to consider..So, I will do that sometimes.

⁴³⁷ Interview with an academic (July 20th, 2011). Interview with an academic (July 15th, 2011).

⁴³⁸ Data derived from interviews conducted with lawyers from April 2011 to November 2011.

*I think there is an unspoken bias, which is very deep in this corner of medicine and in this corner of law relating to this corner of medicine that pharmacology is where it is at and anybody who, it is like the cult of medicine, of chemicals and anybody who doesn't agree with that is shunned and considered nuts. It is almost an unquestioned received wisdom. Anybody who considers treating it this way and that way is proof that they have no insights in their condition. This is routinely in doctor's presentation and routinely accepted by the board as such. So, people who want alternative therapies - homeopathy, sweat lodge, yoga, really the doctor's will present that 'this person is kind of a crackpot.'*⁴³⁹

Thus, respondents recommended that adjudicators should question whether treatment decisions were culturally appropriate for ethno-racial people with mental health disabilities.⁴⁴⁰ Also, to ensure that requests for culturally appropriate treatment and care are not discounted, adjudicators should probe into such issues within the hearings or within the obiter of their written reasons.⁴⁴¹

In regard to accessing culturally appropriate services and care within the community, service providers felt that this was contingent upon the particular health care professional's knowledge, awareness and relationship with various mental health agencies.⁴⁴² Consequently, health care professionals must continue to collaborate and build relationships with various mental health agencies within the community.⁴⁴³ If such services were provided, it was also recommended there should be a focus on creating a positive relationship between the ethno-racial person with a mental health disability and their case-worker/support worker. A service provider explains this as follows:

⁴³⁹ Interview with an adjudicator (June 8th, 2011).

⁴⁴⁰ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁴¹ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁴² Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁴³ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

Most of the real work that gets done is about relationships. The relationship matters, that you have with an individual, just because you are from the same culture, it is not a given that you are going to establish a relationship with someone. I have had many people come and they have been assigned a worker – not necessarily because they want one – okay you are Somali and you get a Somali worker, but your Somali worker is like 40 years older than you, and their experience of being Somali and being Somali in Canada is totally different than yours and sometimes those relationships don't work.⁴⁴⁴

Thus, some respondents suggest that such relationships may be effective for reasons aside from cultural and racial background, such as experience within the mental health system, age, gender, class or religion.⁴⁴⁵

5.4.8 Social Supports

Adjudicators, government advisers, academics and service providers argue that having a support system is crucial for an ethno-racial person with a mental health disability to survive a mental health disability.⁴⁴⁶ Some respondents also felt that there should be individualized supports and services for ethno-racial people with mental health disabilities, since they may reject the mainstream supports and services.⁴⁴⁷

5.4.9 Research Initiatives

In regard to research initiatives, respondents indicate that there is a dearth of literature and research regarding the experiences of ethno-racial people with mental

⁴⁴⁴ Interview with a service provider (May 17th, 2011).

⁴⁴⁵ Interview with a service provider (May 17th, 2011); Interview with a service provider (May 20th, 2011).

⁴⁴⁶ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁴⁷ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

health disabilities who come before the CCB.⁴⁴⁸ Accordingly, it is recommended that psychiatric hospitals and the CCB keep statistics on the ethno-racial and ethnic break-up of its clientele to increase accountability and awareness.⁴⁴⁹ An academic reflects upon this recommendation as follows:

*So lets say we are talking about involuntary, consent and capacity board decisions, just part of our squeamishness talking about race and culture is because we don't have good statistics to take about what is happening. And I think another part of the problem is understanding the scope of the problem is very difficult because of the way that statistics are kept and also, the bifurcated nature of mental health problems in law, so the mental health - health part and the mental health cultural part. It makes it all quite complicated to even define the scope of the cultural, racial discrimination and the mental health interactions with law.*⁴⁵⁰

Given the advent of technological intake assessments at psychiatric hospitals, a service provider recommends that there should be research conducted to evaluate the effectiveness of the “technology of psychiatry” and its relationship to culture, and race.⁴⁵¹ For instance, she argued that the following questions should be examined: Will information collected through the intake assessment records within psychiatric hospitals ensure that ethno-racial people with mental health disabilities have more access to culturally appropriate services and care? Will statistics collected through this system be available to the public or external researchers? Is there a solid informed consent process that ethno-racial clients have to undergo before participating in the intake?⁴⁵²

Lastly, respondents recommend that more research should be conducted which

⁴⁴⁸ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁴⁹ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁵⁰ Interview with an academic (July 20th, 2011).

⁴⁵¹ Interview with a service provider (May 20th, 2011).

⁴⁵² Interview with a service provider (May 20th, 2011).

evaluates the quality of ethno-specific services, and the effectiveness of using other models of justice such as transformative justice and restorative justice for ethno-racial people with mental health disabilities.⁴⁵³

5.4.10 CCB Adjudicators

Respondents indicate that the extent to which the CCB can appropriately address the issues relevant to ethno-racial people with mental health disabilities is a function of the competence and the quality of its members.⁴⁵⁴ Specifically, a number of respondents argued that the quality of the CCB's board members was lacking. Since the pay is so low, adjudicators are often retired, and appointed based on their political backgrounds.⁴⁵⁵ An adjudicator reflects upon these challenges as follows:

*It is an internal government process. They try to make it as transparent by posting the vacancies online, by posting the application online, but at the end of the day, these are appointments that come from the government so people who done a lot of work to assist their MP or people who have made big donations to the governing party may have leg up in terms of getting the appointments. So, to a certain extent, I think the Board is stuck with some people that are appointed by the government and there may be some push and pull... A lot of times, the board is stuck with whoever comes their way. I think the Board needs better quality of member by and large. I think the Board needs to pay adjudicators better because it is hard to attract very high quality people with the small amount of pay they give. It is a part time appointment so either it is retirees who do it who can afford the pittance they pay or it is people who are busy with other things. And those are few and far between. Mostly it is older people who are retired..who frankly for a lot of them..the best years are behind them. And I think they could have attracted much better quality of people if they paid more, like for example, I would sit more often if they paid more. But, I can't sit more often, because I can't afford it.*⁴⁵⁶

⁴⁵³ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁵⁴ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁵⁵ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁵⁶ Interview with an adjudicator (June 8th, 2011).

Thus, respondents argue that the CCB needs better quality control over its adjudicators. Specifically, respondents recommend that the CCB needs a better recruitment process to ensure that adjudicators are qualified, diverse, competent, eager and aware.⁴⁵⁷ It is recommended that the CCB increase the salaries for its members. When interviewing members, respondents felt that the CCB should try to ensure that candidates are genuinely interested in providing due process and procedural protections for people with mental health disabilities.⁴⁵⁸ Lastly, those recruited by the CCB should have an understanding of the types of intersecting discrimination and the legal barriers experienced by ethno-racial people with mental health disabilities.⁴⁵⁹

5.4.11 Training

When questioned about the effectiveness of the training received by CCB adjudicators, respondents indicated that the CCB had tried to increase its adjudicators' awareness of cultural and intersectional issues relevant to equity-seeking groups in the last few years. For instance, there was a half-day training workshop on these issues two years ago.⁴⁶⁰ However, respondents argue that ongoing and consistent training is necessary for all CCB adjudicators.⁴⁶¹ An adjudicator suggests as follows:

⁴⁵⁷ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁵⁸ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁵⁹ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁶⁰ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁶¹ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

*I would say the level of awareness and willingness to deal with these issues appropriately is probably a lot lower than you or I would hope. So, more training is necessary.*⁴⁶²

Respondents had varied conceptions of the types of training that was necessary for CCB adjudicators. For instance, some academics felt that training framed as “cultural sensitivity or cultural competence” could be problematic and limited.⁴⁶³ An academic reflects upon this as follows:

*It is more about the training that is the part where I start to get really interested. Then you read what kinds of things are passed as training in cultural competence and some of those things I find really problematic because they do seem to reify and solidify cultural practices as monolithic and binding on all members of the particular culture in a particular way. And I think those can interfere in understanding both the way that cultural practices shift in a postcolonial context and how people accommodate the world they are living in. The problem is that any kind of anti-racism training is very complicated to deliver to an audience who doesn't think they need it. So, I think what ends up happening is that the training is delivered as cultural competence and not anti-racism and that the cultural competence type of training easily, very easily devolves into – and ‘this is how we dress, this is how we eat, and this is what we think,’ and I think is a presentation about difference and I think that this is how it understood by judges and I think that is hugely, hugely problematic in terms of people then thinking, ‘now I have this knowledge about this difference and now I can just go ahead and apply this knowledge.’ I think as a societal theme, that cannot possibly be the way we that deal that cultural difference and even racialization. We have to be reflective about it, we have to understand the so-called difference is actually just part of our societal cultural makeup. So, I think that it often devolves into a form of rote learning that makes people feel more comfortable and it makes people who exist in a majority part of society because then they feel they understand it, but I think that is probably largely not true.*⁴⁶⁴

In this respect, some respondents recommended that training for CCB adjudicators should not focus on cultural difference. Instead, training sessions should examine inequality and injustice through experiential learning exercises and frameworks

⁴⁶² Interview with an adjudicator (June 8th, 2011).

⁴⁶³ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁶⁴ Interview with an academic (July 20th, 2011).

of anti-oppression and anti-racism.⁴⁶⁵ These training sessions should be delivered in conjunction with other continuous legal education workshops (specifically for lawyer members of the CCB).⁴⁶⁶ Respondents further recommended that ethno-racial people with mental health disabilities, ethno-racial adjudicators and ethno-racial practitioners should be involved in delivering the training sessions.⁴⁶⁷ Also, it was recommended that the CCB collaborate with ethno-specific mental health agencies, the National Judicial Institute and the Equity Advisory Group (EAG) of the Law Society of Upper Canada in order to facilitate its training.⁴⁶⁸

5.4.12 Use of the Cultural Analysis Tool (CAT)

Throughout the study, some adjudicators, academics, government advisers and service providers raised questions regarding the use of the CAT. The following questions arose: How will practitioners know when to use the CAT? How will the CAT ensure that practitioners are aware of their power and privilege within Ontario's civil mental health system?⁴⁶⁹ As such, respondents recommended that the CAT should urge practitioners to

⁴⁶⁵ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁶⁶ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁶⁷ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁶⁸ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁶⁹ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

be self-critical and reflective about their own power and privilege, cultures of dominance and institutional racism.⁴⁷⁰

5.5 CONCLUSION

This chapter presented an overview of the results from the analysis of qualitative interviews. The respondents included: (1) ethno-racial people with mental health disabilities including in-patients and ex-patients, (2) lawyers who practice in the area of mental health law, (3) health care professionals including psychiatrists, nurses and social workers and (4) adjudicators, government advisers and academics and (5) service providers such as front-line case workers at mental health agencies. These results facilitated the creation and development of the Cultural Analysis Tool (CAT).

Through the description and narratives, it appears that there are similarities and differences within each theme, category and sub-category. For instance, all of the respondents highlighted the important role that practitioners have in recognizing how cultural and intersectional issues affecting ethno-racial people with mental health disabilities significantly impact their disparities of outcome when interacting with Ontario's civil mental health laws. Similarly, respondents were in favor of improving the quality and accessibility of interpretation services.⁴⁷¹ Accordingly, the frequently mentioned recommendations amongst all groups of respondents were those pertaining to: the use of cultural interpreters/consultants, the role of cultural evidence, the implementation of an intersectional approach within the CCB, the need for providing

⁴⁷⁰ Data derived from interviews conducted with adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁷¹ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

culturally appropriate treatment and care and social supports, the need for addressing human rights violations within the hospital, the effectiveness of legislative reforms and the various approaches to providing training and education to practitioners, and ethno-racial people with mental health disabilities.⁴⁷²

However, it appeared that respondents were divided in their views of how to address the inherent institutional racism within Ontario's civil mental health system. Unresolved tensions remained as to the extent to which the CCB's hearing process can be improved and whether varying standards of discretion should be used for ethno-racial people with mental health disabilities who appear before the CCB.⁴⁷³ The next chapter will further analyze these tensions and results through a thorough examination of the primary sources (jurisprudence, legislation and policies) and secondary sources, along with the data obtained from the focus groups. This analysis develops and creates the CAT, which is presented in the next chapter.

⁴⁷² Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

⁴⁷³ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

CHAPTER 6

ANALYSIS

6. Introduction

This chapter analyzes and contextualizes the results that emerged from interviews with five participant groups. The themes, categories and sub-categories are examined through an analysis of the primary sources (jurisprudence, legislation and policies) and the secondary sources, along with the data obtained from the focus groups. The secondary sources include the theoretical framework (institutional racism paradigm, the social model of disability, intersectionality and cultural considerations in mental health law), an analysis of the existing legislative and health equity tools and an analysis of literature in law, transcultural psychiatry and mental health. As described in the methodology chapter, in order to inform the research and qualitative data gathering process underlying the CAT's development, Chapters Two and Three analyzed the theoretical framework, the tools themselves, the robust literature surrounding their development and the international laws and principles relevant to mental health laws. Further, the jurisprudence, applicable statutory provisions and legal processes relevant to the implementation of the laws were analyzed.

The study's rigour was increased through an expert review of the CAT involving the qualitative technique of member checking. By shifting the verification procedure from the researchers to the participants, member-checking "consists of taking data and interpretations back to the participants in the study so that they can confirm the credibility

of the information and narrative account.”¹ The expert review was conducted using three focus groups comprised of ethno-racial people with mental health disabilities, mental health lawyers and health care professionals (ie. psychiatrists, nurses and social workers.). The focus group data was further transcribed and analyzed.

In order to create the CAT, this chapter applies the primary and secondary sources and the focus group data to the results of the interviews described in Chapter Five. The purpose of the analysis is to examine how culture, race, ethnicity, class, gender and other intersecting social factors affecting ethno-racial people with mental health disabilities should factor into the implementation of Ontario’s civil mental health laws. There is a focus on the pre-hearing, hearing and post-hearing processes involving voluntary and involuntary admissions, consent and capacity issues in relation to treatment, substitute-decision making, community treatment orders, long term care options, management of property and personal care.²

Within each theme that emerged from the interview data (as described in Chapter 5), I conduct a brief comparative analysis of these themes and I present preliminary questions that arose for the CAT in relation to the data. Then, the focus group data are examined as they increased the rigour of the study and refined the questions in the CAT. The analysis also addresses the varying responses amongst focus group participants and the inherent debate within the CAT’s questions. The modified and additional questions for the CAT are developed in each section and the final version of the CAT is presented

¹ John. W. Creswell and Dana L. Miller, “Determining Validity in Qualitative Inquiry” (2000) 39:3 *Theory Into Practice* 124 at 127.

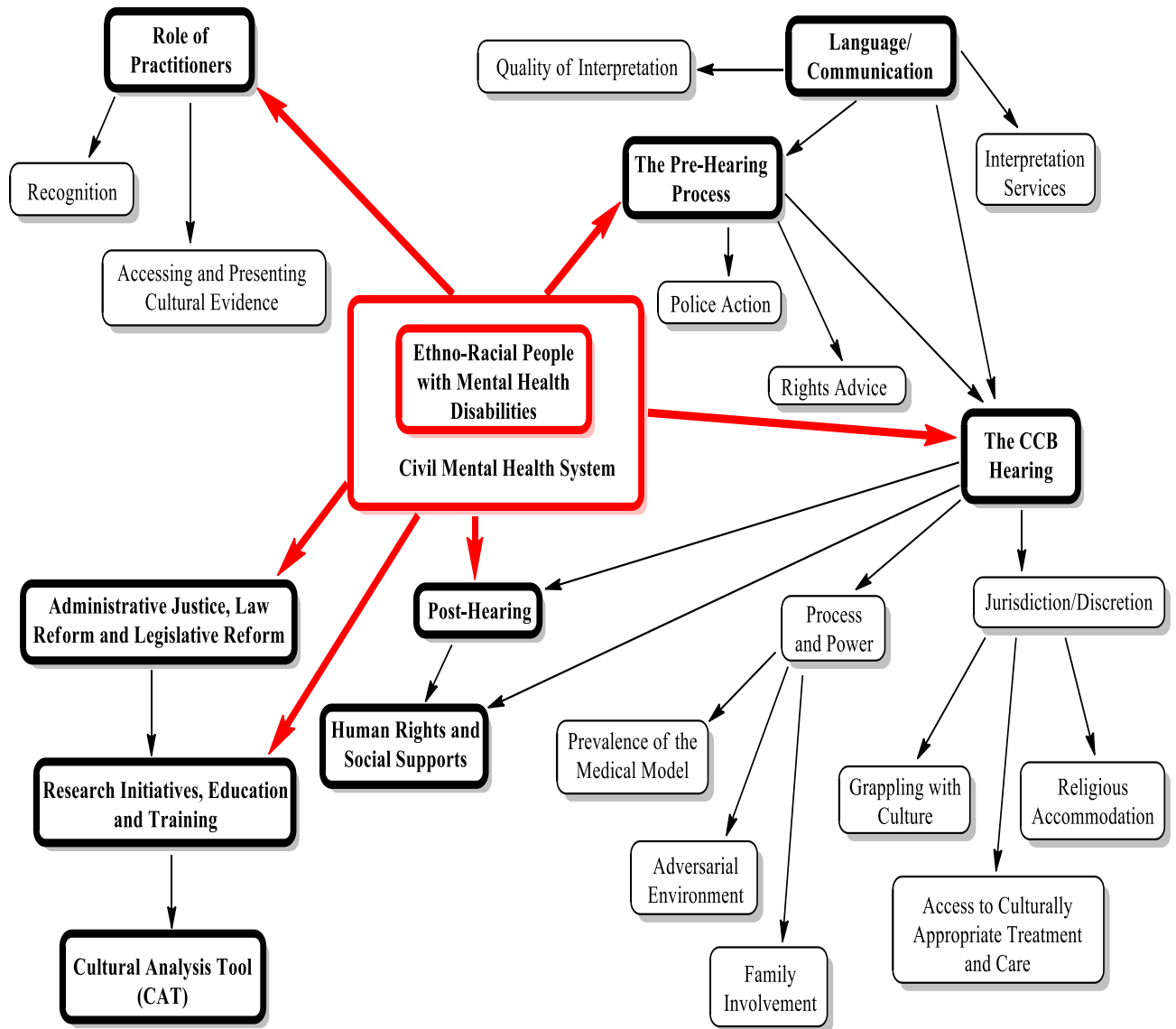
² D’Arcy Hiltz and Anita Szigeti, *A Guide to Consent and Capacity Law in Ontario* (Markham: Lexis Nexis Canada Inc., 2013) at 545.

at the end of this chapter.

i) Conceptual Framework: Emergent Themes Derived from an Analysis of the Results

The diagram below illustrates the interrelationships between the themes and sub-themes that emerged from an analysis of the results, which were derived from the interview data. Drawing from the subject of this study: “Ethno-Racial People with Mental Health Disabilities,” the emerging themes (which are highlighted in black) include: Role of Practitioners; Language/Communication; The Pre-Hearing Process; The CCB Hearing; Post-Hearing; Human Rights and Social Supports; Administrative Justice, Law Reform and Legislative Reform; Research Initiatives, Education and Training and Cultural Analysis Tool. The arrows identify the interrelated sub-themes. The themes, sub-themes and interconnections between these themes are described in Chapter Five and further analyzed in this chapter. Although some of the emergent themes and sub-themes were similar amongst the participants, there were outliers, which were specific to each stakeholder group. In particular, ethno-racial people with mental health disabilities specifically identified the sub-themes of “racism,” and “power,” which are embedded within an analysis of the theme of Human Rights and Social Supports. In both chapters, the themes are presented and analyzed in a logical order because of their importance within the civil mental health system and its underlying legal processes. This analysis facilitated the development of Cultural Analysis Tool (CAT).

Figure 2:
Conceptual Framework: Emergent Themes Derived from an Analysis of the Results



6.1 Role of Practitioners

i) Recognition

Generally, respondents recognized that practitioners in the civil mental health system must be culturally aware throughout the pre-hearing, hearing and post-hearing

processes.³ Accordingly, an analysis of the results under this particular theme suggested the following questions for the CAT:

- 1) Have practitioners attempted to identify and address the intersectional issues relevant to the client throughout the pre-hearing, hearing and post-hearing processes?
- 2) Does the client need accommodation?
- 3) Have practitioners tried to accommodate the clients appropriately?
- 4) Are practitioners trained to acknowledge and examine the relevant cultural factors within the client's case?
- 5) Has the client's lawyer explained the CCB process to the client and his or her family?
- 6) Have practitioners challenged stereotypes and avoided generalizations based on culture, race, gender, class and other social factors?
- 7) Is there an open dialogue amongst practitioners about the institutional racism within the civil mental health system?
- 8) Are the practitioners active and sensitive listeners?
- 9) Do practitioners engage in self-education and peer-learning in order to address the intersectional issues affecting their ethno-racial clients?

The focus group data and research refine and expand upon these questions. A new theme that arose in the focus groups was paternalism vs. client instructed advocacy.

Respondents recommended that lawyers advocating for ethno-racial people with mental health disabilities should embrace a client-instructed advocacy model instead of a paternal, best interests approach.⁴ While contextualizing the unique circumstances of

³ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

⁴ Michael Perlin, "International Human Rights and Comparative Mental Disability Law: The Use of Institutional Psychiatry as a Means of Suppressing Political Dissent" (2006) 39 Isr. L.R. 69 at 74.

their clients, lawyers must overcome their own biases and the inherent paternalism within the civil mental health system. In order to grapple with the varying understandings of mental health disabilities within cultures, lawyers must strive to bring forth cultural information and cultural evidence.⁵

According to the Law Society of Upper Canada's *Rules of Professional Obligation*, "the lawyer shall, as far as reasonably possible, maintain a normal lawyer and client relationship."⁶ Marshall Swadron, a well-known mental health lawyer in Toronto, argues that mental health lawyers should adhere to this rule when adopting a client-instructed advocacy model. Thus, he puts forth the following five strategies for lawyers appearing before the CCB: "1) Hear from the client before forming any opinion, 2) Discuss the substantive issues and explain the process to the client, 3) Present options to the client including recommendations and likely consequences; make it clear that the ultimate decision is the client's, 4) Respect the client's instructions fully within the bounds of one's professional obligations and 5) Advance the client's position to the fullest extent permitted."⁷

In a similar vein, Michael Perlin asserts that lawyers cannot succumb to "sanism,"

⁵ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

⁶ Law Society of Upper Canada, *Rules of Professional Conduct*, online: <http://www.lsuc.on.ca/with.aspx?id=671>, subrule 2.02(6). It is important to note that in *Gligorevic v. McMaster*, 2012 ONCA 115, 254 CRR (2d) 241 (Ont. C.A.), the Ontario Court of Appeal held that a ground of appeal from a treatment capacity decision is "ineffective assistance of counsel." This could be perceived as counsel that does not grapple with the cultural evidence and intersectional issues surrounding a client's case.

⁷ Swadron, Marshall, "Representing the Alleged Incapable Client Before the Consent and Capacity Board", Law Society of Upper Canada's Capacity, Consent and Substitute Decisions – An Essential Update, 2004.

which is described as “an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry...”⁸ Sanism is based upon “stereotype, myth, deindividualization, and is sustained and perpetuated by our use of alleged ‘ordinary common sense’ (OCS) and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process.”⁹ Drawing from Perlin’s analysis, Dhir highlights the problem of sanism amongst mental health lawyers in Ontario:

..patients' counsel can sometimes substitute engaged lawyering with paternalism and can fall into the trap of conflating the presence of mental disability with incapacity. With clinicians and adjudicators exhibiting the same tendency, we are left with the possibility of a sort of nightmare state where antiquated, sanist notions are left untested by rigorous advocacy. The presumption of capacity becomes an "illusory safeguard" and the tribunal hearing to adjudicate capacity becomes a mere ceremonial act, devoid of any real meaning.¹⁰

Perlin suggests that lawyers must overcome “sanist biases” by adopting tenets of “therapeutic jurisprudence.” This approach “forces lawyers to adopt a multi-disciplinary investigation and evaluation of the therapeutic effects of the lawyering process and a case’s ultimate disposition.”¹¹ Lawyers should understand their clients’ perspective and instructions. Perlin argues that lawyers must gather anecdotal cultural information in order to understand the cultural context surrounding their clients’ lives. Through self-awareness, tolerance, empathy and an open mind, lawyers should examine how culture

⁸ Michael Perlin, *supra* note 4 at 74.

⁹ Michael Perlin, *supra* note 4 at 74.

¹⁰ Aaron Dhir, “Relationships of Force: Reflections on Law, Psychiatry and Human Rights” (2008) 25 WRLSO 103 at 108; Rachael Andersen-Watts, “Recognizing Our Dangerous Gifts: Applying the Social Model to Individuals with Mental Illness” (2008) 12 Mich St UJ Med & L 141 at 155.

¹¹ Michael Perlin, *The Hidden Prejudice* (Washington: American Psychological Association 2000) at 301.

may impact mental health and their clients' perspectives. Lawyers should try to grapple with the client's "history of cultural identification and assimilation of the host culture – including normative values, beliefs and attitudes.." throughout the legal processes.¹²

Using this approach, Perlin suggests that all practitioners in the mental health system can be culturally aware.¹³ Similarly, practitioners should also understand and adopt tenets of the social model of disability in order to analyze how social factors such as poverty, homelessness, unemployment, estrangement from their families and lack of access to health care may impact their ethno-racial clients.¹⁴

In regard to health care professionals specifically, the focus group data suggests that the new DSM-V may enhance the cultural sensitivity of health care professionals.¹⁵ Respondents indicate that the DSM-V's cultural formulation interview guide may enable health care professionals to adopt a client-centred approach to psychiatric diagnosis and treatment, thereby avoiding the inherent paternalism in psychiatry.¹⁶ The cultural formulation interview guide is designed to help health care professionals recognize the cultural explanation of the patient's disability and the relevant cultural differences

¹² Michael L. Perlin and Valerie McClain, "Where Souls Are Forgotten: Cultural Competencies, Forensic Evaluations, and International Human Rights" (2009) 15:4 *Psychology, Public Policy and Law* 257 at 264; Michael L. Perlin, "'And My Best Friend, My Doctor, Won't Even Say What It Is I've Got:' The Role and Significance of Counsel in Right to Refuse Treatment Cases" (2005) 42 *San Diego L Rev.* 735 at 736-737.

¹³ *Ibid.*

¹⁴ Aaron Dhir, "Relationships of Force: Reflections on Law, Psychiatry and Human Rights" (2008) 25 *WRLSO* 103 at 108; Rachael Andersen-Watts, "Recognizing Our Dangerous Gifts: Applying the Social Model to Individuals with Mental Illness" (2008) 12 *Mich St UJ Med & L* 141 at 155.

¹⁵ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹⁶ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

between themselves and their patients. Within the guide, there are questions to assess the cultural factors affecting the patients' perceptions of their distress and problems, their symptoms and treatment options.¹⁷ Despite the critique regarding the DSM-V,¹⁸ scholars and mental health practitioners are optimistic that the DSM-V will be an effective tool for health care professionals. Unlike the DSM-IV, the DSM-V's cultural formulation interview guide is not optional and it is not part of the annex.¹⁹ This tool can help to ensure that health care professionals are more self-reflective about their own and their patients' cultural context and beliefs, along with the institutional culture of the mental health care facility.²⁰ The information gathered through the cultural formulation interview guide may play an important part of the evidence and clinical information presented within the CCB hearing.

Given the aforementioned analysis, the following questions were also included in the CAT:

- 10) What degree of involvement does the client have with his or her culture?
- 11) What factors have contributed to the client's mental health disability?
- 12) What is the client's perspective about the case?
- 13) Has the client experienced discrimination, prejudice, or racism?
- 14) What does the client wish to accomplish in the CCB hearing?
- 15) Are the client's instructions at odds with his or her lawyer's or health care

¹⁷ American Psychiatric Association, "DSM-5 Development," online: American Psychiatric Association <http://www.dsm5.org/Pages/Default.aspx>; American Psychiatric Association, "Cultural Concepts in DSM-5," online: American Psychiatric Association <http://www.dsm5.org/Pages/Default.aspx>.

¹⁸ Kwame McKenzie, "Mind Games: Inside the Controversial New Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders" (2013) 5 *The Walrus*, online: *The Walrus* <http://thewalrus.ca/mind-games/>.

¹⁹ *Supra* note 17.

²⁰ *Supra* note 17.

professional's recommendations?

16) Are health care professionals using the cultural formulation interview guide in the DSM-V?

17) Is the information gathered through the DSM-V's cultural formulation interview guide presented in the CCB hearing?

ii) Accessing and Presenting Cultural Evidence

Lawyers were the only participant group that identified this theme. Given the lack of resources for mental health lawyers in Ontario, lawyers found it challenging to access and present cultural evidence.²¹ An analysis of these results suggested the following questions for the CAT:

- 1) Should cultural evidence play a role in this case?
- 2) Is there an appropriate evidentiary basis for presenting the cultural evidence?
- 3) Is the cultural evidence presented in an appropriate and sensitive manner?
- 4) Are there enough resources for lawyers to present the cultural evidence appropriately?
- 5) Does the cultural evidence have a negative or positive impact on the client's case?
- 6) Do practitioners and ethno-racial people with mental health disabilities have access to a cultural resource centre or cultural consultation service?
- 7) Do practitioners have access to someone who can provide them with cultural insights into the various perceptions of mental health disability?

The focus group data and research raised some new questions. For instance, health care professionals questioned:

- 8) What criteria should be used to evaluate the cultural evidence?

²¹ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

9) Is the client's behavior culturally driven, or is it deviant or delusional behavior?

The empirical data and research recognize the inherent dangers of inappropriately using cultural factors and cultural evidence in the implementation of civil mental health laws.²² The challenge is immense for practitioners since psychiatric symptoms can present themselves differently amongst ethno-racial people with mental health disabilities; and in the event lawyers do present cultural evidence/ information, they may risk creating unjust stereotypes based on culture, race, class and gender, etc.²³ In light of these challenges, scholars have debated the extent to which culture, and other intersections can infuse the civil mental health system without inculcating stereotypes.²⁴

Socio-legal scholar Sonia Lawrence suggests that judges are often not equipped and in some cases “unwilling” to understand the complexities of cultural evidence/

²² Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011; Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012; James W. Hicks, "Ethnicity, Race, and Forensic Psychiatry: Are We Color-Blind?" (2004) 32:1 *Journal of the American Academy of Psychiatry and the Law* 21.

²³ James W. Hicks, *ibid.*

²⁴ Sonia Lawrence, "Culture (in) Sensitivity: The Dangers of a Simplistic Approach to Culture in the Courtroom" (2001) 13 *Can J Women and L* 108 at 112; Sherene Razack, "Law, Race and Space" (2000) 15 *Canadian Journal of Law and Society* 1 at 7; David Goldberg, *Racist Culture* (Oxford: Blackwell, 1993) at 149; Carol Aylward, *Canadian Critical Race Theory: Racism and the Law* (Nova Scotia: Fernwood Publishing, 1999) at 34; Wen-Shing Tseng, Daryl Matthews and Todd S. Elwyn, *Cultural Competence in Forensic Mental Health: A Guide for Psychiatrists, Psychologists, and Attorneys*. (New York: Brunner – Routledge, 2004) at 25; Suman Fernando, *Mental Health, Race and Culture* (New York: Palgrave, 2002) at 132.

information.²⁵ By only identifying differences between the non-mainstream, “Other” culture, and a construction of Canadian norms, the practice of adopting “cultural sensitivity” in courtrooms has created “an essentialized view of culture,” giving deference to the constructed view of Canadian norms.²⁶ In Canadian courtrooms, Lawrence indicates that judges are often unable to glean through and interpret the nuances within the cultural evidence/ information being presented by lawyers. There is little attempt to see similarities between the “Other” cultures and the majority culture, and distinguish differences within cultures themselves. In this vein, stereotypes can occur by reducing cultures to certain identifiable elements, practices, traditions, customs and traits without accounting for the contextual complexities of such information and a consideration of culture as non-static and changing.²⁷ Accordingly, Lawrence questions whether cultural evidence/ information should even be presented in legal cases, if it continues to perpetuate such stereotypes and create unjust legal outcomes it is intended to avoid.²⁸

This further raises the following questions:

- 10) Who is putting forth the cultural evidence/ information and what power/control/expertise does he or she have to do so?
- 11) Within the quasi-judicial legal processes, are those from minority cultures given the opportunity to present this cultural evidence/ information in light of the rules of evidence and the type of forum in which cases are heard?
- 12) How are expert witnesses able to respond to the cultural evidence/information at hand?

²⁵ Sonia Lawrence, *ibid* at 112.

²⁶ Sonia Lawrence, *ibid* at 116.

²⁷ Sonia Lawrence, *ibid* at 117-118.

²⁸ Sonia Lawrence, *ibid* at 135.

Despite the unresolved tensions surrounding cultural evidence/information in legal cases, it is also evident that altogether ignoring culture, and other intersecting identities can perpetuate further inequities. In this regard, Razack describes that in certain legal cases, “we see the violent underpinnings of universality- how the very language fairness, sameness, rationality, equal treatment and neutrality can be used to expel racialized bodies from personhood.”²⁹ Similarly, Alyward points to the dangerous consequences of adopting a “color-blind” approach.³⁰ Theorists such as Alyward and Razack, therefore, emphasize the importance of deconstructing the impact that power hierarchies, history and systemic racism can have within the legal context.³¹

The problems with a “color-blind” approach are particularly relevant in a mental health law context where ethno-racial people with mental health disabilities may have unique needs such as those in regard to communication, culturally appropriate treatment options, and assessment procedures that take into account cultural context and beliefs.³² According to Suman Fernando, a “color-blind” approach in psychiatry is a “denial both of individual perceptions in a racist society, and, more importantly, the fact that race matters because of the way most-or all-societies function.”³³

To account for the emerging problem of presenting cultural evidence before administrative tribunals, a number of recommendations have been put forth in the literature. Specifically, Lawrence suggests that practitioners should use cultural

²⁹ Sherene Razack, *supra* note 24 at 7; David Goldberg, *supra* note 24 at 149.

³⁰ Carol Aylward, *supra* note 24 at 34.

³¹ Carol Aylward, *supra* note 24 at 34; Sherene Razack, *supra* note 24 at 7; David Goldberg, *supra* note 24 at 149.

³² Wen-Shing Tseng, Daryl Matthews and Todd. S. Elwyn, *supra* note 24 at 25.

³³ Suman Fernando, *supra* note 24 at 132.

evidence/information cautiously. The inner multi-faceted and complex nature of culture requires “testimony about practices be taken as a guide and not as a strict template of behavior.”³⁴ There must be a recognition of the “intra-cultural dissent and power struggles” inherent within any culture when such testimony is used.³⁵ Practitioners should strive to include alternative narratives to explain cultural practices within legal processes, and they should attempt to compare the dominant culture’s practices with those of the minority culture.³⁶ Community members should also try to be involved in cases where cultural evidence/ information is an issue by submitting *amicus* briefs and highlighting the facts that legal rules, doctrines and conventions are “cultural and contested.”³⁷

When infusing cultural evidence and information into the civil mental health system, adjudicators must be aware of the institutional racism within law and psychiatry. Practitioners should also be allocated the appropriate resources to account for numerous narratives and cultural perspectives.³⁸ Some scholars have recommended developing a cultural consultation service to ensure the dissemination of cultural information and to encourage case-based learning.³⁹

³⁴ Sonia Lawrence, *supra* note 24 at 129.

³⁵ Sonia Lawrence, *supra* note 24 at 129.

³⁶ Sonia Lawrence, *supra* note 24 at 129.

³⁷ Sonia Lawrence, *supra* note 24 at 129. See also, Neil Krishan Aggarwal, “Adapting the Cultural Formulation for Clinical Assessments in Forensic Psychiatry” (2012) 40.1 *The Journal of American Academy of Psychiatry and the Law* 113 at 113; Anthony Good, “Cultural Evidence in Courts of Law” (2008) 14.1 *Journal of the Royal Anthropological Institute* S54.

³⁸ Elena, Marchetti, “Intersectional Race and Gender Analyses: Why Legal Processes Just Don’t Get It” (2008) 17:2 *Social and Legal Studies* 155 at 170.

³⁹ Hendry Ton, Alan Koike and Robert E. Hales, “A Qualitative Needs Assessment for Development of the Cultural Consultation Service” (2005) 42 (3) *Transcultural Psychiatry* 491 at 492.

6. 2 Language/Communication

i) Interpretation Services: Pre-Hearing, Hearing and Post-Hearing

Respondents identified significant barriers for ethno-racial people with mental health disabilities throughout the CCB's pre-hearing, hearing and post-hearing processes. For instance, lawyers argued that they were frustrated by Legal Aid Ontario's inefficient process for obtaining interpreter services during pre-hearing meetings, and the lack of translation available for written legal materials including forms and documentary evidence.⁴⁰ Similarly, health care professionals identified barriers for accessing interpreters to meet the everyday needs of clients, the needs of clients in the emergency department, the needs of clients who speak rare languages and the needs of clients with limited knowledge of English in capacity assessments. In circumstances where no interpreters were used, there appeared to be a higher risk of misdiagnosis, misunderstanding and mismanagement.⁴¹ All of the participant groups were concerned with the fact that legal decisions and reasons were not translated in the post-hearing processes.⁴² Collectively, an analysis of the results indicated the following questions for the CAT:

a) Pre-Hearing

1) Does the client face language or other communication barriers?

⁴⁰ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

⁴¹ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

⁴² Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

- 2) Does the client speak little or no English?
- 3) Does the client understand concepts such as “rights,” “treatment,” “informed consent,” and “CCB hearing?”
- 4) Is the lawyer aware of his or her duty to accommodate the client as per the *Ontario Human Rights Code* when addressing language issues?
- 5) Does the client need to be accommodated in regard to language, communication and/or disability?
- 6) Have the client’s accommodation needs been identified at the outset of the CCB hearing?
- 7) Does the client have access to interpretation services in the hospital within 24 hours?
- 8) Is the client’s lawyer able to access a Legal Aid Ontario interpreter within seven days?
- 9) Is the client’s lawyer able to have an interpreter available during the pre-hearing lawyer-client meetings?
- 10) Does the rights advisors’ list of lawyers specify the language ability of each Legal Aid Ontario lawyer on the list?
- 11) Is an interpreter used in the capacity assessments for a client who speaks little or no English?
- 12) Is the psychiatrist trained to work with an interpreter?
- 13) Could misdiagnoses have occurred because of a language or communication barrier?
- 14) If an interpreter was used, was this charted in the client’s hospital record by a health care professional?
- 15) Do treatment teams have varied language capacities to meet the everyday needs of non-English speaking clients?
- 16) If the client is non-English speaking, have all of the forms been translated in the client’s language of choice?
- 17) Has the rights advice been offered in written form and translated in the client’s language of choice?
- 18) Has the documentary evidence being used for the CCB hearing been translated in the client’s language of choice before the hearing?

b) Hearing

- 19) Is an interpreter provided for in the CCB hearing as per s.18 of the CCB's rules of practice?
- 20) Does the interpreter have experience and expertise working with ethno-racial people with mental health disabilities?
- 21) Are the client's accent, mannerism, body language, gestures and demeanor appropriately understood?
- 22) When an interpreter is used, is simultaneous translation actually occurring?
- 23) Is the interpreter appropriately giving the client a voice?
- 24) Is the interpreter non-biased and non-judgmental?
- 25) Have the guidelines involving the interpreter's role been fully explained by the CCB at the outset of the hearing?
- 26) In cases where cultural evidence is being presented, is the interpreter able to appropriately contextualize the translation and understand the cultural nuances involved?

c) Post- Hearing

- 27) Has the client received a written decision specifying the reasons for the outcome of the CCB hearing?
- 28) Has the CCB translated the written decision and reasons for clients who do not speak English?
- 29) Is the requirement to translate decisions and reasons for clients who do not speak English included in the CCB's rules of practice?
- 30) Does the client fully understand the overall outcome of his or her CCB hearing?
- 31) Are the legal reasons adequate?
- 32) Do the written decision and reasons avoid the use of "legalese"?
- 33) Is the written decision and reasons presented in a plain, clear and accessible language?
- 34) Did the client receive a one-page summary of the legal decision and reasons along with the entire set of reasons?

35) Has the lawyer explained the appeal process to the client?

Amongst the focus group participants, there was a debate regarding whether or not forms should be translated and who should be responsible for covering the cost of translating the forms.⁴³ The majority of the lawyers indicated that forms involving liberty issues such as the Application by Physician for Psychiatric Assessment, the Order for Examination under Section 16, the Certificate of Involuntary Admission and the Certificate of Renewal must be translated for clients who are non-English speaking. It was recommended that translation of the forms should be the responsibility of the Ministry of Health. However, a few lawyers felt that since rights advice is provided for in CCB cases, the rights advisers should be responsible for getting the forms translated.⁴⁴ As indicated in the CAT, lawyers also argued that the CCB should be responsible for translating the decisions for clients who do not speak English.⁴⁵ In a similar vein, some health care professionals argued that clinical documents such as clinical summaries and discharge notes should not be translated as it may be lengthy and costly to complete the

⁴³ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

⁴⁴ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011; Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

⁴⁵ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

translations within seven days. It was recommended that an oral interpretation of these documents would suffice.⁴⁶

The client's right to an interpreter in civil administrative law proceedings is codified in common law, and federal statutes including the *Charter of Rights and Freedoms*⁴⁷ and the *Canadian Bill of Rights*.⁴⁸ For instance, s. 14 of the *Charter* states:

A party or witness in any proceeding who does not understand or speak the language in which the proceedings are conducted or who is deaf has the right to the assistance of an interpreter.⁴⁹

Both s. 14 of the *Charter* and s. 2 (g) of the *Canadian Bill of Rights* have been interpreted to apply to civil litigation.⁵⁰ In *R v. Tran*,⁵¹ the Supreme Court of Canada developed guidelines to ensure “continuity, precision, impartiality, competency and contemporaneousness,”⁵² when examining the quality of interpretation services being provided.⁵³ Despite these provisions, Lorne Sossin argues that linguistic access continues to be a significant barrier for those appearing before administrative tribunals in Ontario.⁵⁴

⁴⁶ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

⁴⁷ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (U.K.), 1982 C 11, s 14 [*Charter*].

⁴⁸ *Canadian Bill of Rights*, RSC 1985, App III, s 2(g).

⁴⁹ *Charter*, *supra* note 47 at s 14.

⁵⁰ *Wyllie v Wyllie* (1987) 37 DLR (4th) 376 1987 CLB 865, 4 ACWS (3d) 183, 30 CRR 191; Annalisa Edoo, Lynn Fournier-Ruggles, Charine Mattis, Kaitlyn Matulewicz and Farlon Rogers, “White Paper on Quality Court Interpretation Services,” (Toronto: York University, 2010) at 10.

⁵¹ [1994] 2 S.C.R. 951.

⁵² *Ibid* at 977-78.

⁵³ *Ibid*.

⁵⁴ Lorne Sossin, “Access to Administrative Justice and Other Worries,” in Colleen Flood and Lorne Sossin, eds, *Administrative Law in Context*, 2nd ed (Emond Montgomery, 2012) at 222.

The Ontario Human Rights Commission has also recognized that language accommodation is a systemic issue for people with mental health disabilities.⁵⁵ Those without appropriate language accommodation may be labeled “non-compliant” and face differential treatment in hospital settings.⁵⁶ This is evident in CCB cases such as *S.A. (Re)*⁵⁷ and *S.M.T. v. Abouelnasr*,⁵⁸ where the CCB itself recognizes how language and communication barriers may result in misdiagnosis and unnecessary involuntary detention. For instance, in *S.M.T. v. Abouelnasr*,⁵⁹ the CCB found:

The panel was worried by the spectre of a patient unable to communicate in the English language, who remained in the custody of a psychiatric facility solely as a result of language barriers. The panel was on guard against the possibility that Mr. T. had improved over the years, but that his advances had gone unnoticed because of his inability to speak English, and the lack of a suitable interpreter to communicate on his behalf with staff.⁶⁰

Cases such as these indicate that ethno-racial people with mental health disabilities may face language and communication barriers throughout the CCB’s pre-hearing, hearing and post-hearing processes. In regard to the hearing process, Sossin argues that the following issues and questions should be addressed to improve linguistic access before administrative tribunals. These include: “Whether tribunals or legal aid or the government or some other service providers should be responsible for interpreter and translation services, and into which languages for which tribunals? Should a government

⁵⁵ Ontario Human Rights Commission, “Minds that Matter: Report on the Consultation on Human Rights, Mental Health and Addictions,” (Toronto: Ontario Human Rights Commission, 2012) at 33.

⁵⁶ *Ibid* at 33.

⁵⁷ *S.A. (Re)*, 2007 CanLII 37457 (ON CCB), TO-07-1551.

⁵⁸ *S.M.T. v. Abouelnasr*, 171 CRR (2d) 344, 166 ACWS (3d) 569 (Ont. SCJ).

⁵⁹ *Ibid*.

⁶⁰ *Ibid*.

sponsored or administered roster of approved interpreters and translators be established?”⁶¹

Given this analysis, the CAT was modified to include these questions:

36) Have forms involving liberty issues such as the Application by Physician for Psychiatric Assessment, the Order for Examination under Section 16, the Certificate of Involuntary Admission and the Certificate of Renewal been translated for a client who is non-English speaking?

37) Has the Ministry of Health translated these forms appropriately?

38) Does the Ministry of Attorney General have a roster of interpreters that is current and accessible to practitioners?

39) If the client is deaf, is an interpreter/translator available throughout the CCB’s pre-hearing, hearing and post-hearing processes?

40) Are the client and his or her family using the interpretation services available through the psychiatric hospital?

41) Are the interpreters accessible and effective?

42) Are interpreters available to meet the everyday needs of clients, the needs of clients in the emergency department and clients who speak rare languages?

43) Are lists made of the languages that the treatment staff speak in order to accommodate the everyday language needs of the client?

44) Are treatment teams working collaboratively with ethicists and lawyers to overcome language and communication barriers?

45) Are interpreter services available and accessible in the community for ethno-racial people with mental health disabilities?

46) Do service providers working in the community have on-site interpreters and case workers from diverse backgrounds available to support ethno-racial people with mental health disabilities?

⁶¹ Lorne Sossin, “Access to Administrative Justice and Other Worries,” in Colleen Flood and Lorne Sossin, eds, *Administrative Law in Context*, 2nd ed (Emond Montgomery, 2012) at 223.

In a discussion of the use of interpreters during the pre-hearing psychiatric capacity assessments, one of the focus group participants amongst the health care professionals had the following insight, “sometimes, it seems like it is the interpreter who decides whether the patient makes sense.”⁶² As such, Westermeyer argues:

Unlike the dyadic clinician-patient model and its single relationship, the triangle clinician-interpreter-patient model involves three relationships. Thus, it is 200 percent more complex and involves the patient’s transference to both clinician and interpreter, countertransference among both of the latter toward the patient, and the co-worker relationship between clinician and interpreter.⁶³

The relationship between language and meaning is complex, multi-faceted and contested.⁶⁴ For practitioners in the civil mental health system who work with interpreters, there are opportunities for learning about the “different views of psychological well-being, forms of client presentation, idioms of distress, explanatory health benefits and world views.”⁶⁵ Accordingly, it is recognized that practitioners who have the expertise and skill-set to effectively work with interpreters will deliver better service and equitable outcomes for ethno-racial people with mental health disabilities.⁶⁶

⁶² Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

⁶³ Joseph Westermeyer, “Working with an interpreter in psychiatric assessment and treatment,” (1990) 178 (12) *Journal of Nervous and Mental Disease* 745 at 747.

⁶⁴ Harlene Anderson and Harold Goolishian, “Client as an Expert” in Sheila McNamee and Kenneth Gergen, *Therapy as a Social Construction* (London: Sage, 1992) at 10.

⁶⁵ The British Psychological Society, *Working With Interpreters in Health Settings: Guidelines for Psychologists* (Leicester: The British Psychological Society, 2008) at 2.

⁶⁶ Centre for Addiction and Mental Health, “Resources for Health Care Interpreters,” online: CAMH http://knowledgex.camh.net/health_equity/interpreters/Pages/default.aspx; Toronto Central Local Health Integration Network and Hospital for Sick Children, *Improving Health Equity Through Language Access: A Model for Integrated Language Services throughout the Toronto Central LHIN*, (Toronto: LHIN, 2010).

Given the lack of mental health training available for interpreters in Ontario,⁶⁷ practitioners should consider mechanisms and approaches to support interpreters throughout the CCB's pre-hearing, hearing and post-hearing processes. For instance, Lipton argues that interpreters have a challenging role to play as they are often obliged to convey troubling information to clients regarding involuntary detention and forced psychiatric treatment.⁶⁸ It is important for practitioners to be aware of these challenges and to initiate a dialogue with interpreters on topics including self-care and creating boundaries vis a vis clients.⁶⁹

Thus, the following questions regarding the relationship between interpreters and practitioners and the role of the interpreter were included in the CAT:

- 47) Have practitioners received training to work with interpreters?
- 48) Have practitioners offered support to interpreters?
- 49) Has the practitioner given the interpreter written guidelines to adhere to?
- 50) Has a contract between the practitioner and the interpreter been signed?
- 51) Is the interpreter aware of his or her professional boundaries?
- 52) Has the interpreter received in-depth mental health training?
- 53) Does the interpreter speak the same dialect of the language as the client?

⁶⁷ Centre for Addiction and Mental Health, "Mental Health Interpreter Training Course," online: CAMH http://knowledgex.camh.net/health_equity/Pages/MentalHealthInterpreterTrainingCourse.aspx.

⁶⁸ G. Lipton, M. Arends, K. Bastian, B. Wright and P. O'Hara, "The Psychosocial Consequences Experienced by Interpreters in Relation to Working with Torture and Trauma Clients: A Western Pilot Study" (2002) *Synergy* 3 at 5.

⁶⁹ *Ibid.*

54) Is the interpreter fluent in the two languages being used and does he or she have an understanding of the two different cultural contexts at issue?

55) Is it necessary to match the interpreter's gender, age and religion with that of the client?

ii) Quality of Interpretation

In regard to the quality of interpretation, all of the respondents felt that the quality of interpretation could be improved throughout the CCB's pre-hearing, hearing and post-hearing processes. Accordingly, an analysis of the results under this particular theme indicated the following questions for the CAT:

- 1) Has the interpreter received mental health training?
- 2) Does the interpreter have experience and expertise working with ethno-racial people with mental health disabilities?
- 3) Are there standards to ensure the interpreters are well-trained and qualified to work within the mental health and cultural context within which they are practising?
- 4) Are there provincial or national standards for qualifying interpreters to work in the mental health context?
- 5) Have the psychiatric hospital's policies regarding interpretation and translation been followed? In particular, has a linguistic competence strategy been implemented?
- 6) Is the client's standard of care being diminished because of language or communication barriers?
- 7) Do clients who need access to interpretation services for their everyday needs have access to an interpreter at least twice a week?

In Ontario, there is a lack of mental health training available for interpreters working at the psychiatric hospitals.⁷⁰ CAMH recognizes that there is "very little formal training in mental health interpretation available in Toronto, or in Canada."⁷¹ Interpreters

⁷⁰ *Supra* note 67.

⁷¹ *Ibid.*

often do not have the expertise and experience grappling with the cultural nuances involved with providing interpretation services to ethno-racial people with mental health disabilities.⁷² This is further complicated by the fact that there are significant barriers for ethno-racial people to have access to interpreters to meet their everyday needs.

At the hearing stage, the CCB primarily hires accredited interpreters from the Ministry of Attorney General's roster.⁷³ The guidelines for becoming an accredited interpreter include:

- Pass a bilingual or English Court Interpreting Test,
- Attend a training seminar and pass a written test in courtroom procedures and interpreter ethics,
- Complete a background check with the Canadian Police Information Centre, and
- Sign a fee for service contract setting out the roles and responsibilities of the Ministry and the interpreter.⁷⁴

Within these guidelines, there is no mention of cultural competency and mental health training. Respondents in the focus group also confirmed that there were many problems with the quality of interpretation services provided during CCB hearings.⁷⁵ Thus,

⁷² Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

⁷³ *Ibid.*

⁷⁴ Ontario Ministry of Attorney General, "Court Interpretation Services in Ontario," online: Ontario Ministry of Attorney General <http://www.attorneygeneral.jus.gov.on.ca/english/courts/interpreters/faqs.asp>.

⁷⁵ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

recommendations were put forth to have national and provincial standards for qualifying interpreters to work in the CCB context.⁷⁶

Research indicates that there are a number of initiatives which have been taken to improve the quality of interpretation and translating services being provided in Ontario.⁷⁷ For instance, the Ministry of Attorney General is working with the Vancouver Community College (VCC) to examine and assess the interpreter tests.⁷⁸ Re-testing occurred for accredited interpreters in 2009-2010. Also, the Association of Translators and Interpreters of Ontario has created quality assurance standards for community interpreters who work in public services including the hospital, legal and government. These quality assurance standards address issues such as confidentiality, professionalism, respect, competence, accuracy and fidelity for community interpreters.⁷⁹

In the health care setting, interpreters must successfully complete the Cultural Interpreters Language and Interpreting Skills Assessment Test (CILISAT) or Interpreter Language and Skills Assessment Test (ILISAT).⁸⁰ Training is also available in medical terminology and the role of interpreters working in health care settings.⁸¹ Scholars have also recognized the importance of understanding how mediated communication occurs

⁷⁶ Annalisa Edo, Lynn Fournier-Ruggles, Charine Mattis, Kaitlyn Matulewicz and Farlon Rogers, "White Paper on Quality Court Interpretation Services," (Toronto: York University, 2010) at 10.

⁷⁷ *Ibid* at 23; Healthcare Interpretation Network, *National Standard Guide for Community Interpretation Services* (Toronto: Healthcare Interpretation Network, 2007).

⁷⁸ *Supra* note 76 at 10.

⁷⁹ Healthcare Interpretation Network, *supra* note 77 at 2 and 12.

⁸⁰ *Ibid* at 16.

⁸¹ *Ibid*; Toronto Central Local Health Integration Network and Hospital for Sick Children, *Improving Health Equity Through Language Access: A Model for Integrated Language Services throughout the Toronto Central LHIN* (Toronto: LHIN, 2010).

within mental health settings.⁸² As Holder suggests:

In addition to the factors influencing language and culture, it must be remembered that conversation conducted using interpreters is mediated communication, mediated through an interpreter or through a second language, a process that can bring inadvertent changes. Given that interpreters must process the material with which they are dealing through their own subjective experiences, the very act of interpreting shapes the material in some way.⁸³

In light of this analysis, the CAT was refined as follows:

- 8) Is the interpreter aware of the cultural differences and similarities amongst clients?
- 9) Does the interpreter understand the appropriate cultural etiquette required by the client?
- 10) Is the interpreter respectful of the client?
- 11) Are the interpreters professionally accountable?
- 12) Does the interpreter follow the rules of confidentiality?
- 13) Is the interpreter conducting himself or herself in a professional and ethical manner?
- 14) Does the interpreter appear to be advocating on behalf of the client? If so, is this appropriate?
- 15) Is the interpreter impartial?

iii) Cultural Interpreters/Consultants

Generally, lawyers and ethno-racial people with mental health disabilities were in agreement that cultural interpreters/consultants should be available and accessible for

⁸² R. Holder, *The Impact of Mediated Communication on Psychological Therapy with Refugees and Asylum Seekers: Practitioners' Experiences* (MSc thesis, City University, 2002) [unpublished].

⁸³ The British Psychological Society, *Working With Interpreters in Health Settings: Guidelines for Psychologists* (Leicester: The British Psychological Society, 2008) at 10; R. Holder, *supra* note 82.

practitioners and clients to use.⁸⁴ However, health care professionals and adjudicators were divided in their views regarding the appropriateness of developing cultural interpretations/consultant services in Ontario given the risks of creating “experts of the culture.”⁸⁵ Further, the health care professionals argue that there are currently “no cultural interpreters” available since formal training of this nature is not offered.⁸⁶

In an analysis of these results, the following questions arise:

- 1) Does the interpreter have an understanding of the client’s cultural background and cultural context?
- 2) Can the question be rephrased differently since it may have a different interpretation in another culture or language?
- 3) In the client’s culture, is there a different interpretation for the word or phrase?
- 4) Should the client have a cultural interpreter/ consultant?
- 5) Should there be a cultural interpreter/consultant available along with a language interpreter?
- 6) Should practitioners have access to a cultural interpreter/consultant?
- 7) Does the Human Rights or Ombudsmen Office provide for a cultural consultant/interpreter?
- 8) Can the cultural interpreter/consultant help the client create networks in the hospital and community?

Cultural interpreters/ consultants will “ideally be familiar with both the patient’s cultural norms and basic psychiatric assessment skills. They are distinguished from an

⁸⁴ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

⁸⁵ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011

⁸⁶ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

interpreter, as they are familiar with systems' issues, and can often serve as a liaison between the staff and the patient."⁸⁷ Throughout the pre-hearing, hearing and post-hearing processes, cultural interpreters/ consultants can ensure that "cultural and contextual variables"⁸⁸ are considered. This is often crucial during the psychiatrists' capacity assessments.⁸⁹

Other models of interpretation include "the linguistic mode" (interpretation of the words), "the psychotherapeutic or constructionist mode" (interpretation of the meaning/ feelings of words) and "the advocacy or community mode" (interpretation that has an advocacy component).⁹⁰ The focus group data suggested that practitioners and interpreters should decide which model to use in the pre-hearing process.⁹¹ Given the inherent risks with using a cultural interpretation/consultation model, Westerman identifies the following factors that should be addressed for an effective consultation:

- i) practitioners must ask the question 'is there a cultural reason why you can't be involved?'
- ii) practitioners were culturally knowledgeable and competent;
- iii) the client nominated the cultural consultant; and
- iv) the community validated this choice or 'vouched' for the person as appropriate.⁹²

In the focus group with health care professionals, participants highlighted the practical

⁸⁷ Juan E. Mezzich and Giovanni Caracci (eds), *Cultural Formulation: A Reader for Psychiatric Diagnosis* (Maryland: Rowman and Littlefield Publishing Group, 2008) at 140.

⁸⁸ The British Psychological Society, *Working With Interpreters in Health Settings: Guidelines for Psychologists* (Leicester: The British Psychological Society, 2008) at 13.

⁸⁹ Lawrence J. Kirmayer, Danielle Groleau, Jaswant Guzder, Caminee Blake and Eric Jarvis, "Cultural Consultation: A Model of Mental Health Service for Multicultural Societies" (2003) 48 (3) *Can. J. Psychiatry* 145 at 146.

⁹⁰ *Ibid.*

⁹¹ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

⁹² Tracey Westerman, "Engagement of Indigenous Clients in Mental Health Services: What Role do Cultural Differences Play?" (2004) 3 *Advances in Mental Health* 88 at 89.

challenges of accessing an appropriate cultural interpreter in Toronto and Canada generally.⁹³ Thus, recommendations were made to ensure that models of cultural consultation services be developed in Ontario.⁹⁴ In this respect, the Cultural Consultation Services (CCS) of the Sir Mortimer B. Davis-Jewish General Hospital (JHG), the Montreal Children's Hospital (MCH), and Hôpital Jean-Talon (HJT) use cultural interpreters/consultants to ensure clients from diverse communities receive appropriate assessment, evaluation, treatment, cultural information, and referrals to community resources.⁹⁵ Within these services, cultural interpreters/consultants are trained to grapple with language barriers and cultural complexities of diagnosis and treatment of a client's case and trained to write a cultural formulation report. It is important to note that within these services, cultural interpreters/consultants may include psychiatrists, social workers, psychologists, nurses, social scientists and others with the relevant linguistic and cultural assessment skills.⁹⁶ Each cultural consultation service is specialized in various areas of transcultural psychiatry and the use of cultural interpreters/consultants as follows:

1. The JGH has used a consultation-liaison model and emphasized integrating the perspectives of medical anthropology with conventional psychiatric, cognitive behavioural and family systems perspectives.
2. The MCH has emphasized a pluralistic approach and focused on

⁹³ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

⁹⁴ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

⁹⁵ McGill, Cultural Consultation Service, "Development and Evaluation of the Cultural Consultation Services," online: McGill <http://www.mcgill.ca/culturalconsultation/report/final/development>.

⁹⁶ McGill, Cultural Consultation Service, "Role of the Consultant," online: McGill <http://www.mcgill.ca/culturalconsultation/handbook/consultant>.

providing flexible services for immigrant and refugee children, especially those who have suffered organized violence. It has worked closely with schools and community organizations to integrate community resources and perspectives.

3. The HJT has adapted an ethnopschoanalytic model that uses a multicultural group of clinicians and people accompanying the patient to reframe the problem from multiple points of view, and mobilize the cultural frames of reference of the patient and his or her entourage.⁹⁷

Assessments and studies of these services indicate their success in Canada.⁹⁸ The focus group data further confirmed these findings.⁹⁹ For instance, the qualitative evaluation of the CCS service in Sir Mortimer B. Davis-Jewish General Hospital (JHG) revealed how cultural misunderstandings, misdiagnosis and culturally inappropriate treatment may have resulted if the cultural interpreters/consultants had not intervened.¹⁰⁰ Since the JHG primarily uses psychiatrists, social workers and psychologists as cultural interpreters/consultants, clinicians were able to speak the clients' requisite language.¹⁰¹ It appeared that the "most common reasons for consultation were requests for help with clarifying a diagnosis or the meaning of specific symptoms or behaviors (58%), treatment planning (45%), and request for information or a link to organizations and resources related to a specific ethnocultural group or issue (e.g. refugee status (25%)."¹⁰² These

⁹⁷ *Supra* note 95.

⁹⁸ *Ibid.*

⁹⁹ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹⁰⁰ Lawrence J. Kirmayer, Danielle Groleau, Jaswant Guzder, Caminee Blake and Eric Jarvis, "Cultural Consultation: A Model of Mental Health Service for Multicultural Societies" (2003) 48 (3) *Can. J. Psychiatry* 145 at 151.

¹⁰¹ *Ibid* at 148.

¹⁰² McGill, Cultural Consultation Service, "Development and Evaluation of the Cultural Consultation Services: Final Report," online: McGill Cultural Consultation Service <http://www.mcgill.ca/culturalconsultation/report/final/development> .

findings suggest that cultural interpreters/ consultants will require specialized training and supervision, along with mechanisms for ensuring their competence.¹⁰³

The majority of focus group participants recommended that similar specialized cultural consultation services would have positive outcomes in Ontario. However, some participants were opposed to the use of cultural interpreters/consultants instead of language interpreters. In light of these findings, the following questions were added to the CAT:

- 9) Which model of interpretation is appropriate in the client's circumstances?
- 10) Would the client prefer having a cultural interpreter/consultant?
- 11) Is a cultural interpreter/consultant accessible?
- 12) Can the cultural interpreter/ consultant be someone within the treatment team (i.e. psychiatrist, nurse, social worker, psychologist etc.)?
- 13) If a cultural interpreter/ consultant is being used, is the client supportive of and comfortable with him or her?
- 14) Have the health care professionals been trained to work with cultural interpreter/consultants?
- 15) Are there appropriate resources to improve the linkages between health care professionals and community mental health services?
- 16) Are there appropriate resources available to create a Cultural Consultation Service?
- 17) Are the cultural interpreters/consultants receiving the appropriate training and supervision?
- 18) Have mechanisms been developed to ensure the competency of the cultural interpreters/consultants?
- 19) Has the cultural interpreter/consultant assisted in writing the cultural formulation report in accordance with the DSM-V?

¹⁰³ *Supra* note 100.

6.3 The Pre-Hearing Process

i) Police Action

Respondents indicated the dangers of having police transport ethno-racial people with mental health disabilities to psychiatric facilities.¹⁰⁴ A number of health care professionals were concerned about the use of “excessive force,” to de-escalate an ethno-racial person with mental health disabilities.¹⁰⁵ Accordingly, an analysis of the results under this theme raised the following questions for the CAT:

- 1) Are police officers acting in accordance with ss.16 and 17 of the *Mental Health Act* when interacting with the client and transporting the client to a psychiatric facility?
- 2) Are police officers trying to avoid the use of force when interacting with the client?
- 3) Are police officers sensitive to the language and communication barriers that may be affecting the client?
- 4) Have the police officers received cultural sensitivity training? If so, has the cultural sensitivity training been facilitated in collaboration with service providers working with ethno-racial people with mental health disabilities?
- 5) Do police officers have access to an interpreter if necessary?

The focus group participants raised the systemic issue of discrimination.¹⁰⁶

¹⁰⁴ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

¹⁰⁵ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

¹⁰⁶ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

Amongst them, a young, ethno-racial man suggested feeling “degraded, misunderstood and discriminated against by police officers,”¹⁰⁷ as he was transported to the hospital.

¹⁰⁸The majority of lawyers and service providers in the focus group suggested that such systemic issues should be addressed by ensuring crisis workers and service providers working in the community should always accompany police officers in their interactions with ethno-racial people with mental health disabilities.¹⁰⁹ In this regard, the Ministry of Health has provided funding to various police departments and divisions within Ontario to work in collaboration with community mental health services to address mental health situations.¹¹⁰

However, since this is not mainstreamed, focus group participants advised that such collaborations should be mandatory for all police departments in Ontario.¹¹¹

The Toronto Police Service Skills Development has a sixty-day training program for its new police officers. Included within the training program is fifteen hours of anti-racism training and training about diversity issues.¹¹² Specifically, there are workshops

¹⁰⁷ Data derived from focus groups conducted with ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹⁰⁸ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹⁰⁹ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹¹⁰ Central East LHIN, “Police Team Up with Community Mental Health Services To Answer Mental Health Calls,” online: Central East LHIN http://www.centraleastlhin.on.ca/newsroom_display.aspx?id=6668; accessed 2 June 2013; Mental Health Commission of Canada, *Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing* (Ottawa: Mental Health Commission of Canada, 2010) at 21-26.

¹¹¹ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

on “human rights, harassment, gay and lesbian issues, racial profiling, fair and equitable policing, disability issues, elder abuse and senior issues, demographics and diversity.”¹¹³

In a “Cultural Competency Manual for Law and Mental Health Professionals,” Mount Sinai hospital put forth the following recommendations for police officers interacting with ethno-racial people with mental health disabilities:

1. Observe, Listen and Assess the Situation;
2. Use Body Language to Turn Conflict into Cooperation;
3. Use a Gentle Voice and Speak Slowly;
4. Call for Communicative Back-Up.¹¹⁴

In regard to cultural competency training specifically, the following guidelines have been put forth:

- There are no experts in cultural competence, it is a life-long learning process;
- To be effective, cultural competence must occur at both the intellectual and emotional level;
- Competence training alone does not change organizational cultures; and
- The impact is at both the organizational and individual level.¹¹⁵

Given this research, the following questions are included to refine the CAT:

- 6) Do police officers understand the relevant provisions of the mental health, human rights and privacy legislation?
- 7) Have police officers determined whether the client is able to understand and respond to their directions?
- 8) Do police officers recognize that standard procedures, which may otherwise stabilize a non-mentally disabled person, may have an adverse impact on the client?

¹¹² Toronto Police Service, *Policing a World within a City: The Race Relations Initiatives of the Toronto Police Service* (Toronto: Toronto Police Service, 2003) at 51; Mount Sinai Hospital, *A Cultural Competency Training Manual for Law and Mental Health Professionals* (Toronto: Mental Health Court Support Program and Law Foundation of Ontario, 2009) at 16.

¹¹³ Mount Sinai, *ibid* at 16; Toronto Police Service, *ibid* at 51-53.

¹¹⁴ Mount Sinai, *ibid* at 47-48; Toronto Police Service, *ibid* at 51-53.

¹¹⁵ Mount Sinai, *ibid* at 15-16.

- 9) Have police officers used cultural competency techniques to de-escalate conflict when interacting with the client?

ii) Rights Advice

Respondents were concerned that ethno-racial people with mental health disabilities were often not able to understand the concept of rights and the process of rights advice. Thus, the results suggested that the rights advice should be provided in writing and in plain-language.¹¹⁶ Lawyers argue that the CCB must have a policy in place to ensure that the accommodation requests identified by the rights advisers are addressed. However, when fulfilling their obligations, rights advisers should be weary of taking on an advocacy role for their clients.¹¹⁷ To address these issues, adjudicators, government advisers, academics and service providers suggested that there should be other resources regarding “client rights” within the hospital and community.¹¹⁸ Accordingly, an analysis of the results under this particular theme indicated the following questions for the CAT:

- 1) Has the client received appropriate rights advice in accordance with s. 15, Reg. 741 of the *Mental Health Act*?
- 2) Has the rights advisor alerted the CCB of the client’s accommodation needs? If so, has the CCB taken steps to accommodate these requests for the hearing?
- 3) Is the rights advisor acting as an advocate for the client?

¹¹⁶ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

¹¹⁷ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

¹¹⁸ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisers and service providers from April 2011 to November 2011.

- 4) Does the client understand the concept of “rights”?
- 5) Does the client understand what “rights advice” means?
- 6) Does the client understand the different types of treatment options?
- 7) Does the client know the name of the treatment which he or she is receiving?
- 8) Does the client understand concepts such as “involuntary treatment,” “capacity,” “incapacity,” and “informed consent?”
- 9) Is the rights advisor using plain-language and effective communication methods?
- 10) Does the rights adviser use simple examples when explaining legal concepts?
- 11) Did the rights advice include a discussion about the dangerous side-effects of taking psychiatric medications?
- 12) Is the rights advice also provided in written form (i.e. facts sheets)?
- 13) Is the written rights advice translated in the client’s language and presented in plain-language?
- 14) Has the client received a CAMH Bill of Client Rights in his or her language?
- 15) Does the client have access to resources about human rights and other intersectional issues?

According to s. 15, Reg. 741 of the *Mental Health Act*, the rights adviser must give “rights advice” to a person who is an involuntary psychiatric patient, a person who is found incapable to make decisions about his or her psychiatric treatment or management of her property, a person who is an informal patient between the ages of twelve and fifteen and a person who is notified of an “intent to issue or renew a CTO.”¹¹⁹ Amongst the focus group participants, lawyers identified communication barriers for clients in

¹¹⁹ s 15 Reg. 741 to MHA, RRO 1990, c. M 7.; D’Arcy Hiltz and Anita Szigeti, *supra* note 2 at 318-319.

long-term facilities, who have no statutory entitlement to rights advice.¹²⁰ In this regard, Ontario's Advocacy Centre for the Elderly, "commonly receives complaints from substitute decision makers who are concerned about a mentally incapable person in a long-term care home being given medication they know nothing about."¹²¹ This is often further complicated in cases involving ethno-racial people with mental health disabilities in light of the intersecting barriers they may experience.¹²²

Since the Minister of Health and Long-Term Care only designates rights advisers in recognized psychiatric institutions under the *Mental Health Hospitals Act*,¹²³ lawyers and service providers suggested that all clients must receive rights advice within 72 hours of being admitted into all hospitals or long-term care facilities. An analysis of the case law suggests a failure to provide rights advice as per the statute¹²⁴ and a substantial delay in providing rights advice can invalidate a finding of incapacity or its continuance.¹²⁵ Given the importance of providing rights advice to all clients, it was recommended that all of Ontario's hospitals or long-term care facilities should have designated rights advisers,

¹²⁰ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹²¹ Ontario Human Rights Commission, "Minds that Matter: Report on the Consultation on Human Rights, Mental Health and Addictions," (Toronto: Ontario Human Rights Commission, 2012) at 33.

¹²² Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

¹²³ s. 14, Reg. 741 to MHA, R.R.O. 1990, c. M.7.

¹²⁴ Re: A.P., 040596, March 12, 2004.

¹²⁵ R.H., OT-04-0882, March 23, 2004.

regardless of the statutory requirements.¹²⁶ Thus, the following questions were added to the CAT:

- 16) Is the client in a recognized psychiatric institution as per the *Mental Health Hospitals Act*? If not, has he or she still received rights advice?
- 17) Has the client received rights advice within 72 hours of admission to the hospital or long-term care facility?

iii) Psychiatrists' Capacity Assessments

All of the respondent groups felt that the psychiatrists' capacity assessments did not often appreciate alternative cultural explanations of mental health disability and the impact of cultural background, class, social history, ethnicity and other socio-cultural factors.¹²⁷ In particular, health care professionals indicated the problems with the diagnostic approaches and tools used for ethno-racial people with mental health disabilities.¹²⁸ Recommendations were made to make use of recovery based tools and models for diagnostic assessments and the DSM-V's cultural formulation guidelines.¹²⁹

In an analysis of these results, the following questions arise for the CAT:

¹²⁶ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹²⁷ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

¹²⁸ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

¹²⁹ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

- 1) Does the psychiatrist's capacity assessment recognize the client's cultural background, class, social history, gender, and other intersectional factors?
- 2) Does the psychiatrist's capacity assessment recognize the client's cultural standards of normality vs. abnormality?
- 3) Is the psychiatrist able to address how psychological distress can be expressed differently amongst cultures?
- 4) Are there enough resources and time for the psychiatrist to address the intersectional issues affecting the client during the capacity assessment?
- 5) Is the psychiatrist using the DSM-V's cultural formulation interview guide during the capacity assessment of the client?
- 6) Is the client's behavior being pathologized during the capacity assessment?
- 7) Is there an alternative explanation of describing the client's behavior and symptoms?
- 8) Has the psychiatrist and/or treatment team tried to obtain collateral information about the client from his or her family?
- 9) Has the psychiatrist used recovery based tools and models when diagnosing the client?
- 10) Is the psychiatrist questioning his or her own cultural biases?
- 11) Is the psychiatrist considering culturally appropriate treatment options and care for the client?
- 12) Do health care professionals understand the client's treatment expectations?
- 13) Are health care professionals able to recognize and challenge the institutional racism within mental health system?
- 14) Are health care professionals using the "mental status examination" in their interactions with the client?

Health care professionals in the focus group raised concerns about psychiatric diagnoses which failed to recognize the impact of culture. There was a recognition that the notion of "capacity," psychiatric diagnosis, and understandings of mental health

disability can vary across cultures.¹³⁰ Lawyers, service providers and ethno-racial people with mental health disabilities argued that psychiatrists should question their own biases and cultural context throughout the capacity assessment process.¹³¹ Drawing from the institutional racism paradigm, Mezzich et al. suggest that the “culture of the clinician includes 1) the cultural influences of the dominant society; 2) the cultural identity and background of the practitioner; 3) the institutional culture of the hospital, culture, clinic or other setting where diagnosis and treatment are delivered; and 4) the professional cultures of biomedicine and psychiatry.”¹³² In this vein, given the complexity of culture, respondents indicated that a health care professional should not be deceived by the perception that having a similar cultural background as the client will resolve cultural misunderstandings and bias. Instead, health care professionals should adopt a critical and systemic approach that avoids the use of assumptions. Open-ended questions should be used to understand the client’s way of conceptualizing his or her mental health disability.¹³³

The focus group data and research further emphasize the importance of using the DSM-V’s cultural formulation interview guide to conduct cultural formulations during the psychiatric capacity assessments. The cultural formulation is often part of the

¹³⁰ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹³¹ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹³² Juan E. Mezzich, Giovanni Caracci, Horacio Fabrega, Jr. and Lawrence J. Kirmayer, “Cultural Formulation Guidelines” (2009) 46 (3) *Transcultural Psychiatry* 383 at 384.

¹³³ *Ibid* at 395.

entire diagnostic assessment,¹³⁴ and it “aims to complement the multiaxial diagnosis of a person’s health problems with a review of his or her cultural identity, experience of illness and self-seeking behavior, social functioning and social supports based on cultural constructs and standards, and the potential cultural conflicts of the clinician-patient relationship.”¹³⁵ Lawrence et al. argue that cultural consultations can improve the therapeutic and clinical alliance between the psychiatrist and client.¹³⁶ By examining the cultural complexities involved in a client’s case, the psychiatrist is able to demonstrate his or her empathy and understanding of the client’s cultural framework.¹³⁷

However, a respondent amongst the health care professionals argued that culture should not impact the diagnosis of the patient. In response, Perlin and McClain engage in this debate by arguing that the clinician should interpret results from the multiaxial diagnosis in a “culturally meaningful way” in accordance with the *United Nations Convention on the Rights of Persons with Disabilities*.¹³⁸ Although culture may not directly impact the diagnosis, cultural factors may be relevant when examining

¹³⁴ *Ibid* at 386.

¹³⁵ *Ibid* at 391.

¹³⁶ Lawrence J. Kirmayer, Danielle Groleau, Jaswant Guzder, Caminee Blake and Eric Jarvis, “Cultural Consultation: A Model of Mental Health Service for Multicultural Societies” (2003) 48 (3) *Can. J. Psychiatry* 145 at 146. See also Juan E. Mezzich and Giovanni Caracci (eds), *Cultural Formulation: A Reader for Psychiatric Diagnosis* (Maryland: Rowman and Littlefield Publishing Group, 2008) at 140; Juan E. Mezzich, Giovanni Caracci, Horacio Fabrega, Jr. and Lawrence J. Kirmayer, “Cultural Formulation Guidelines” (2009) 46 (3) *Transcultural Psychiatry* 383 at 392.

¹³⁷ *Ibid*.

¹³⁸ Michael L. Perlin and Valerie McClain, *supra* note 12 at 264-265.

“stressors” in the client’s social context and facilitating access to social services and supports.¹³⁹

6.4 The CCB Hearing

Respondents identified the multiple barriers faced by ethno-racial people with mental health disabilities within the CCB hearing. The following themes that were analyzed to develop the CAT include: process, prevalence of the medical model, adversarial environment, family involvement, jurisdiction and discretion, grappling with culture, access to culturally appropriate treatment and care and religious accommodation. Ethno-racial people with mental health disabilities recommended that their individual experiences must be taken into account throughout the CCB hearing process, while health care professionals suggested that the process of accessing and obtaining legal representation before the CCB must be improved for ethno-racial people with mental health disabilities.¹⁴⁰ There were unresolved tensions amongst all respondents as to how CCB adjudicators should appropriately use their discretion to grapple with the intersectional and systemic issues at play within cases.¹⁴¹ Recommendations were made to ensure that adjudicators use an inductive/deductive, intersectional and non-judgmental

¹³⁹ *Ibid.*

¹⁴⁰ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

¹⁴¹ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

approach.¹⁴² The issue of jurisdiction and discretion was contentious amongst lawyers.

Although some lawyers argued that the spirit of the *Mazzei* decision should be implemented in the civil mental health context, others suggested that the CCB should not be given power involving treatment.¹⁴³ Through an analysis of these results, the questions for the CAT are presented under the major themes of “process” and “jurisdiction/ discretion” as follows:

i) Process and Power

- 1) Is the CCB hearing process accessible for clients?
- 2) Is the CCB hearing process efficient for all of the participants?
- 3) Has the client been appropriately accommodated in the hearing process?
- 4) Are equity concerns being addressed in the CCB hearing process?
- 5) Do clients understand what is happening throughout the CCB hearing?
- 6) Does the client have access to an effective and experienced lawyer? If not, how is the CCB assisting the client throughout the hearing process?
- 7) Are the arguments made on the client’s behalf regarding culture, religion and other social factors acknowledged by the CCB adjudicators?
- 8) Is the client’s perspective being recognized?
- 9) Is the client’s voice heard and understood in the CCB hearing?
- 10) Are there free educational workshops about the CCB hearing process available for the client?
- 11) Are adjudicators drawing from paradigms such as cultural competency, anti-racism, human rights and ethics in their adjudication of the case?

¹⁴² Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

¹⁴³ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

- 12) Are the adjudicators sensitive, active listeners and aware of the cultural issues involved?
- 13) Are there ethno-racial people with mental health disabilities appointed to positions of power within the CCB, the hospital and community agencies?
- 14) Are the adjudicators qualified and competent?
- 15) Do the adjudicators come from diverse backgrounds?
- 16) Are adjudicators culturally sensitive and critical?
- 17) Are adjudicators genuinely interested in taking equity concerns seriously?
- 18) Are adjudicators committed to providing due process and procedural protections for the client?
- 19) Are adjudicators being compensated appropriately?
- 20) Do adjudicators have an understanding of the type of intersecting discrimination and the legal barriers experienced by the client?

Prevalence of the Medical Model

- 1) Is the hearing process institutionally biased in favour of medical expertise?
- 2) Have adjudicators considered the non-mental health illness related explanations for the client's circumstances and actions?
- 3) Have adjudicators ensured that the client has access to culturally appropriate treatment options and care?
- 4) Are adjudicators able to appropriately question the physician's authority?
- 5) Do the adjudicators have the requisite analytical skills necessary to address cultural and other intersectional issues?
- 6) Are the adjudicators positive and willing to probe into relevant cultural and other intersectional issues?

Adversarial Environment

- 1) Is the CCB hearing adversarial? If so, has mediation been considered for those who would prefer a less adversarial CCB hearing?
- 2) Has the well-being of the client been compromised as a result of the CCB hearing?
- 3) Does the CCB use a client-centred approach in the hearing?
- 4) Are legal technicalities avoided in the CCB hearing?
- 5) Do the health care professionals feel targeted in the CCB hearing?
- 6) Will the therapeutic relationship between the client and physician be compromised as a result of the CCB hearing?
- 7) Is there civility and respect amongst the lawyers involved in the CCB hearing?
- 8) Is there an open dialogue amongst all participants in the CCB hearing?

Family Involvement

- 1) Are the client's family members involved in the CCB hearing?
- 2) Are the client's family members receiving deference in the CCB hearing?
- 3) Do health care professionals have an open dialogue and clear communication with the client's substitute decision maker?
- 4) If the client's family is involved in the CCB case, are there issues around confidentiality and the boundaries of disclosure? How is this dealt with?
- 5) To what extent has the client's family been informed about the client's treatment and care decisions?
- 6) What are the client's family members' perspectives? Is this at odds with the client's perspective?
- 7) If family members are involved in the CCB hearing, have adjudicators attempted to gather as much collateral information as possible from them?
- 8) Is the client able to communicate with his or her family over the phone?

9) If necessary, are practitioners helping facilitate communication between the client and his or her family?

10) Are practitioners aware of the family dynamics involved in the client's case?

A theme that arose in the focus groups in regard to the CCB's hearing process was procedural fairness and the duty to inquire. Lawyers in the focus group debated the following question: Does the CCB have a duty to proactively inquire into cultural and intersectional issues for its hearing processes to be considered procedurally fair? A number of lawyers suggest that the CCB does have a duty to make inquiries into these issues because it is a board of inquiry and it has a duty to accommodate ethno-racial people with mental health disabilities.¹⁴⁴ In this respect, ARCH Disability Law Centre states:

Even when the tribunal process is designed to be accessible, some persons may require accommodation in order to participate fully. Persons with disabilities experience “disability” in different ways. Appropriate accommodation, therefore, depends on the party's particular disability-related needs.¹⁴⁵

In administrative law, the duty to accommodate people with disabilities in tribunal hearings arises from “(i) the duty of procedural fairness, (ii) *Charter* principles/values, (iii) quasi-constitutional anti-discrimination protections, and (iv) other statutory protections.” As such, the content of the principle of procedural fairness will vary

¹⁴⁴ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹⁴⁵ ARCH Disability Law Centre, “Addressing the Capacity of Parties Before Ontario's Administrative Tribunals: A Practical Guide for Ontario Lawyers and Paralegals,” (Toronto: Law Foundation of Ontario, 2009) at 8.

according to the particular circumstances of the case and the nature of the right involved.¹⁴⁶ According to the CCB's inquisitorial nature, the duty of procedural fairness and the duty to accommodate, I argue that the CCB does have a duty to inquire into these intersectional issues. However, the results, focus group data and research confirmed that this duty to inquire has not been adhered to within the CCB's adjudicative processes. Specifically, the CCB does not appropriately examine the contextual, cultural and intersectional factors impacting a client's case. The problem with the "color blind approach" is further exemplified in cases where discrimination, arising from racial discrimination or otherwise, was the precursor to the deterioration of mental health for ethno-racial people with mental health disabilities. This is evident in cases such as *S.K. (Re)*,¹⁴⁷ *J.T. (Re)*,¹⁴⁸ *L*; *File TO-06-1167 (Re)*,¹⁴⁹ *B.*; *File TO-05-6467 (Re)*,¹⁵⁰ *S.M.T. (Re)*,¹⁵¹ and a number of others which were observed during the qualitative data collection process (for which reasons were not given by the CCB).

The CCB's hearing is not meant to be adversarial and/or countertherapeutic.¹⁵²

However, as Anita Szigeti and D'Arcy Hiltz suggest:

In practice, however, the process is somewhat adversarial, or can be, due to the adjudicative nature of the Board even while it inquires into matters before it. It is a party-driven process and the parties choose the way in which they present evidence, or whether they choose to present evidence or testimony of witnesses of the Board.¹⁵³

¹⁴⁶ *Burroughs (Guardian ad litem of) v. CUPE*, [1999] 184 Nfld & PEIR 191.

¹⁴⁷ *S.K. (Re)*, 2010 CanLII 11151 (ON CCB), TO-07-1551.

¹⁴⁸ *J.T. (Re)*, 2011 CanLII 86362 (ON CCB), LO-11-3548.

¹⁴⁹ [2006] OCCBD No. 148 at para 10.

¹⁵⁰ [2005] OCCBD No.211 at para. 17.

¹⁵¹ [2007] CanLII 50499 (ON CCB).

¹⁵² D'Arcy Hiltz and Anita Szigeti, *A Guide to Consent and Capacity Law in Ontario* (Markham: Lexis Nexis Canada Inc., 2013) at 588-589.

¹⁵³ *Supra* note 2 at 588-589.

In order to address this issue, lawyers and service providers in the focus group suggested that the physician should not be the opposing party. Instead, there should be a state appointed counsel to carry out the case instead of the physician.¹⁵⁴ A respondent explains this recommendation as follows:

It seems to me a huge waste of resources, to actually be the party rather than appearing as a witness (neutrally setting it out), telling the board, having some person whose job it is, some paralegal or lawyer – to actually prosecute or carry the state’s burden for the deprivation of liberty. The physician should not and cannot be the opposing party because it is contrary to their therapeutic relationship with the client.¹⁵⁵

Using this model, the state appointed person should be an agent of the state, thereby reducing the amount of physician resources, the adversarial nature of the hearing and the presumed conflicts of interests inherent in the adjudicative process. A few respondents further emphasized that the process should not result in mediation since “capacity cannot be negotiated and it is hard to mediate capacity.”¹⁵⁶

ii) Jurisdiction/Discretion

As previously described, the results illustrated the unresolved tensions amongst respondents in regard to the theme within “jurisdiction/discretion.”¹⁵⁷ An analysis of the results indicated the following questions for the CAT:

¹⁵⁴ Data derived from focus groups conducted with lawyers and service providers from November 2011 to February 2012.

¹⁵⁵ Data derived from focus groups conducted with lawyers and service providers from November 2011 to February 2012.

¹⁵⁶ Data derived from focus groups conducted with lawyers and service providers from November 2011 to February 2012.

¹⁵⁷ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

- 1) Have CCB adjudicators used their discretion to take culture, race, gender, class and other social factors into account when considering s. 41 (2) of the MHA, s. 1 of the MHA and s. 39.1 of the MHA?
- 2) Has the time frame for considering applications to review the client's community treatment order (s. 39.1 of the MHA) been extended from the seven-day period?
- 3) Have CCB adjudicators encouraged and directed health care professionals and service providers to provide culturally appropriate treatment programs for the client?
- 4) Can the CCB's jurisdiction be increased to consider relevant cultural information and cultural evidence?
- 5) Can the CCB's jurisdiction be increased to consider culturally appropriate treatment and care?
- 6) Are CCB adjudicators adopting an intersectional approach in their adjudication of the client's case?
- 7) Do CCB adjudicators understand how to apply an intersectional approach? Have they received appropriate training to do this?

Grappling with Culture

- 1) Have the adjudicators asked questions pertaining to the client's culture, race, ethnicity, class, religion, gender, disability, and other social factors? Have these factors played a role in the legal outcome?
- 2) Have the client's cultural context and history been probed into and understood by the adjudicators?
- 3) Has the client's lawyer been given the opportunity to present all of the cultural evidence relevant to the case?
- 4) Have the cultural evidence and cultural information been addressed and analyzed in the legal reasons of the decision?
- 5) Is there recognition of the client's identity and his or her strengths and weaknesses?
- 6) Have the health care professionals helped facilitate a discussion and analysis of the cultural and intersectional issues involved during the CCB hearing?

- 7) In the health care professional's submissions to the CCB, is there a detailed summary of the client's cultural background, history, context, and cultural aspects of the case?
- 8) Have the client's cultural and/or religious requests been addressed or accommodated in the CCB hearing?
- 9) Has the client's lawyer posed questions to the physician regarding his or her assumptions and potential cultural biases?
- 10) Have adjudicators ensured that clients from ethno-racial communities have the same quality of experience before the CCB as others?
- 11) Have adjudicators recognized and addressed the CCB's institutional bias?
- 12) Have adjudicators used their discretion to grapple with the intersectional and systemic issues at play within cases?
- 13) Are adjudicators engaging with cultural evidence by asking relevant questions and active listening?
- 14) Are adjudicators impartial?
- 15) Are the adjudicators seeking out cultural evidence and cultural information?
- 16) Have the adjudicators created a dialogue amongst themselves and other practitioners regarding cultural and other intersectional issues?

Access to Culturally Appropriate Treatment and Care

- 1) Is culturally appropriate treatment and care available and accessible for the client?
- 2) Is there evidence to indicate that the alternative treatment will be effective?
- 3) Is it ethical for the psychiatrist to prescribe and recommend the alternative treatment?
- 4) Are practitioners helping to advocate for culturally appropriate treatment and care for the client?
- 5) Would the client be treatment compliant if he or she had more options for culturally appropriate treatment and care within the civil mental health system?
- 6) Does the client have access to counseling and psychotherapy?
- 7) Are practitioners aware of the ethno-specific service providers and organizations that provide culturally specific treatment and care?

- 8) Are practitioners collaborating with ethno-specific mental health organizations to provide culturally appropriate treatment and care?
- 9) Are in-patient and out-patient mental health services being delivered in a culturally appropriate manner?
- 10) Do members of in-patient and out-patient treatment teams have varied language capacities?
- 11) Are members of in-patient and out-patient treatment teams from diverse backgrounds?
- 12) Is the client open to working with well-trained case-workers and social workers who are outside of their culture?
- 13) Is there enough funding available for ethno-specific mental health organizations such as Across Boundaries and Hong Fook Mental Health Association?
- 14) Are there initiatives to ensure that the client can participate in cultural activities and social gatherings within their communities?
- 15) Are practitioners able to challenge the stigma surrounding mental health disability within various cultures?
- 16) Is recreational programming and peer support available for the client within the hospital?
- 17) Are there objective measures to ensure consistency and transparency when matching the client to culturally appropriate mental health services?
- 18) Is a culturally appropriate housing arrangement needed for the client? If so, has a referral been made?
- 19) Is the CCB's treatment decision culturally appropriate?
- 20) Did the adjudicators probe into whether or not the client's treatment is culturally appropriate within the hearing or within the obiter of their written decision?
- 21) Does the client have a positive relationship with his or her case-worker?
- 22) Do practitioners have required standards of practice for providing culturally appropriate treatment and care? If so, are these standards being adhered to?
- 23) If the client is on a CTO, does the client have access to culturally appropriate treatment and care?

Religious Accommodation

- 1) Does the client need religious accommodation?
- 2) Are the client's religious accommodation requests being met?
- 3) Does the client have access to spirituality services?
- 4) Can the client practice his or her religion freely within the hospital and the community?
- 5) Have the client's religious accommodation requests been brought forth to the CCB, the Ontario Human Rights Tribunal or the Psychiatric Patient Advocate Office?
- 6) Did the CCB address the client's right to have religious accommodation?
- 7) Can the hospital provide the appropriate space and privacy to support the client's religious accommodation requests?
- 8) Have the client's religious observance and beliefs been pathologized?
- 9) To what extent should the client be accommodated in regard to religion?
- 10) Do practitioners know if a certain practice or belief is based on a religion?

Respondents had conflicting views about the aforementioned themes.¹⁵⁸ Ethno-racial people with mental health disabilities indicated that CCB hearing processes did not give them an opportunity to protect their rights.¹⁵⁹ These rights include “negative rights” such as the freedom from involuntary detention and forced psychiatric medication and “positive rights” such as access to culturally appropriate treatment and quality care.¹⁶⁰ The majority of lawyers felt that although the CCB hearing process has the potential to

¹⁵⁸ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹⁵⁹ Data derived from focus groups conducted with ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹⁶⁰ Data derived from focus groups conducted with ethno-racial people with mental health disabilities from November 2011 to February 2012.

create a dialogue, this ideal is often not realized.¹⁶¹ A few health care professionals felt that the CCB hearing process was an affront to their clinical judgment.¹⁶² A health care professional posed the following question: How can the CCB hearing process raise the standards of treatment and care for ethno-racial people with mental health disabilities?¹⁶³

When grappling with this question, the majority of focus group participants recommended that the CCB should not restrict its jurisdiction unnecessarily and it should use its discretion to address the intersectional issues and barriers faced by ethno-racial people with mental health disabilities.¹⁶⁴ For instance, lawyers and service providers confirmed that s. 41 (2) of the *Mental Health Act*, which gives the CCB discretion to rescind an involuntary admission certificate, could be exercised with consideration of the cultural factors impacting an ethno-racial client's case.¹⁶⁵ Lawyers and service providers further suggested that the CCB should act in accordance with *Charter* values when exercising its discretion and statutory powers.¹⁶⁶ The relevant sections of the *Charter* that apply to the CCB include sections 15, 7, 9, 10 and 12.¹⁶⁷

¹⁶¹ Data derived from focus groups conducted with lawyers and service providers from November 2011 to February 2012.

¹⁶² Data derived from focus groups conducted with health care professionals from November 2011 to February 2012.

¹⁶³ Data derived from focus groups conducted with health care professionals from November 2011 to February 2012.

¹⁶⁴ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹⁶⁵ Data derived from focus groups conducted with lawyers and service providers from November 2011 to February 2012.

¹⁶⁶ Data derived from focus groups conducted with lawyers and service providers from November 2011 to February 2012.

¹⁶⁷ Joaquin Zuckerbeg, "Jurisdiction of Mental Health Tribunals to Provide Positive Remedies: Application, Challenges and Prospects," (2011) 57 (2) McGill LJ 267 at 270.

Administrative tribunals have an obligation to “act consistently with the *Charter* and its values when exercising their statutory functions.”¹⁶⁸ In *R v. Conway*,¹⁶⁹ the Supreme Court identified a tri-partite test, which clarified the role between administrative tribunals, the scope of the *Charter* and *Charter* remedies.¹⁷⁰ Before this decision, the *Charter* jurisdiction of administrative tribunals was specific to the remedy being sought by the litigant.¹⁷¹

The Supreme Court’s test is as follows:

Building on the jurisprudence, therefore, when a remedy is sought from an administrative tribunal under s. 24(1), the proper initial inquiry is whether the tribunal can grant *Charter* remedies generally. To make this determination, the first question is whether the administrative tribunal has jurisdiction, explicit or implied, to decide questions of law. If it does, and unless it is clearly demonstrated that the legislature intended to exclude the *Charter* from the tribunal’s jurisdiction, the tribunal is a court of competent jurisdiction and can consider and apply the *Charter* — and *Charter* remedies — when resolving the matters properly before it.¹⁷²

In an application of the first branch of the *Conway* test to the CCB, it is clear that the CCB does have the jurisdiction to consider general questions of law.¹⁷³ However, when considering the second branch of the test, there is uncertainty in light of the *Health Care Consent Act* 1996 (HCCA)¹⁷⁴ provision, which states, “The Board shall not inquire into or make a decision concerning the constitutional validity of a provision of an Act or

¹⁶⁸ *R v Conway*, 2010 SCC 22, [2010] 1 S.C.R. 765 at para. 78 [*Conway*].

¹⁶⁹ *Ibid.*

¹⁷⁰ Evan Fox-Decent and Alexander Pless, “The *Charter* and Administrative Law: Cross-Fertilization or Inconstancy,” in Colleen Flood and Lorne Sossin, eds, *Administrative Law in Context*, 2nd ed (Emond Montgomery, 2012) at 442-444; Ruby Dhand, Anita Szigeti and D’Arcy Hiltz, *Halsbury’s Laws of Canada: Mental Health Law* (Lexis Nexis: Toronto, 2011) at 103.

¹⁷¹ *Conway*, *supra* note 168 at para 23.; Ruby Dhand, Anita Szigeti and D’Arcy Hiltz, *Halsbury’s Laws of Canada: Mental Health Law*, *supra* note 170 at 103.

¹⁷² *Conway*, *supra* note 168 at para. 81.

¹⁷³ *Supra* note 2 at 572.

¹⁷⁴ *Health Care and Consent Act*, S.O. 1996, c.2 [HCCA].

a regulation.”¹⁷⁵ According to Szigeti and Hiltz, this provision was made pursuant to section 52 (1) of the *Constitution Act*, 1982,¹⁷⁶ in contrast to section 24 (1) of the *Charter*¹⁷⁷ as considered in *Conway*.¹⁷⁸ As such, the CCB legislation does not remove the opportunity for it to be able to grant the “appropriate and just remedy in the circumstances”¹⁷⁹ in violation of the *Charter*.¹⁸⁰ *Charter* remedies may be available to those appearing before the CCB, who have faced *Charter* violations during their detention or treatment and care.¹⁸¹ Szigeti and Hiltz argue that the most “fertile ground for asserting *Charter* rights and seeking the appropriate remedies is found in the discretion built into section 41 (2) of the MHA.”¹⁸² For ethno-racial people with mental health disabilities, the focus group data suggest that arguments regarding access to culturally appropriate treatment and care, religious accommodation, the unwarranted use of seclusion and restraint and reviews of Community Treatment Orders provide an opportunity for *Charter* compliance to be tested before the CCB.¹⁸³

¹⁷⁵ HCCA, *ibid* at s 70.1 (1) [HCCA].

¹⁷⁶ Schedule B to the *Canada Act* 1982 (U.K.), 1982, c. 11.

¹⁷⁷ *Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (U.K.), 1982 C 11, s 24 (1).

¹⁷⁸ D’Arcy Hiltz and Anita Szigeti, *supra* note 2 at 573; *Conway*, *supra* note 168 .

¹⁷⁹ *Charter*, *supra* note 177 at s 24 (1).

¹⁸⁰ D’Arcy Hiltz and Anita Szigeti, *supra* note 2 at 573.

¹⁸¹ Ruby Dhand, Anita Szigeti and D’Arcy Hiltz, *Halsbury’s Laws of Canada: Mental Health Law* (Lexis Nexis: Toronto, 2011) at 103.

¹⁸² *Supra* note 2 at 574.

¹⁸³ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

An examination of the statutory criteria underlying the legal questions before the CCB may inevitably result in interpreting the health care professional's treatment plan.¹⁸⁴ However, a few lawyers argue that the CCB is not appropriately equipped to address constitutional issues because it lacks the institutional resources and this may contravene its mandate. Further questions that arose within the focus groups include: Will addressing *Charter* issues before the CCB result in varying standards for ethno-racial people with mental health disabilities and others? If *Charter* issues are addressed before the CCB, will the adjudication process be efficient and time sensitive?

Some health care professionals felt that increasing the CCB's jurisdiction to have the ability to make binding recommendations regarding an ethno-racial client's treatment plan would be an "affront to their clinical opinions and expertise."¹⁸⁵ To address this issue, some lawyers suggested that the CCB should be granted the power and jurisdiction to only put forth non-binding recommendations in regard to client treatment and care. Other Canadian mental health tribunals such as those in Nova Scotia¹⁸⁶ and Newfoundland¹⁸⁷ endorse this approach. However, a limitation of this approach is that these recommendations may have no legal influence to ensuring that ethno-racial people with mental health disabilities have access to culturally appropriate treatment and care.

Accordingly, the CAT was refined to include the following questions:

¹⁸⁴ Data derived from focus groups conducted with lawyers and service providers from November 2011 to February 2012; Genevra Richardson and David Machin, "Doctors on Tribunals: A Confusion of Roles" (2000) 176:2 *British Journal of Psychiatry* 110 at 113.

¹⁸⁵ Data derived from focus groups conducted with lawyers and service providers from November 2011 to February 2012

¹⁸⁶ *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42 at s 68 (2).

¹⁸⁷ *Mental Health Care and Treatment Act*, SNL 2006, c M 9.1 at ss 72 (1) (c), 72 (2).

- 1) Have *Charter* arguments pertaining to sections 15, 7, 9, 10 and/or 12 been put forth and addressed within the hearing?
- 2) Are *Charter* arguments regarding access to culturally appropriate treatment and care, religious accommodation, the unwarranted use of seclusion and restraint and reviews of Community Treatment Orders relevant to the client's case? Have these arguments been put forth by counsel?
- 3) Should the CCB put forth non-binding recommendations regarding the client's treatment and care?

6.5 Post-Hearing

In regard to the post-hearing process generally, respondents recognized that there are limited resources for ethno-racial people with mental health disabilities to challenge the CCB's decisions. It was recommended that there should be resources available for ethno-racial people with mental health disabilities to make appeals, to make complaints to the Ontario Human Rights Tribunal and to have access to legal advice/resources on their immigration status.¹⁸⁸ An analysis of these results indicated the following questions for the CAT:

- 1) Are there resources and support available for the client to appeal his or her CCB decision?
- 2) Are there resources and support available for the client to make applications before the Ontario Human Rights Tribunal?
- 3) Does the client have access to legal advice and resources on their immigration status?

¹⁸⁸ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

Appellants (clients/patients) are generally unrepresented in appeals from the CCB.¹⁸⁹ Consequently, the appeals regarding treatment capacity “have been noted to languish without receiving a timely hearing.”¹⁹⁰ In *Hilier v Milojevic*¹⁹¹ and *Cavalier v Ramshaw*,¹⁹² Justice Brown of the Superior Court put forth effective procedures for case-management of these appeals and appointing *amicus curiae* to support unrepresented litigants. However, it appears that these procedures have not been implemented in the Toronto region. As Anita Szigeti and D’Arcy Hiltz argue, “there is no guarantee, based in statute or established practice, that the appellant will have expert legal assistance or any on these appeals.”¹⁹³ This is extremely problematic since the CCB will dismiss applications to review findings of incapacity if six months have gone by before a “final resolution of an appeal,” unless written submissions have been made.¹⁹⁴ Further, the CCB will not hear applications for treatment capacity cases if the health care professional does not have a proposed treatment for the client.

As a result of these factors, appellants often have to bring forth fresh evidence in an appeal “to demonstrate improvement in his or her mental condition or the fact that there has been no deterioration despite having had no treatment administered pending appeal.”¹⁹⁵ Accordingly, there must be mechanisms in place to ensure that ethno-racial

¹⁸⁹ *Supra* note 2 at 576.

¹⁹⁰ *Supra* note 2 at 576.

¹⁹¹ 2010 ONSC 435, [2010] OJ No 159 at paras 38 and 39.

¹⁹² 2010 ONSC 5402, [2010] OJ No 4192.

¹⁹³ *Supra* note 2 at 578.

¹⁹⁴ *Supra* note 2 at 578.

¹⁹⁵ *Supra* note 2 at 578.

clients have to access quality legal counsel when appealing the CCB's decisions.¹⁹⁶

Further, lawyers may request the CCB to reconsider its decision as per Rule 31¹⁹⁷ in light of the strict seven-day deadline to file an appeal and the possible negative consequences that may ensue with proceeding with an appeal.¹⁹⁸

The following question further refined the CAT:

4) Has the lawyer considered using the CCB's reconsideration mechanism as per Rule 31?

6.6 Human Rights and Social Supports

A common and significant theme within "Human Rights and Social Supports" amongst ethno-racial people with mental health disabilities was racism. For instance, ethno-racial people with mental health disabilities described experiences of feeling isolated, alienated and stereotyped based on racist assumptions throughout their interactions with the police and their experiences in the emergency department, in the psychiatrists' capacity assessments, in hospital with health care professionals and during the CCB hearings. For this particular theme, academics recommended that the issue of

¹⁹⁶ *Supra* note 2 at 578; Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

¹⁹⁷ Rule 31 states as follows:

31.1 "The Board may at any time correct a typographical error, error of calculation, clerical error, or other similar error made in its decision or reasons."

31.2 "The Board may at any time, if considers it advisable, review all or part of its own decision or order, and may confirm, vary, suspend or cancel the decision or order."

Consent and Capacity Board, "CCB Rules of Practice," online: Consent and Capacity Board <http://www.ccboard.on.ca/scripts/english/legal/rulesofpractice.asp>.

¹⁹⁸ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

racism should be named explicitly and be identified.¹⁹⁹ In regard to social supports, ethno-racial people with mental health disabilities identified barriers to accessing adequate housing, community supports, and ethno-specific supports. Recommendations were made to improve access and awareness to social supports for ethno-racial people with mental health disabilities.²⁰⁰

An analysis of these results put forth the following questions for the CAT:

- 1) Is the client able to stay with dignity in the hospital?
- 2) Is the client comfortable?
- 3) Is the client experiencing seclusion and restraint?
- 4) Is the client's lawyer trained to assist the client in making human rights complaints?
- 5) Is the client aware of and able to access organizations such as the CAMH Empowerment Council, the Human Rights Legal Support Centre, Across Boundaries, Hong Fook Mental Health Association, and the Ethno-Racial People with Disabilities Coalition of Ontario?
- 6) Is funding available for the client to make a human rights complaint?
- 7) Has the client experienced racism within the CCB's pre-hearing, hearing and post-hearing processes? If so, has this been addressed?
- 8) Has the client experienced racism within the hospital? If so, has this been addressed?
- 9) Is cultural programming for the client available within the hospital?
- 10) Does the client have access to treatment staff from diverse communities?
- 11) If the client has been admitted into a long-term care facility, does he or she feel comfortable?

¹⁹⁹ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

²⁰⁰ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

- 12) If the client has been released into the community, is he or she living in poverty?
- 13) Does the client have access to adequate social supports including adequate housing, community supports and ethno-specific supports?
- 14) Does the client need individualized social supports or mainstream ones?
- 15) Does the client have access to individualized ethno-specific social supports?

To address the multiple themes within “Human Rights and Social Supports,” focus group respondents suggested that the CCB should use its discretion to interpret legal issues arising for clients under the *Ontario Human Rights Code*. In *Tranchemontagne v. Ontario (Director, Disability Support Program)*,²⁰¹ the Supreme Court distinguished between the "categories of questions of law" within constitutional law and provincial human rights codes.²⁰² The majority of the court held that administrative tribunals do have jurisdiction to consider legal issues as per the human rights codes and tribunals must use their discretion to consider relevant code related legal issues.²⁰³ Accordingly, extending this liberal interpretation to the CCB, it is evident that the CCB should be addressing and applying legal issues under the *Ontario Human Rights Code*. However, it appears that only four of the CCB’s decisions apply the *Ontario Human Rights Code*.²⁰⁴ As such, the lawyers amongst the focus group respondents recommended that the CCB should actively be applying the *Ontario Human Rights Code* when considering intersectional legal issues for the client such as experiences of racism,

²⁰¹ 2006 SCC 14, [2006] 1 SCR 513.

²⁰² *Ibid* at para 32.

²⁰³ *Ibid*.

²⁰⁴ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

restraint, seclusion, intolerance, discrimination, inequality, powerlessness and sexism.²⁰⁵ Legal Aid Ontario should try to provide “Gladue type funding” for lawyers who obtain mental health certificates to make human rights codes arguments before the CCB and the Ontario Human Rights Tribunal. Further, it was recommended by both ethno-racial people with mental health disabilities and lawyers in the focus group that Legal Aid Ontario should create a mental health law clinic that advocates for people with mental health disabilities on an individual and systemic level.²⁰⁶

If the *Ontario Human Rights Code* did apply to the CCB, perhaps the spirit of international laws such as the *United Nations Convention on the Rights of Persons with Disabilities*²⁰⁷ could also be recognized. For instance, Article 19 of the *Convention* suggests that people with disabilities should be able to live closer to their community.²⁰⁸ Similarly, a Form 19 (Application to the Board for an Involuntary Patient’s Transfer to Another Psychiatric Facility under s. 39.2 of the Act) could be invoked before the CCB in order to suggest that ethno-racial heritage and the need to live closer to a community should be a consideration when transferring a person with a mental health disability to a psychiatric facility.²⁰⁹ Accordingly, it is important to recognize that the core principles within the *Convention on the Rights of Persons with Disabilities* are also within the

²⁰⁵ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

²⁰⁶ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

²⁰⁷ *Convention on the Rights of Persons with Disabilities*, GA Res. 61/106, at 25(d), UN Doc. A/RES/61/106 (Dec. 13, 2006) [hereinafter CRPD].

²⁰⁸ CRPD, *ibid* at s 19.

²⁰⁹ Application to the Board for an Involuntary Patient’s Transfer to Another Psychiatric Facility under s. 39.2 of the Act), *Mental Health Act*, RSO 1990, c M 7, s. 20 [MHA].

Ontario Human Rights Code. Both statutes use an intersectional approach and recognize the multiple barriers faced by people with disabilities. Lastly, it is recommended that principle 14 of the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* suggesting that “a mental health facility shall have access to the same level of resources...to provide each patient with privacy and a program of appropriate and active therapy”²¹⁰ should be respected within Ontario’s psychiatric hospitals.²¹¹

Drawing from this analysis, the CAT was refined through the following questions:

16) Is the client facing a human rights violation as per the *Ontario Human Rights Code*? If so, has the CCB used its discretion to consider relevant code related legal issues?

17) Has the client faced a rights violation as per the *United Nations Convention on the Rights of Persons with Disabilities*? If so, how can this be addressed?

18) Does the client have access to varied food options?

19) Does the client feel comfortable sharing a room with a member of the opposite sex? If not, is there an adequate alternative?

6.7 Administrative Justice, Law Reform and Legislative Reform

The theme of legislative reform emerged from the data derived from interviews with lawyers and ethno-racial people with mental health disabilities. Lawyers argued that since the CCB considers itself to be a “creature of statute,” legislative reform is needed to ensure intersectional factors impacting ethno-racial people with mental health disabilities

²¹⁰ *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, GA Res. 46/119 (1991).

²¹¹ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

are addressed.²¹² Thus, legislative reform was recommended by both groups of stakeholders to ensure that mental health statutes incorporate criteria for considerations of culture, race, ethnicity, class, religion, gender, disability, and other social factors.

Lawyers further raised the importance of continuous systemic advocacy, along with the movement to create legislative reform.²¹³

In regard to the theme of “CCB adjudicators,”²¹⁴ adjudicators recognized that the competence and quality of its members impacts the extent to which the CCB can appropriately address these intersectional issues.²¹⁵ Lawyers suggested that the recruitment process should be improved to ensure that members are highly qualified, and genuinely interested in taking equity concerns seriously.²¹⁶ In an analysis of these results, the following questions arise for the CAT:

- 1) Is the CCB appointment process based on merit?
- 2) Is the CCB appointment process transparent?
- 3) In the CCB’s review of the client’s involuntary committal, financial capacity, treatment capacity or a CTO status, were relevant cultural considerations taken into account?

²¹² Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

²¹³ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

²¹⁴ This theme was incorporated into the themes of “administrative justice” and “Process and Power,” which were used to develop the CAT.

²¹⁵ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

²¹⁶ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

- 4) Should Ontario's mental health laws include criteria for considerations of culture, race, ethnicity, class, religion, gender, disability, and other social factors?
- 5) Should the definition of mental disorder within the law include factors of culture, race, ethnicity, class, religion, gender, disability and other social factors?
- 6) Is legislative reform a viable solution? If so, have all of the appropriate stakeholders been consulted?
- 7) If legislative reforms are being implemented, is ongoing systemic advocacy occurring simultaneously?

Given the current political and legislative atmosphere, the focus group data suggest that putting a focus on legislative reform may be futile and unproductive.²¹⁷ Archie Kaiser recognizes, "it is often difficult to interest legislators in genuine mental health law reform, which should put consumer interests first."²¹⁸ Thus, I question the viability of legislative reform and propose sustained systemic advocacy as a feasible option to improve the inequities faced by ethno-racial people with mental health disabilities in the civil mental health system.²¹⁹

Within the theme of administrative justice, lawyers within the focus group recommend that the CCB should ensure its adjudicators are culturally sensitive, impartial, qualified and competent in order to appropriately adjudicate intersectional issues

²¹⁷ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

²¹⁸ Archibald Kaiser, "Restraint and Seclusion in Canadian Mental Health Facilities: Assessing the Prospects for Improved Access to Justice" (2001) 19 Windsor Y.B. Access Jus. 391-418 at 403; Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

²¹⁹ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

impacting ethno-racial people with mental health disabilities.²²⁰ In this respect, the *Adjudicative Tribunals Accountability, Governance and Appointments Act, 2009*²²¹ “entrenches a commitment to both merit-based appointment and to adjudicative independence.”²²² The Act ensures that all tribunals create policy documents such as a mandate and mission statement, service standard policy, ethics plan, conflict of interest policy, member accountability framework, public accountability documents, memorandum of understanding and business plan with the tribunal’s responsible minister. The Act further recognizes that there should be a “competitive, merit-based process”²²³ used to appoint adjudicative tribunal members. Accordingly, it appears that this Act may be a positive step for the CCB to ensure that adjudicators are well-trained, culturally sensitive, culturally competent, ethical and qualified to contribute to “administrative justice.”²²⁴

As Lorne Sossin argues:

While arguably not its intent, by articulating a new series of shared obligations, the Act, in my view, contributes in a significant way to making the administrative justice system a reality. For example, once a shared template for codes of conduct is mandated, a shared administrative model for investigating complaints becomes possible, and I would suggest, necessary. Thus, a natural next step following this Act in Ontario may well be an “administrative council” for peer adjudication of complaints into the ethical conduct of

²²⁰ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

²²¹ SO 2009, c 33, Sch. 5.

²²² Lorne Sossin, 17 Reflections on the UK Tribunal Reform from a Canadian Perspective (2011) 24 Can. J. Admin. L. & Prac. 17 at 2.

²²³ *Adjudicative Tribunals Accountability, Governance and Appointments Act, 2009*, SO 2009, c 33, Sch 5.

²²⁴ *Supra* note 222 at 2; Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

adjudicators and regulators.²²⁵

6.8 Research Initiatives, Education and Training

The themes of research initiatives, education and training were grouped together in this analysis. Respondents agreed that further research should examine the inequities faced by ethno-racial people with mental health disabilities in the civil mental health system. A number of recommendations were given to enhance the research agenda such as conducting pilot studies to evaluate equity tools including the CAT, comparative studies, and statistical studies, which document the number of ethno-racial people with mental health disabilities entering psychiatric hospitals and those appearing before the CCB.²²⁶ Empirical research should be conducted to evaluate the quality of ethno-specific services, and alternative models of justice such as transformative justice and restorative justice.²²⁷ To improve education, health care professionals and ethno-racial people with mental health disabilities put forth recommendations to include mandatory classes on cultural competence/cultural sensitivity or health equity in the Canadian medical schools and to provide educational classes about the CCB's legal processes free of cost to ethno-racial people with mental health disabilities.²²⁸

²²⁵ *Supra* note 222 at 2.

²²⁶ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

²²⁷ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

²²⁸ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

Lastly, all of the participant groups except ethno-racial people with mental health disabilities raised the theme of training. The majority of respondents felt that CCB adjudicators and all mental health practitioners should receive sustained and ongoing cultural sensitivity, diversity and anti-racism or anti-oppression training.²²⁹ Tensions arose as to which training approach was appropriate. Despite these unresolved tensions, a number of respondents suggested using experiential learning exercises, which examine inequality and injustice. It was recommended that ethno-racial people with mental health disabilities, ethno-racial adjudicators and ethno-racial practitioners should be actively involved in delivering the training sessions.²³⁰

An analysis of these results put forth the following questions for the CAT:

- 1) Is there funding available to support research on the experiences of ethno-racial people with mental health disabilities in Ontario's civil mental health disabilities?
- 2) Are there statistics available on the number of ethno-racial clients appearing before the CCB? If so, are these data accessible to the public or external researchers?
- 3) Are there statistics available on the number of ethno-racial clients entering the psychiatric hospitals? If so, are these data accessible to the public or external researchers?
- 4) Is there a solid informed consent process that the client has to undergo before participating in a research study?
- 5) Is there research available on how ethnopharmacology may impact diagnosis, involuntary medication and treatment plans of the client?
- 6) Is there research available on the effectiveness of using other models of justice for the client?

²²⁹ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

²³⁰ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

- 7) Is there research available that evaluates the quality of ethno-specific services in Ontario?
- 8) Does research inspire and direct systemic advocacy on behalf of the client?
- 9) Are classes on cultural sensitivity/cultural competency or health equity part of the mainstream medical education curriculum?
- 10) Are practitioners receiving education on how to challenge the institutional racism within the civil mental health system?
- 11) Are cultural sensitivity/ cultural competency or health equity requirements embedded within the continuous medical education requirements for health care professionals?
- 12) Are cultural sensitivity/ cultural competency or health equity requirements embedded within the continuous legal education requirements for mental health lawyers?
- 13) Have all practitioners had ongoing cultural sensitivity, diversity, anti-racism or anti-oppression training?
- 14) Do all practitioners have access to cultural sensitivity, diversity, anti-racism or anti-oppression training?
- 15) Do CCB adjudicators have to undergo mandatory training regarding cultural and intersectional issues?
- 16) Are guest speakers from ethno-racial communities, experienced lawyers, and those specializing in providing ethno-specific mental health services involved in the CCB's training?
- 17) Are there experiential learning exercises within the training workshops?
- 18) Is there adequate funding available for cultural sensitivity, diversity, anti-racism or anti-oppression training?

Archie Kaiser suggests that there must be a national research agenda for mental health law which puts clients first and draws from interdisciplinary perspectives.²³¹ In this respect, he suggests “to further direct the perception of outcomes in a reconfigured

²³¹ Archibald Kaiser, “Imagining An Equality Promoting Alternative to the Status Quo of Canadian Mental Health Law”, (2003, special ed) Health LJ 185 at 201.

mental health system, the input of consumers is sought in establishing what is a good outcome, from the point of view of maximizing community participation and hence, equality.”²³² As such, ongoing evaluations should be conducted to examine the experiences of ethno-racial people with mental health disabilities in the civil mental health system with “consumer-stipulated indices of effectiveness and satisfaction.”²³³ For instance, researchers could pose questions such as: Do ethno-racial people with mental health disabilities in the civil mental health system have better outcomes when using ethno-specific mental health service? In this vein, focus group participants confirmed that further research should be conducted to create and evaluate legal tools and frameworks such as the CAT, which address the inequities faced by ethno-racial people in the civil mental health system.²³⁴ A few health care professionals in the focus group recommended that empirical studies should be conducted on the racial and cultural characteristics of individuals formed and contesting their status before the CCB.²³⁵ Accordingly, data gathered from the Tri-Hospital and Toronto Public Health Health Equity Data Collection Research Project Report could positively contribute to future research studies.²³⁶

Lawyers in the focus group acknowledged the creation of the Mental Health

²³² *Ibid* at 202.

²³³ *Ibid* at 202.

²³⁴ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

²³⁵ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

²³⁶ CAMH, “The Tri-Hospital and Toronto Public Health Health Equity Data Collection Research Project Report,” online: CAMH https://knowledgex.camh.net/health_equity/Pages/TRI+TPH.aspx

Commission of Canada's Mental Health and Human Rights Evaluation Instrument²³⁷ which was created to "evaluate the extent to which current provincial and territorial mental health legislation, policies and standards reflect the key principles and human rights of persons living with a mental illness."²³⁸ However, the limitations of this instrument include the following: 1) it only evaluates the content of Canada's mental health laws (forensic and civil) not its implementation or the outcomes of those interacting with them; 2) the consultation process used to create the instrument did not incorporate Ontario's perspective since the stakeholder consultations were conducted in Nova Scotia, Manitoba and British Columbia; 3) the instrument does not specifically address the barriers faced by ethno-racial people with mental health disabilities in the civil mental health system²³⁹ and 4) the methodology and the theoretical perspectives underlying the development of the tool differ from this study.²⁴⁰

In regard to training, the majority of focus group participants suggested that practitioners should be cautious of those involved in delivering the training sessions.

²³⁷ Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

²³⁸ Mental Health Commission of Canada, *Mental Health and Human Rights Evaluation Instrument* online: Mental Health Commission of Canada <http://www.mentalhealthcommission.ca/English/issues/law?routetoken=e240252ec2dad583f7953efd6ebda18c&terminal=24>

²³⁹ Within the instrument, the only mention of these issues is Principle 8, which broadly addresses "respect for cultural diversity, including language, values, beliefs and traditions." Mental Health Commission of Canada, *ibid* at 23.

²⁴⁰ Mental Health Commission of Canada, *ibid*; Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

A few service providers suggest that diversity consultants may unintentionally inculcate further stereotypes. Recommendations were made to have ethno-racial people with mental health disabilities facilitate the training. Also trainers should actively include perspectives from the institutional racism paradigm into the sessions to ensure that there is a “focus on the actions of institutions rather than individuals.”²⁴¹ This may depoliticize the issues at play.²⁴²

6.9 Cultural Analysis Tool

This Cultural Analysis Tool serves as a cultural and equity analysis instrument.²⁴³ The thematic questions can serve as a guide for practitioners when they have a client from an ethno-racial community interacting with Ontario's civil mental health laws. These critical questions can also be used to scrutinize the application of Ontario's mental health laws in order to address issues of culture and equity for ethno-racial people with mental health disabilities. Cultural considerations emphasize the need to use cultural information²⁴⁴ and knowledge throughout the legal processes, including the psychiatrists'

²⁴¹ Kwame McKenzie, “Something Borrowed From the Blues? We Can Use the Lawrence Inquiry Findings to Help Eradicate Racial Discrimination in the NHS” (1999) 318 *British Medical Journal* 616-617.

²⁴² Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

²⁴³ A shortened version of the CAT is available in Appendix A.

²⁴⁴ “Cultural information refers to a set of information relating to cultural matters that can be presented and debated in court.” Wen-Shing Tseng, Daryl Matthews, Todd S. Elwyn, *Cultural Competence in Forensic Mental Health: A Guide for Psychiatrists, Psychologists, and Attorneys* (New York: Brunner-Routledge, 2004) at 20. It is important to note that the word “culture” is conceptually different from terms such as race and ethnicity, which are socially defined. “Race is primarily physical, culture is sociological and ethnicity is psychological. Culture refers to ‘conceptual structures – a flexible system of values and worldviews that people live by, define their identities by

pre-hearing capacity assessment, the formulation of the treatment plan and the legal proceedings.²⁴⁵ The tool will also recognize how systemic barriers, such as discrimination faced by ethno-racial people with mental health disabilities, result in a restriction of civil rights.²⁴⁶ As evident from the results, the questions within the CAT should urge practitioners to be self critical and reflective about their own power and privilege, cultures of dominance and institutional racism.²⁴⁷

CULTURAL ANALYSIS TOOL (CAT)²⁴⁸

I. Role of Practitioners

i) Recognition

- 1) Have practitioners attempted to identify and address the intersectional issues relevant to the client throughout the pre-hearing, hearing and post-hearing processes?
- 2) Does the client need accommodation?
- 3) Have practitioners tried to accommodate the clients appropriately?
- 4) Are practitioners trained to acknowledge and examine the relevant cultural factors within the client's case?
- 5) Has the client's lawyer explained the CCB process to the client and his or her family?
- 6) Have practitioners challenged stereotypes and avoided generalizations based on culture, race, gender, class and other social factors?
- 7) Is there an open dialogue amongst practitioners about the institutional racism within the civil mental health system?

and negotiate their lives by.” Suman Fernando, *Mental Health, Race and Culture* (New York: Palgrave, 2002) at 11-13. These terms are further defined in Chapter One.

²⁴⁵ Wen-Shing, Tseng, Daryl Matthews, Todd. S. Elwyn, *ibid.* at 20.

²⁴⁶ Helen Watchirs, “Human Rights Audit of Mental Health Legislation – Results of an Australian Pilot,” (2008) 28 *In'l J.L. & Psychiatry* 99 at 100.

²⁴⁷ Data derived from interviews conducted with lawyers from April 2011 to February 2012.

²⁴⁸ A shortened version of the CAT is available in Appendix A.

- 8) Are the practitioners active and sensitive listeners?
- 9) Do practitioners engage in self-education and peer-learning in order to address the intersectional issues affecting their ethno-racial clients?
- 10) What degree of involvement does the client have with his or her culture?
- 11) What factors have contributed to the client's mental health disability?
- 12) What is the client's perspective about the case?
- 13) Has the client experienced discrimination, prejudice, or racism?
- 14) What does the client wish to accomplish in the CCB hearing?
- 15) Are the client's instructions at odds with his or her lawyer's or health care professional's recommendations?
- 16) Are health care professionals using the cultural formulation interview guide in the DSM-V?
- 17) Is the information gathered through the DSM-V's cultural formulation interview guide presented in the CCB hearing?

ii) Accessing and Presenting Cultural Evidence

- 1) Should cultural evidence play a role in this case?
- 2) Is there an appropriate evidentiary basis for presenting the cultural evidence?
- 3) Is the cultural evidence presented in an appropriate and sensitive manner?
- 4) Are there enough resources for lawyers to present the cultural evidence appropriately?
- 5) Does the cultural evidence have a negative or positive impact on the client's case?
- 6) Do practitioners and ethno-racial people with mental health disabilities have access to a cultural resource centre or cultural consultation service?
- 7) Do practitioners have access to someone who can provide them with cultural insights into the various perceptions of mental health disability?
- 8) What criteria should be used to evaluate the cultural evidence?
- 9) Is the client's behavior culturally driven, or is it deviant or delusional behavior?

10) Who is putting forth the cultural evidence/ information and what power/control/expertise does he or she have to do so?

11) Within the quasi-judicial legal processes, are those from minority cultures given the opportunity to present this cultural evidence/ information in light of the rules of evidence and the type of forum in which cases are heard?

12) How are expert witnesses able to respond to these issues at hand?

II. Language/Communication

i) Interpretation Services: Pre-Hearing, Hearing and Post-Hearing

a) Pre-Hearing

1) Does the client face language or other communication barriers?

2) Does the client speak little or no English?

3) Does the client understand concepts such as “rights,” “treatment,” “informed consent,” and “CCB hearing?”

4) Is the lawyer aware of his or her duty to accommodate the client as per the *Ontario Human Rights Code* when addressing language issues?

5) Does the client need to be accommodated in regard to language, communication and/or disability?

6) Have the client’s accommodation needs been identified at the outset of the CCB hearing?

7) Does the client have access to interpretation services in the hospital within 24 hours?

8) Is the client’s lawyer able to access a Legal Aid Ontario interpreter within seven days?

9) Is the client’s lawyer able to have an interpreter available during the pre-hearing lawyer-client meetings?

10) Does the rights advisors’ list of lawyers specify the language ability of each Legal Aid Ontario lawyer on the list?

11) Is an interpreter used in the capacity assessments for a client who speaks little or no English?

12) Is the psychiatrist trained to work with an interpreter?

- 13) Could misdiagnoses have occurred because of a language or communication barrier?
- 14) If an interpreter was used, was this charted in the client's hospital record by a health care professional?
- 15) Do treatment teams have varied language capacities to meet the everyday needs of non-English speaking clients?
- 16) If the client is non-English speaking, have all of the forms been translated in the client's language of choice?
- 17) Has the rights advice been offered in written form and translated in the client's language of choice?
- 18) Has the documentary evidence being used for the CCB hearing been translated in the client's language of choice before the hearing?

b) Hearing

- 19) Is an interpreter provided for in the CCB hearing as per s.18 of the CCB's rules of practice?
- 20) Does the interpreter have experience and expertise working with ethno-racial people with mental health disabilities?
- 21) Are the client's accent, mannerism, body language, gestures and demeanor appropriately understood?
- 22) When an interpreter is used, is simultaneous translation actually occurring?
- 23) Is the interpreter appropriately giving the client a voice?
- 24) Is the interpreter non-biased and non-judgmental?
- 25) Have the guidelines involving the interpreter's role been fully explained by the CCB at the outset of the hearing?
- 26) In cases where cultural evidence is being presented, is the interpreter able to appropriately contextualize the translation and understand the cultural nuances involved?

c) Post- Hearing

- 27) Has the client received a written decision specifying the reasons for the outcome of the CCB hearing?

- 28) Has the CCB translated the written decision and reasons for clients who do not speak English?
- 29) Is the requirement to translate decisions and reasons for clients who do not speak English included in the CCB's rules of practice?
- 30) Does the client fully understand the overall outcome of his or her CCB hearing?
- 31) Are the legal reasons adequate?
- 32) Do the written decision and reasons avoid the use of "legalese"?
- 33) Is the written decision and reasons presented in a plain, clear and accessible language?
- 34) Did the client receive a one-page summary of the legal decision and reasons along with the entire set of reasons?
- 35) Has the lawyer explained the appeal process to the client?
- 36) Have forms involving liberty issues such as the Application by Physician for Psychiatric Assessment, the Order for Examination under Section 16, the Certificate of Involuntary Admission and the Certificate of Renewal been translated for a client who is non-English speaking?
- 37) Has the Ministry of Health translated these forms appropriately?
- 38) Does the Ministry of Attorney General have a roster of interpreters that is current and accessible to practitioners?
- 39) If the client is deaf, is an interpreter/translator available throughout the CCB's pre-hearing, hearing and post-hearing processes?
- 40) Are the client and his or her family using the interpretation services available through the psychiatric hospital?
- 41) Are the interpreters accessible and effective?
- 42) Are interpreters available to meet the everyday needs of clients, the needs of clients in the emergency department and clients who speak rare languages?
- 43) Are lists made of the languages that the treatment staff speak in order to accommodate the everyday language needs of the client?
- 44) Are treatment teams working collaboratively with ethicists and lawyers to overcome language and communication barriers?

- 45) Are interpreter services available and accessible in the community for ethno-racial people with mental health disabilities?
- 46) Do service providers working in the community have on-site interpreters and case workers from diverse backgrounds available to support ethno-racial people with mental health disabilities?
- 47) Have practitioners received training to work with interpreters?
- 48) Have practitioners offered support to interpreters?
- 49) Has the practitioner given the interpreter written guidelines to adhere to?
- 50) Has a contract between the practitioner and the interpreter been signed?
- 51) Is the interpreter aware of his or her professional boundaries?
- 52) Has the interpreter received in-depth mental health training?
- 53) Does the interpreter speak the same dialect of the language as the client?
- 54) Is the interpreter fluent in the two languages being used and does he or she have an understanding of the two different cultural contexts at issue?
- 55) Is it necessary to match the interpreter's gender, age and religion with that of the client?

ii) Quality of Interpretation

- 1) Has the interpreter received mental health training?
- 2) Does the interpreter have experience and expertise working with ethno-racial people with mental health disabilities?
- 3) Are there standards to ensure the interpreters are well-trained and qualified to work within the mental health and cultural context within which they are practising?
- 4) Are there provincial or national standards for qualifying interpreters to work in the mental health context?
- 5) Have the psychiatric hospital's policies regarding interpretation and translation been followed? In particular, has a linguistic competence strategy been implemented?

- 6) Is the client's standard of care being diminished because of language or communication barriers?
- 7) Do clients who need access to interpretation services for their everyday needs have access to an interpreter at least twice a week?
- 8) Is the interpreter aware of the cultural differences and similarities amongst clients?
- 9) Does the interpreter understand the appropriate cultural etiquette required by the client?
- 10) Is the interpreter respectful of the client?
- 11) Are the interpreters professionally accountable?
- 12) Does the interpreter follow the rules of confidentiality?
- 13) Is the interpreter conducting himself or herself in a professional and ethical manner?
- 14) Does the interpreter appear to be advocating on behalf of the client? If so, is this appropriate?
- 15) Is the interpreter impartial?

iii) Cultural Interpreters/Consultants

- 1) Does the interpreter have an understanding of the client's cultural background and cultural context?
- 2) Can the question be rephrased differently since it may have a different interpretation in another culture or language?
- 3) In the client's culture, is there a different interpretation for the word or phrase?
- 4) Should the client have a cultural interpreter/ consultant?
- 5) Should there be a cultural interpreter/consultant available along with a language interpreter?
- 6) Should practitioners have access to a cultural interpreter/consultant?
- 7) Does the Human Rights or Ombudsmen Office provide for a cultural consultant/interpreter?
- 8) Can the cultural interpreter/consultant help the client create networks in the hospital and community?

- 9) Which model of interpretation is appropriate in the client's circumstances?
- 10) Would the client prefer having a cultural interpreter/consultant?
- 11) Is a cultural interpreter/consultant accessible?
- 12) Can the cultural interpreter/consultant be someone within the treatment team (i.e. psychiatrist, nurse, social worker, psychologist etc.)?
- 13) If a cultural interpreter/consultant is being used, is the client supportive of and comfortable with him or her?
- 14) Have the health care professionals been trained to work with cultural interpreter/consultants?
- 15) Are there appropriate resources to improve the linkages between health care professionals and community mental health services?
- 16) Are there appropriate resources available to create a Cultural Consultation Service?
- 17) Are the cultural interpreters/consultants receiving the appropriate training and supervision?
- 18) Have mechanisms been developed to ensure the competency of the cultural interpreters/consultants?
- 19) Has the cultural interpreter/consultant assisted in writing the cultural formulation report in accordance with the DSM-V?

III. The Pre-Hearing Process

i) Police Action

- 1) Are police officers acting in accordance with ss.16 and 17 of the *Mental Health Act* when interacting with the client and transporting the client to a psychiatric facility?
- 2) Are police officers trying to avoid the use of force when interacting with the client?
- 3) Are police officers sensitive to the language and communication barriers that may be affecting the client?
- 4) Have the police officers received cultural sensitivity training? If so, has the cultural sensitivity training been facilitated in collaboration with service providers working with ethno-racial people with mental health disabilities?
- 5) Do police officers have access to an interpreter if necessary?

- 6) Do police officers understand the relevant provisions of the mental health, human rights and privacy legislation?
- 7) Have police officers determined whether the client is able to understand and respond to their directions?
- 8) Do police officers recognize that standard procedures, which may otherwise stabilize a non-mentally disabled person, may have an adverse impact on the client?
- 9) Have police officers used cultural competency techniques to de-escalate conflict when interacting with the client?

ii) Rights Advice

- 1) Has the client received appropriate rights advice in accordance with s. 15, Reg. 741 of the *Mental Health Act*?
- 2) Has the rights advisor alerted the CCB of the client's accommodation needs? If so, has the CCB taken steps to accommodate these requests for the hearing?
- 3) Is the rights advisor acting as an advocate for the client?
- 4) Does the client understand the concept of "rights"?
- 5) Does the client understand what "rights advice" means?
- 6) Does the client understand the different types of treatment options?
- 7) Does the client know the name of the treatment which he or she is receiving?
- 8) Does the client understand concepts such as "involuntary treatment," "capacity," "incapacity," and "informed consent"?
- 9) Is the rights advisor using plain-language and effective communication methods?
- 10) Does the rights adviser use simple examples when explaining legal concepts?
- 11) Did the rights advice include a discussion about the dangerous side-effects of taking psychiatric medications?
- 12) Is the rights advice also provided in written form (i.e. facts sheets)?
- 13) Is the written rights advice translated in the client's language and presented in plain-language?
- 14) Has the client received a CAMH Bill of Client Rights in his or her language?

15) Does the client have access to resources about human rights and other intersectional issues?

16) Is the client in a recognized psychiatric institution as per the *Mental Health Hospitals Act*? If not, has he or she still received rights advice?

17) Has the client received rights advice within 72 hours of admission to the hospital or long-term care facility?

iii) Psychiatrists' Capacity Assessments

1) Does the psychiatrist's capacity assessment recognize the client's cultural background, class, social history, gender, and other intersectional factors?

2) Does the psychiatrist's capacity assessment recognize the client's cultural standards of normality vs. abnormality?

3) Is the psychiatrist able to address how psychological distress can be expressed differently amongst cultures?

4) Are there enough resources and time for the psychiatrist to address the intersectional issues affecting the client during the capacity assessment?

5) Is the psychiatrist using the DSM-V's cultural formulation interview guide during the capacity assessment of the client?

6) Is the client's behavior being pathologized during the capacity assessment?

7) Is there an alternative explanation of describing the client's behavior and symptoms?

8) Has the psychiatrist and/or treatment team tried to obtain collateral information about the client from his or her family?

9) Has the psychiatrist used recovery based tools and models when diagnosing the client?

10) Is the psychiatrist questioning his or her own cultural biases?

11) Is the psychiatrist considering culturally appropriate treatment options and care for the client?

12) Do health care professionals understand the client's treatment expectations?

13) Are health care professionals able to recognize and challenge the institutional racism within mental health system?

14) Are health care professionals using the “mental status examination” in their interactions with the client?

IV. The CCB Hearing

i) Process and Power

- 1) Is the CCB hearing process accessible for clients?
- 2) Is the CCB hearing process efficient for all of the participants?
- 3) Has the client been appropriately accommodated in the hearing process?
- 4) Are equity concerns being addressed in the CCB hearing process?
- 5) Do clients understand what is happening throughout the CCB hearing?
- 6) Does the client have access to an effective and experienced lawyer? If not, how is the CCB assisting the client throughout the hearing process?
- 7) Are the arguments made on the client’s behalf regarding culture, religion and other social factors acknowledged by the CCB adjudicators?
- 8) Is the client’s perspective being recognized?
- 9) Is the client’s voice heard and understood in the CCB hearing?
- 10) Are there free educational workshops about the CCB hearing process available for the client?
- 11) Are adjudicators drawing from paradigms such as cultural competency, anti-racism, human rights and ethics in their adjudication of the case?
- 12) Are the adjudicators sensitive, active listeners and aware of the cultural issues involved?
- 13) Are there ethno-racial people with mental health disabilities appointed to positions of power within the CCB, the hospital and community agencies?
- 14) Are the adjudicators qualified and competent?
- 15) Do the adjudicators come from diverse backgrounds?
- 16) Are adjudicators culturally sensitive and critical?

- 17) Are adjudicators genuinely interested in taking equity concerns seriously?
- 18) Are adjudicators committed to providing due process and procedural protections for the client?
- 19) Are adjudicators being compensated appropriately?
- 20) Do adjudicators have an understanding of the type of intersecting discrimination and the legal barriers experienced by the client?

Prevalence of the Medical Model

- 1) Is the hearing process institutionally biased in favour of medical expertise?
- 2) Have adjudicators considered the non-mental health illness related explanations for the client's circumstances and actions?
- 3) Have adjudicators ensured that the client has access to culturally appropriate treatment options and care?
- 4) Are adjudicators able to appropriately question the physician's authority?
- 5) Do the adjudicators have the requisite analytical skills necessary to address cultural and other intersectional issues?
- 6) Are the adjudicators positive and willing to probe into relevant cultural and other intersectional issues?

Adversarial Environment

- 1) Is the CCB hearing adversarial? If so, has mediation been considered for those who would prefer a less adversarial CCB hearing?
- 2) Has the well-being of the client been compromised as a result of the CCB hearing?
- 3) Does the CCB use a client-centred approach in the hearing?
- 4) Are legal technicalities avoided in the CCB hearing?
- 5) Do the health care professionals feel targeted in the CCB hearing?
- 6) Will the therapeutic relationship between the client and physician be compromised as a result of the CCB hearing?

- 7) Is there civility and respect amongst the lawyers involved in the CCB hearing?
- 8) Is there an open dialogue amongst all participants in the CCB hearing?

Family Involvement

- 1) Are the client's family members involved in the CCB hearing?
- 2) Are the client's family members receiving deference in the CCB hearing?
- 3) Do health care professionals have an open dialogue and clear communication with the client's substitute decision maker?
- 4) If the client's family is involved in the CCB case, are there issues around confidentiality and the boundaries of disclosure? How is this dealt with?
- 5) To what extent has the client's family been informed about the client's treatment and care decisions?
- 6) What are the client's family members' perspectives? Is this at odds with the client's perspective?
- 7) If family members are involved in the CCB hearing, have adjudicators attempted to gather as much collateral information as possible from them?
- 8) Is the client able to communicate with his or her family over the phone?
- 9) If necessary, are practitioners helping facilitate communication between the client and his or her family?
- 10) Are practitioners aware of the family dynamics involved in the client's case?

ii) Jurisdiction/Discretion

- 1) Have CCB adjudicators used their discretion to take culture, race, gender, class and other social factors into account when considering s. 41 (2) of the MHA, s. 1 of the MHA and s. 39.1 of the MHA?
- 2) Has the time frame for considering applications to review the client's community treatment order (s. 39.1 of the MHA) been extended from the seven-day period?
- 3) Have CCB adjudicators encouraged and directed health care professionals and service providers to provide culturally appropriate treatment programs for the client?

- 4) Can the CCB's jurisdiction be increased to consider relevant cultural information and cultural evidence?
- 5) Can the CCB's jurisdiction be increased to consider culturally appropriate treatment and care?
- 6) Are CCB adjudicators adopting an intersectional approach in their adjudication of the client's case?
- 7) Do CCB adjudicators understand how to apply an intersectional approach? Have they received appropriate training to do this?
- 8) Have *Charter* arguments pertaining to sections 15, 7, 9, 10 and/or 12 been put forth and addressed within the hearing?
- 9) Are *Charter* arguments regarding access to culturally appropriate treatment and care, religious accommodation, the unwarranted use of seclusion and restraint and reviews of Community Treatment Orders relevant to the client's case? Have these arguments been put forth by counsel?
- 10) Should the CCB put forth non-binding recommendations regarding the client's treatment and care?

Grappling with Culture

- 1) Have the adjudicators asked questions pertaining to the client's culture, race, ethnicity, class, religion, gender, disability, and other social factors? Have these factors played a role in the legal outcome?
- 2) Have the client's cultural context and history been probed into and understood by the adjudicators?
- 3) Has the client's lawyer been given the opportunity to present all of the cultural evidence relevant to the case?
- 4) Have the cultural evidence and cultural information been addressed and analyzed in the legal reasons of the decision?
- 5) Is there recognition of the client's identity and his or her strengths and weaknesses?
- 6) Have the health care professionals helped facilitate a discussion and analysis of the cultural and intersectional issues involved during the CCB hearing?
- 7) In the health care professional's submissions to the CCB, is there a detailed summary of the client's cultural background, history, context, and cultural aspects of the case?

- 8) Have the client's cultural and/or religious requests been addressed or accommodated in the CCB hearing?
- 9) Has the client's lawyer posed questions to the physician regarding his or her assumptions and potential cultural biases?
- 10) Have adjudicators ensured that clients from ethno-racial communities have the same quality of experience before the CCB as others?
- 11) Have adjudicators recognized and addressed the CCB's institutional bias?
- 12) Have adjudicators used their discretion to grapple with the intersectional and systemic issues at play within cases?
- 13) Are adjudicators engaging with cultural evidence by asking relevant questions and active listening?
- 14) Are adjudicators impartial?
- 15) Are the adjudicators seeking out cultural evidence and cultural information?
- 16) Have the adjudicators created a dialogue amongst themselves and other practitioners regarding cultural and other intersectional issues?

Access to Culturally Appropriate Treatment and Care

- 1) Is culturally appropriate treatment and care available and accessible for the client?
- 2) Is there evidence to indicate that the alternative treatment will be effective?
- 3) Is it ethical for the psychiatrist to prescribe and recommend the alternative treatment?
- 4) Are practitioners helping to advocate for culturally appropriate treatment and care for the client?
- 5) Would the client be treatment compliant if he or she had more options for culturally appropriate treatment and care within the civil mental health system?
- 6) Does the client have access to counseling and psychotherapy?
- 7) Are practitioners aware of the ethno-specific service providers and organizations that provide culturally specific treatment and care?

- 8) Are practitioners collaborating with ethno-specific mental health organizations to provide culturally appropriate treatment and care?
- 9) Are in-patient and out-patient mental health services being delivered in a culturally appropriate manner?
- 10) Do members of in-patient and out-patient treatment teams have varied language capacities?
- 11) Are members of in-patient and out-patient treatment teams from diverse backgrounds?
- 12) Is the client open to working with well-trained case-workers and social workers who are outside of their culture?
- 13) Is there enough funding available for ethno-specific mental health organizations such as Across Boundaries and Hong Fook Mental Health Association?
- 14) Are there initiatives to ensure that the client can participate in cultural activities and social gatherings within their communities?
- 15) Are practitioners able to challenge the stigma surrounding mental health disability within various cultures?
- 16) Is recreational programming and peer support available for the client within the hospital?
- 17) Are there objective measures to ensure consistency and transparency when matching the client to culturally appropriate mental health services?
- 18) Is a culturally appropriate housing arrangement needed for the client? If so, has a referral been made?
- 19) Is the CCB's treatment decision culturally appropriate?
- 20) Did the adjudicators probe into whether or not the client's treatment is culturally appropriate within the hearing or within the obiter of their written decision?
- 21) Does the client have a positive relationship with his or her case-worker?
- 22) Do practitioners have required standards of practice for providing culturally appropriate treatment and care? If so, are these standards being adhered to?
- 23) If the client is on a CTO, does the client have access to culturally appropriate treatment and care?

Religious Accommodation

- 1) Does the client need religious accommodation?
- 2) Are the client's religious accommodation requests being met?
- 3) Does the client have access to spirituality services?
- 4) Can the client practice his or her religion freely within the hospital and the community?
- 5) Have the client's religious accommodation requests been brought forth to the CCB, the Ontario Human Rights Tribunal or the Psychiatric Patient Advocate Office?
- 6) Did the CCB address the client's right to have religious accommodation?
- 7) Can the hospital provide the appropriate space and privacy to support the client's religious accommodation requests?
- 8) Have the client's religious observance and beliefs been pathologized?
- 9) To what extent should the client be accommodated in regard to religion?
- 10) Do practitioners know if a certain practice or belief is based on a religion?

V. Post-Hearing

- 1) Are there resources and support available for the client to appeal his or her CCB decision?
- 2) Are there resources and support available for the client to make applications before the Ontario Human Rights Tribunal?
- 3) Does the client have access to legal advice and resources on their immigration status?
- 4) Has the lawyer considered using the CCB's reconsideration mechanism as per Rule 31?

VI. Human Rights and Social Supports

- 1) Is the client able to stay with dignity in the hospital?
- 2) Is the client comfortable?

- 3) Is the client experiencing seclusion and restraint?
- 4) Is the client's lawyer trained to assist the client in making human rights complaints?
- 5) Is the client aware of and able to access organizations such as the CAMH Empowerment Council, the Human Rights Legal Support Centre, Across Boundaries, Hong Fook Mental Health Association, and the Ethno-Racial People with Disabilities Coalition of Ontario?
- 6) Is funding available for the client to make a human rights complaint?
- 7) Has the client experienced racism within the CCB's pre-hearing, hearing and post-hearing processes? If so, has this been addressed?
- 8) Has the client experienced racism within the hospital? If so, has this been addressed?
- 9) Is cultural programming for the client available within the hospital?
- 10) Does the client have access to treatment staff from diverse communities?
- 11) If the client has been admitted into a long-term care facility, does he or she feel comfortable?
- 12) If the client has been released into the community, is he or she living in poverty?
- 13) Does the client have access to adequate social supports including adequate housing, community supports and ethno-specific supports?
- 14) Does the client need individualized social supports or mainstream ones?
- 15) Does the client have access to individualized ethno-specific social supports?
- 16) Is the client facing a human rights violation as per the *Ontario Human Rights Code*? If so, has the CCB used its discretion to consider relevant code related legal issues?
- 17) Has the client faced a rights violation as per the *United Nations Convention on the Rights of Persons with Disabilities*? If so, how can this be addressed?
- 18) Does the client have access to varied food options?
- 19) Does the client feel comfortable sharing a room with a member of the opposite sex? If not, is there an adequate alternative?

VII. Administrative Justice, Law Reform and Legislative Reform

- 1) Is the CCB appointment process based on merit?
- 2) Is the CCB appointment process transparent?
- 3) In the CCB's review of the client's involuntary committal, financial capacity, treatment capacity or a CTO status, were relevant cultural considerations taken into account?
- 4) Should Ontario's mental health laws include criteria for considerations of culture, race, ethnicity, class, religion, gender, disability, and other social factors?
- 5) Should the definition of mental disorder within the law include factors of culture, race, ethnicity, class, religion, gender, disability and other social factors?
- 6) Is legislative reform a viable solution? If so, have all of the appropriate stakeholders been consulted?
- 7) If legislative reforms are being implemented, is ongoing systemic advocacy occurring simultaneously?

VIII. Research Initiatives, Education and Training

- 1) Is there funding available to support research on the experiences of ethno-racial people with mental health disabilities in Ontario's civil mental health disabilities?
- 2) Are there statistics available on the number of ethno-racial clients appearing before the CCB? If so, are these data accessible to the public or external researchers?
- 3) Are there statistics available on the number of ethno-racial clients entering the psychiatric hospitals? If so, are these data accessible to the public or external researchers?
- 4) Is there a solid informed consent process that the client has to undergo before participating in a research study?
- 5) Is there research available on how ethnopharmacology may impact diagnosis, involuntary medication and treatment plans of the client?
- 6) Is there research available on the effectiveness of using other models of justice for the client?
- 7) Is there research available that evaluates the quality of ethno-specific services in Ontario?

- 8) Does research inspire and direct systemic advocacy on behalf of the client?
- 9) Are classes on cultural sensitivity/cultural competency or health equity part of the mainstream medical education curriculum?
- 10) Are practitioners receiving education on how to challenge the institutional racism within the civil mental health system?
- 11) Are cultural sensitivity/ cultural competency or health equity requirements embedded within the continuous medical education requirements for health care professionals?
- 12) Are cultural sensitivity/ cultural competency or health equity requirements embedded within the continuous legal education requirements for mental health lawyers?
- 13) Have all practitioners had ongoing cultural sensitivity, diversity, anti-racism or anti-oppression training?
- 14) Do all practitioners have access to cultural sensitivity, diversity, anti-racism or anti-oppression training?
- 15) Do CCB adjudicators have to undergo mandatory training regarding cultural and intersectional issues?
- 16) Are guest speakers from ethno-racial communities, experienced lawyers, and those specializing in providing ethno-specific mental health services involved in the CCB's training?
- 17) Are there experiential learning exercises within the training workshops?
- 18) Is there adequate funding available for cultural sensitivity, diversity, anti-racism or anti-oppression training?

CHAPTER 7

SUMMARY AND CONCLUSION

Ethno-racial people with mental health disabilities interacting with Ontario's civil mental health system experience multiple inequities such as barriers to accessing culturally appropriate treatment,¹ a higher involuntary admission rate,² a higher likelihood of being diagnosed with psychosis,³ and increased use of seclusion, restraint⁴

¹ Mental Health Commission of Canada and CAMH, "Improving Mental Health Services for Immigrant, Refugee, Ethno-Cultural and Racialized Groups: Issues and Options for Service Improvement" (Toronto: Mental Health Commission, 2009) at 4; Rob Whitley, Laurence J. Kirmayer and Danielle Groleau, "Understanding Immigrants' Reluctance to Use Mental Health Services: A Qualitative Study from Montreal" (2006) 51 *Can. J. Psychiatry* 205 at 206.

² There are no specific statistics available in Canada and Ontario specifically on the number of ethno-racial patients being involuntarily admitted to psychiatric facilities. In the United Kingdom, the Count Me in Census is a valuable resource. Care Quality Commission, "Count Me In 2010" (London: NHS, 2011). Other studies drawing on statistics from the United Kingdom include: D.J. Vinkers, S.C. de Vries, A.W.B. van Baars and C.L. Mulder, "Ethnicity and Dangerousness Criteria for Court Ordered Admission to a Psychiatric Hospital" (2010) 45 *Soc. Psychiatry Epidemiology* 221 at 221; Kwame McKenzie and Kamaldeep Bhui, "Institutional Racism in Mental Health Care" (2007) 334 *British Medical Journal* 649 at 649. Globally, the WHO reports that minorities have a higher likelihood of being involuntarily detained. World Health Organization (WHO), *WHO Resource Book on Mental Health, Human Rights and Legislation* (Geneva: World Health Organization, 2005) at 85.

³ G. Eric Jarvis, Irene Toniolo, Andrew G. Ryder, Francesco Sessa, Carla Cremonese, "High Rates of Psychosis for Black Inpatients in Padua and Montreal: Different Contexts, Similar Findings" (2010) 46 (3) *Social Psychiatry and Psychiatry Epidemiology* 247 at 251. The study found that black patients from the emergency department in a community hospital in Montreal, Quebec were three to four times more likely than "white patients" to be given the diagnosis of psychosis. Also, see Suman Fernando, "Inequalities and the Politics of 'Race' in Mental Health" in Suman Fernando and Frank Keating, eds., *Mental Health in a Multi-Ethnic Society: A Multidisciplinary Handbook* (New York: Routledge, 2009) at 47. Drawing on research from the United Kingdom, Suman Fernando suggests that black/ethnic minorities are more often diagnosed as schizophrenic.

⁴ Susan Stefan, "Leaving Civil Rights to the 'Experts': From Deference to Abdication Under the Professional Judgment Standard" (1992) 102 *Yale L.J.* 639 at 660.

and emergency psychiatric medication.⁵ They are exceedingly vulnerable during contact with the Ontario's Consent and Capacity's (CCB's) pre-hearing, hearing and post-hearing processes. Given the dearth of research on this particular topic,⁶ there is a critical need to develop legal tools and approaches that address these disparities of outcome and intersecting issues. Thus, this study created a Cultural Analysis Tool (CAT) consisting of specific and meaningful thematic questions that can be used by practitioners when addressing issues of culture and equity for ethno-racial people with mental health disabilities interacting with Ontario's civil mental health laws. It is hoped that the CAT, and the research underlying its development, will enable practitioners to critically question whether cultural and intersecting concerns are being appropriately addressed within an ethno-racial client's case and, furthermore, how equitable outcomes can be achieved.⁷

This study is grounded in interdisciplinary scholarship that draws from qualitative empirical research with key participants in the civil mental health system, and various disciplines such as law, psychiatry, psychology and sociology. As described in Chapter One, the theory of inequity underlying the development of the CAT recognizes that the

⁵ G. Eric Jarvis, *Emergency Psychiatric Treatment of Immigrants with Psychosis* (Master of Science Thesis, Mc Gill University Institute of Community and Family Psychiatry, 2000) [unpublished]. This quantitative study was conducted in Montreal and it suggested that the administration of anti-psychotic medication may be motivated by patient ethnicity; Susan Stefan, "Leaving Civil Rights to the 'Experts: From Deference to Abdication Under the Professional Judgment Standard" (1992) 102 Yale L.J. 639 at 660; Suman Fernando, *supra* note 3 at 47.

⁶ Aaron Dhir, "Relationships of Force: Reflections on Law, Psychiatry and Human Rights" (2008) 25 WRLSO 103 at 108. Dhir suggests, "as compared with other fields, there is a dearth of progressive Canadian legal literature addressing the most pressing challenges facing those with psychiatric disabilities – let alone doing so from a critical, interdisciplinary perspective" (108).

⁷ The final version of the CAT is presented at the end of Chapter 6. A shortened version of the CAT is available in Appendix A.

causes of the inequities experienced by ethno-racial people with mental health disabilities are complex and contested. Certain factors which explain the disparities of outcome include the lack of consideration given to culture and equity⁸ within Ontario's civil mental health laws and the CCB's processes,⁹ the difficulties with communication and interpretation, cultural misunderstandings, internalized racism, stigma, complex familial relationships, poverty, institutional racism and challenges faced by practitioners involved in trying to understand differences in illness models, psychotherapy and preferred mental health services and treatment for ethno-racial people with mental illness.¹⁰ This theory of inequity drew from the theoretical framework, described in Chapter Two. In that chapter, I described the theoretical underpinnings and relevant tenets of the institutional racism paradigm, intersectionality and the social model of disability. Chapter Two dealt with the following questions: To what extent can a conception of justice address these colliding

⁸ It appears that cultural considerations are not often incorporated into the implementation of Ontario's civil mental health laws. Ruby Dhand, "Access to Justice for Ethno-Racial Psychiatric Consumer/Survivors in Ontario" (2011) 29:11 Windsor YB Access Just 127-162. According to Wen-Shing Tseng, Daryl Matthews and Todd. S. Elwyn, "cultural considerations emphasize the need to use cultural information and knowledge throughout the legal process, including the psychiatrists' pre-hearing capacity assessment, the formulation of the treatment plan and the legal proceedings." Wen-Shing Tseng, Daryl Matthews, Todd. S. Elwyn *Cultural Competence in Forensic Mental Health: A Guide for Psychiatrists, Psychologists, and Attorneys* (New York: Brunner-Routledge, 2004) at 20.

⁹ Ruby Dhand, *Challenging Exclusion: A Critique of the Legal Barriers Faced by Ethno-Racial Psychiatric Consumer/Survivors in Ontario* (LL.M. Thesis, University of Toronto Faculty of Law, 2009) [unpublished]; Ruby Dhand, "Access to Justice for Ethno-Racial Psychiatric Consumer/Survivors in Ontario" (2011) 29:11 Windsor YB Access Just 127-162.

¹⁰ Kwame McKenzie and Kamaldeep Bhui, *supra* note 2; Kwame McKenzie and Kamaldeep Bhui, "Better Mental Healthcare for Minority Ethnic Groups – Moving Away from the Blame Game and Putting Patients First: Commentary on..Institutional Racism in Psychiatry" (2007) 31 The Psychiatrist 368 at 368; Michael L. Perlin and Valerie McClain, "Where Souls Are Forgotten: Cultural Competencies, Forensic Evaluations, and International Human Rights" (2009) 15:4 Psychology, Public Policy and Law 257 at 264.

intersections without essentializing and stereotyping the identities of ethno-racial people with mental health disabilities? How do these theoretical approaches approach the complexities of these intersections while taking into account the context, systemic racism and multiple power hierarchies inherent in both law and psychiatry? Using a theoretical lens, I analyzed the extent to which culture, and other intersections can infuse the civil mental health system without inculcating stereotypes.

The theoretical framework informed the literature review, methodology and development of the CAT. The literature review in Chapter Three presented an overview of Ontario's civil mental health laws and the Consent and Capacity Board's pre-hearing, hearing and post-hearing processes. In addition, I critiqued the evaluative tools developed in other jurisdictions for mental health legislation and its processes including Australia's Rights Analysis Tool, the United Kingdom's Race Equality Impact Assessment, the *Convention on the Rights of Persons with Disabilities* (CRPD), the Scottish Recovery Tool, and the World Health Organization's Mental Health and Human Rights checklist. Throughout the chapter, I analyzed the tools themselves, the methodology used to create the tools, the robust literature surrounding their development, together with the types of indicators and international human rights laws that relate directly to my study. The following questions were examined: How effective was the methodology to create the tool? Which stakeholders were included in the consultation and interview process? How are interdisciplinary approaches incorporated within the creation, and implementation of the evaluative tool? How are issues of culture, race, ethnicity, gender, class and other social factors incorporated within the tool?

Drawing from the analysis in Chapters Two and Three, Chapter Four describes the methodology used for this study. The qualitative research methods that were used include the grounded theory approach, the constant comparative method and the member-checking method. The CAT was developed through an iterative and flexible process involving an analysis of the theoretical framework, review of the literature¹¹ and qualitative data. After obtaining ethics approval from York University's Human Participants Review Sub-Committee in the Office on Research Ethics,¹² and CAMH's Research Ethics Board,¹³ I conducted thirty-five semi-structured interviews with seven members of each of the following participants: (1) ethno-racial people with mental health disabilities including in-patients and ex-patients, (2) mental health lawyers, (3) health care professionals including psychiatrists, nurses and social workers, (4) service providers such as front-line case workers at mental health agencies and (5) adjudicators, government advisers and academics. Throughout the data collection stage, I attended weekly CCB hearings. I was given access to the case materials and I was often able to observe the pre-hearing meetings between the lawyer and the client and the client's interactions with health care professionals and CCB adjudicators. During the hearings, I examined and documented the subtle nuances of the legal proceedings and how issues of equity pertaining to ethno-racial people with mental health disabilities were addressed.

¹¹ This includes the theoretical framework consisting of the institutional racism paradigm, the social model of disability, the intersectional approach and cultural considerations on mental health law. The literature review includes an analysis of the existing legislative evaluative tools for mental health legislation, and the applicable international laws.

¹² I received ethics approval from the York University's Human Participants Review Sub-Committee in the Office on Research Ethics on February 10, 2011.

¹³ I received ethics approval from the CAMH Research Ethics Board on June 21, 2011.

After personally transcribing all thirty-five interviews, I continued to conduct an in-depth analysis of the data using the secondary literature and Glaser and Strauss' constant comparative method.¹⁴ The process of data gathering, transcription and data analysis occurred concurrently. Accordingly, the study's rigour was increased through an expert review of the CAT involving the qualitative technique of member checking and adopting Lincoln and Guba's framework for "trustworthiness." The expert review was conducted using three focus groups comprised of ethno-racial people with mental health disabilities, mental health lawyers and health care professionals (i.e. psychiatrists, nurses and social workers.).

As described in Chapter Four, limitations of this study include the sample size, the participants and the location. In particular, there were thirty-five participants interviewed and approximately nineteen participants involved in the focus groups. The interviews were conducted in Toronto since the majority of CCB hearings take place in Toronto,¹⁵ there are a large number of people with mental health disabilities from various ethno-racial communities,¹⁶ and the Centre for Addiction and Mental Health (CAMH) in

¹⁴ Barney Glaser and Anselm Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (New York: Aldine de Gruyter, 1967) at 105

¹⁵ Interview with an adjudicator, 2011.

¹⁶ Statistics Canada, *Population Projections of Visible Minority Groups, Canada, Provinces and Regions 2001 to 2017*, online: Statistics Canada <<http://www.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=91-541-XIE&lang=eng>>; Centre for Addiction and Mental Health, *Research Report 2002/2003* (Toronto: Centre for Addiction and Mental Health, 2003) at 54; Mental Health Commission of Canada and CAMH, "Improving Mental Health Services for Immigrant, Refugee, Ethno-Cultural and Racialized Groups: Issues and Options for Service Improvement" (November 2009) at 4 online: Mental Health Commission of Canada <http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2010/Issues_Options_FINAL_English%2012Nov09.pdf>.

Toronto is Canada's largest psychiatric institution.¹⁷ Thus, it is not possible to make conclusive statements from this empirical evidence as these findings are grounded in the views of the participants. In light of these limitations, strengths of the study include the in-depth analysis and portrait of the participants' perceptions and narratives of how to improve legal processes and the mental health system, the participants' level of candor and the quality of information provided vis-à-vis their particular experiences, which is often inaccessible.

In Chapter Five, the data-derived themes and sub-categories developed through the analysis were presented. These were examined according to each participant group and the CCB's pre-hearing, hearing and post-hearing processes. The major sections and themes include: role of practitioners, language/communication, the pre-hearing process, the CCB hearing, the post-hearing process, human rights in the hospital, access to culturally appropriate treatment and care, religious accommodation, accountability, power, admission to long term care facilities, legislative reform, research initiatives, CCB adjudicators, training and education. The respondents' narratives recognized the multiple barriers and inequities faced by ethno-racial people with mental health disabilities within the civil mental health system.¹⁸ These results highlighted the similarities and differences of these narratives and the recommendations amongst each respondent group. In this regard, all the respondents suggested that the quality and accessibility of interpretation

¹⁷ Centre for Addiction and Mental Health, "About CAMH" online: CAMH http://www.camh.net/About_CAMH/index.html. The interviews were conducted primarily in Toronto and the findings of this study might have varied if there were interviews conducted in rural areas of Ontario. In light of these limitations, these findings are not conclusive statements and they are grounded in the views of the respondents.

¹⁸ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

services should be improved.¹⁹ However, respondents were divided as to how they can address the institutional racism within Ontario's civil mental health system and the CCB's hearing process.²⁰ This is further addressed within Chapter Six.

Chapter Six analyzes and contextualizes the results that emerged from interviews with five participant groups. The themes, categories and sub-categories were analyzed through a thorough analysis of primary sources (jurisprudence, legislation and policies) and the secondary sources, along with the data obtained from the focus groups. Since the themes are the same as those that arose in Chapter Five, I further analyzed and compared the responses of each participant group within the thematic categories. This enabled the development of the CAT. The purpose of the analysis was to examine how culture, race, ethnicity, class, gender and other intersecting social factors affecting ethno-racial people with mental health disabilities should factor into the implementation of Ontario's civil mental health laws. First, I gave a brief comparative analysis of the results and presented the questions that arose for the CAT. These questions were then further analyzed and refined according to the focus group data and the relevant literature. The analysis also addressed the varying responses and inherent debate within the questions themselves. Accordingly, the modified and additional questions for the CAT were developed in each section. The final version of the CAT is presented at the end of the Chapter.²¹

Chapter Six critically examined the unresolved tensions amongst practitioners and

¹⁹ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

²⁰ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011.

²¹ A shorter version of the CAT is presented in Appendix A.

academics regarding how to address the intersecting inequities faced by ethno-racial people interacting with Ontario's civil mental health laws. In particular, lawyers felt that they should overcome their own biases and the inherent paternalism within the civil mental health system. Accordingly, to further grapple with the varying understandings of mental health disabilities, lawyers suggested that cultural information and cultural evidence should be brought to the CCB hearing. Drawing from Perlin's work, questions were developed within the CAT to overcome the "sanism"²² within the civil mental health system.²³ Health care professionals argued that the DSM-V's cultural formulation guide should be used in the psychiatrist's capacity assessments to adopt a client-centred approach to psychiatric diagnosis and treatment.²⁴ The analysis further examined how psychiatric symptoms can present themselves differently amongst ethno-racial people with mental health disabilities; and in the event lawyers do present cultural evidence/information, they may risk creating unjust stereotypes based on culture, race, class and gender, etc. Scholars recommend that practitioners should use cultural evidence cautiously. If there is an appropriate evidentiary basis to bring forth the cultural evidence,

²² Michael Perlin, "International Human Rights and Comparative Mental Disability Law: The Use of Institutional Psychiatry as a Means of Suppressing Political Dissent" (2006) 39 *Isr. L.R.* 69 at 74.

²³ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011; Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

²⁴ Data derived from interviews conducted with lawyers, health care professionals, ethno-racial people with mental health disabilities, adjudicators, academics, government advisors and service providers from April 2011 to November 2011; Data derived from focus groups conducted with lawyers, service providers, health care professionals and ethno-racial people with mental health disabilities from November 2011 to February 2012.

practitioners should recognize the intra-cultural dissent amongst ethno-racial groups, and they should try to involve community members by submitting *amicus briefs*.

Chapter Six further assessed the language and communication barriers throughout the pre-hearing, hearing and post-hearing processes. The CAT was developed to address the inefficient process for obtaining interpretation during the pre-hearing meetings between lawyers and clients, the lack of translation available for written legal materials including forms and documentary evidence, the lack of interpretation available for the everyday needs of clients, the needs of clients who speak rare languages and dialects and the needs of clients with limited knowledge of English in capacity assessments. The debate regarding translation of forms, the quality of interpretation services and the use of cultural interpreters/consultants was further analyzed using the CCB's cases and legislation.

In analyzing the CCB's pre-hearing, hearing and post-hearing processes, the CAT examines how institutional racism and systemic discrimination impacts the experiences of ethno-racial people with mental health disabilities within the civil mental health system. In particular, recommendations were made to improve police interactions with ethno-racial people with mental health disabilities and the rights advice process. Within the psychiatrists' capacity assessments, practitioners should strive to appreciate cultural explanations of mental health disability and the impact of cultural background, class, social history, ethnicity and other socio-cultural factors. The analysis critiqued diagnostic approaches and tools and the DSM V's cultural formulation interview guide. In regard to the CCB hearing, ethno-racial people with mental health disabilities recommended that their individual experiences must be taken into account. Although there were unresolved

tensions of how CCB adjudicators should appropriately use their discretion to grapple with the intersectional and systemic issues at play, the CAT suggests that adjudicators should draw from paradigms such as cultural competency, anti-racism, human rights and ethics in the adjudication of cases. The data suggested that the CCB should not restrict its jurisdiction unnecessarily and it should use its discretion to address intersectional issues and barriers faced by ethno-racial people with mental health disabilities.

Through an analysis of *R v. Conway* and the focus group data, the CAT considers how arguments regarding access to culturally appropriate treatment and care, religious accommodation, the unwarranted use of seclusion and restraint and reviews of Community Treatment Orders provide an opportunity for *Charter* compliance to be tested before the CCB. In regard to the post-hearing processes, mechanisms must be in place to ensure that ethno-racial clients have access to quality legal counsel when appealing the CCB's decisions. The CAT suggests that lawyers consider using the CCB's reconsideration mechanisms as per Rule 31 to avoid the possible negative consequences of proceeding with an appeal. Within themes of Human Rights and Social Supports, Administrative Justice, Law Reform and Legislative Reform and Research Initiatives, Education and Training, the CAT further addresses issues of institutional racism, power, equity, injustice and barriers to accessing culturally appropriate treatment, adequate housing, community supports, and ethno-specific supports.

The CAT will be useful for practitioners to understand and identify the cultural nuances in legal processes and cases involving voluntary and involuntary admissions, consent and capacity issues in relation to treatment, substitute-decision making, community treatment orders, long term care options, management of property and

personal care, etc.²⁵ The aim of the CAT is to contribute to a better understanding of how equitable outcomes for ethno-racial people with mental illness interacting with Ontario's civil mental health laws can be achieved. However, it is evident that additional research is needed to investigate the cost and feasibility of implementing the CAT amongst mental health practitioners. This feasibility study should investigate the viability of using the tool and having access to culturally appropriate resources. Future research should also examine how to adapt the CAT for other Canadian jurisdictions.

If access to justice is to be realized for ethno-racial people with mental health disabilities and mental health supports and services are to be provided equitably, this study suggests that all practitioners should understand the impact of factors such as race, ethnicity, culture, poverty and other forms of social exclusion when interacting with and implementing mental health laws. It is my hope that the CAT will enable practitioners to critically use the questions to contribute in the journey of creating equitable outcomes for ethno-racial people with mental health disabilities within the civil mental health system.

²⁵ D'Arcy Hiltz and Anita Szigeti, *A Guide to Consent and Capacity Law in Ontario* (Markham: Lexis Nexis Canada Inc., 2013) at ix.

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APPENDIX A

SHORTENED CULTURAL ANALYSIS TOOL (CAT)

I. Role of Practitioners

i) Recognition

Have practitioners attempted to identify and address the intersectional issues relevant to the client throughout the pre-hearing, hearing and post-hearing processes?

The following factors should be considered:

- Client's need for accommodation,
- Relevant cultural factors,
- Client's understanding of the CCB hearing process,
- Stereotypes and generalizations,
- Institutional racism within the civil mental health system,
- Self-education and peer-learning,
- Client's involvement with his or her culture,
- Client's perspective of the case,
- Client's desired outcome of the case,
- Client's instructions,
- Use of the DSM-V's cultural formulation interview guide.

ii) Accessing and Presenting Cultural Evidence

Should cultural evidence play a role in this case?

The following factors should be considered:

- Evidentiary basis for presenting the cultural evidence,
- Presentation of the cultural evidence,
- Availability of resources,
- Impact of the cultural evidence on the client's case,

- Accessibility of a cultural resource center or cultural consultation service,
- Criteria needed to evaluate the cultural evidence,
- Expertise of the person putting forth the cultural evidence,
- Opportunity for expert witnesses to respond.

II. Language/Communication

i) Interpretation Services: Pre-Hearing, Hearing and Post-Hearing

a) Pre-Hearing

Does the client face language or other communication barriers?

The following factors should be considered:

- Client's ability to speak English,
- Client's understanding of key concepts ("rights, treatment, informed consent and CCB hearing"),
- Lawyer's awareness of his/her duty to accommodate the client's language issues,
- Client's need to be accommodated in regard to language, communication and/or disability,
- Client's accessibility of interpretation services in the hospital within 24 hours,
- Client's lawyer's ability to access a Legal Aid Ontario interpreter within seven days for the lawyer-client meetings and the hearing,
- Specificity of language ability on the rights advisors' list of lawyers
- Use of interpreters in capacity assessments,
- Training of psychiatrists to work with interpreters,
- Misdiagnosis as a result of language/communication barriers,
- Charting of the use of interpreters,
- Language capacities of the treatment team,
- Translation of the forms,
- Offering rights advice in written form,
- Translation of rights advice,
- Translation of documentary evidence.

b) Hearing

Is an interpreter provided for in the CCB hearing as per s.18 of the CCB's rules of practice?

The following factors should be considered:

- Experience and expertise of the interpreter,
- Appropriate understanding of the client's accent, mannerism, body language, gestures and demeanor,
- Simultaneous translation,
- Client's ability to be heard,
- Interpreter's bias,
- CCB's explanation of the interpreter rules at the outset of the hearing,
- Interpreter's ability to appropriately contextualize the translation and understand the cultural nuances when cultural evidence is presented.

c) Post- Hearing

Has the CCB translated the written decision and reasons for clients who do not speak English?

The following factors should be considered:

- Translation of the outcome of the decision,
- Requirements within the CCB's rules of practice,
- Client's understanding of the overall outcome of his or her CCB hearing,
- Appropriate legal reasons,
- Avoidance of "legalese,"
- Use of plain, clear and accessible language,
- Inclusion of a one-page summary along with the reasons,
- Lawyer's explanation of the appeal process,
- Appropriate translation of forms (Application by Physician for Psychiatric

- Assessment, the Order for Examination under Section 16, the Certificate of Involuntary Admission and the Certificate of Renewal),
- Current and accessible roster of interpreters,
 - Interpreters/translators for a deaf client,
 - Accessibility and effectiveness of interpretation services,
 - Interpreters which meet the everyday needs of clients, the needs of clients in the emergency department and clients who speak rare languages,
 - Lists of languages spoken by treatment staff,
 - Collaboration between treatment teams, ethicists and lawyers,
 - Accessibility of interpreter services and case workers within the community,
 - Training of practitioners to work with interpreters,
 - Written guidelines for the interpreter,
 - Contractual arrangements between the practitioner and interpreter,
 - Interpreter's awareness of his or her professional boundaries,
 - Mental health training for the interpreter,
 - Dialect spoken by the interpreter,
 - Interpreter's understanding of the client's cultural contexts,
 - Similarity of interpreter's gender, age and religion with the client.

ii) Quality of Interpretation

Does the interpreter have experience and expertise working with ethno-racial people with mental health disabilities?

The following factors should be considered:

- Mental health training,
- Provincial or national standards for interpreters,
- Understanding of the cultural context and cultural etiquette,
- Hospital policies,
- Client's standard of care,
- Everyday needs of the client,

- Respect and professional accountability,
- Rules of confidentiality,
- Impartiality.

iii) Cultural Interpreters/Consultants

Should the client have a cultural interpreter/ consultant?

The following factors should be considered:

- Language interpreter's understanding of the client's cultural background and cultural context,
- Varied interpretations of words or phrases in the client's culture or language,
- Practitioners' need for a cultural interpreter/consultant,
- Accessibility of a cultural interpreter/consultant,
- Model of interpretation appropriate for the client,
- Client preference,
- Availability of training and supervision.

III. The Pre-Hearing Process

i) Police Action

Have police officers used cultural competency techniques to de-escalate conflict when interacting with the client?

The following factors should be considered:

- ss.16 and 17 of the *Mental Health Act*,
- Avoiding the use of force,
- Sensitivity to language and communication barriers,
- Cultural sensitivity training in collaboration with service providers,

- Accessibility of interpreters,
- Police officers' understanding of the relevant mental health, human rights and privacy legislation,
- Client's ability to respond to directions,
- Procedures which have an adverse impact on the client.

ii) Rights Advice

Has the client received appropriate rights advice in accordance with s. 15, Reg. 741 of the *Mental Health Act*?

The following factors should be considered:

- Client's accommodation needs,
- Advocacy vs. Rights Advice,
- Client's understanding of the concept of "rights," "involuntary treatment," "capacity," "incapacity," and "informed consent,"
- Client's understanding of the types of treatment options,
- Client's understanding of his or her treatment,
- Use of plain-language and effective communication methods,
- Dangerous side-effects of psychiatric medications,
- Providing rights in written form (i.e. fact sheets),
- Translation of rights advice,
- CAMH Bill of Client Rights,
- Resources available to the client,
- Client's access to rights advice within 72 hours of admission.

iii) Psychiatrists' Capacity Assessments

Does the psychiatrist's capacity assessment recognize the client's cultural background, class, social history, gender, and other intersectional factors?

The following factors should be considered:

- Client's cultural standards of normality vs. abnormality,
- Varied psychological distress amongst cultures,
- Resources and time available for the psychiatrist's capacity assessment,
- Use of the DSM-V's cultural formulation interview guide,
- Alternative explanations of the client's behavior and symptoms,
- Collateral information from the client's family,
- Recovery based tools and models,
- Cultural bias,
- Cultural appropriate treatment options and care,
- Client's treatment expectations,
- Institutional racism within the civil mental health system.

IV. The CCB Hearing

i) Process and Power

Is the CCB hearing process accessible for clients?

The following factors should be considered:

- Efficiency of the CCB hearing process,
- Client's accommodation requests,
- Client's equity concerns,
- Client's understanding of the CCB hearing;
- Access to an effective and experienced lawyer;

- Acknowledgment of the arguments made regarding the client's culture, religion and other social factors;
- Recognition of the client's perspective and voice;
- Free educational workshops about the CCB hearing process for the client;
- Adjudicators' use of paradigms such as cultural competency, anti-racism, human rights and ethics;
- Positions of power for ethno-racial people with mental health disabilities;
- Qualified and competent adjudicators;
- Adjudicators from diverse backgrounds;
- Adjudicators who are culturally sensitive and critical;
- Provision of due process and procedural protections for the client;
- Appropriate compensation for the adjudicators;
- Adjudicator's understanding of the type of intersecting discrimination and the legal barriers experienced by the client;

Prevalence of the Medical Model

Is the hearing process institutionally biased in favour of medical expertise?

Consider factors such as:

- Consideration of non-mental health illness related explanations for the client's circumstances and actions;
- Client's access to culturally appropriate treatment options and care;
- Adjudicators' ability to appropriately question the physician's authority;
- Adjudicators' requisite analytical skills and willingness to address cultural and intersectional skills;

Adversarial Environment

Has the well-being of the client been compromised as a result of the CCB hearing?

Consider factors such as:

- Adversarial nature of the CCB hearing;
- Mediation for a client;
- Use of a client-centred approach in the hearing;
- Avoidance of legal technicalities;
- Therapeutic relationship between the client and physician;
- Civility amongst the lawyers involved;
- Open dialogue amongst all participants;

Family Involvement

Are practitioners aware of the family dynamics involved in the client's case?

Consider factors such as:

- Involvement of the family members in the CCB hearing;
- Deference given to family members in the CCB hearing;
- Dialogue with the client's substitute decision maker;
- Confidentiality and boundaries of disclosure;
- Information regarding client's treatment and care decisions;
- Client's perspective vs. client's family members' perspectives;
- Collateral information gathered from the client's family
- Communication between the client and his or her family;
- Practitioners' role as facilitators;

ii) Jurisdiction/Discretion

Have CCB adjudicators used their discretion to take culture, race, gender, class and other social factors into account when considering s. 41 (2) of the MHA, s. 1 of the MHA and s. 39.1 of the MHA?

Consider factors such as:

- Extending the time frame for considering applications to review the client's community treatment order;
- Providing culturally appropriate treatment programs for the client;
- Increasing the CCB's jurisdiction to consider relevant cultural information and cultural evidence;
- Increasing the CCB's jurisdiction to consider culturally appropriate treatment and care;
- Adjudicators' use of an intersectional approach;
- Lawyers' use of *Charter* arguments;
- CCB's inclusion of non-binding recommendations regarding the client's treatment and care;

Grappling with Culture

Have the adjudicators asked questions pertaining to the client's culture, race, ethnicity, class, religion, gender, disability, and other social factors? Have these factors played a role in the legal outcome?

Consider factors such as:

- Client's cultural context and history;
- Opportunity for the client's lawyer to present relevant cultural evidence;
- Analysis of cultural evidence and cultural information;
- Recognition of client's identity and his or her strengths and weaknesses;

- Dialogue regarding cultural and intersectional issues;
- Detailed summary of the client's cultural background, history, context, and cultural aspects of the case in the health care professionals submissions to the CCB;
- Accommodation of client's cultural and/or religious requests;
- Cultural bias;
- Quality of experience for the client;
- Institutional bias;
- Active listening;

Access to Culturally Appropriate Treatment and Care

Is culturally appropriate treatment and care available and accessible for the client?

Consider factors such as:

- Evidence to indicate the alternative treatment will be effective;
- Ethical issues;
- Advocacy on behalf of the practitioners;'
- Client's likelihood of being treatment compliant;
- Accessibility of culturally specific treatment and care;
- Varied language capacities of in-patient and out-patient treatment teams;
- Members of in-patient and out-patient treatment teams from diverse backgrounds;
- Funding for ethno-specific mental health organizations;
- Initiatives to ensure that the client can participate in cultural activities and social gatherings within their communities;
- Recreational programming and peer support available for the client;
- Availability of a culturally appropriate housing arrangement;
- Adjudicators' probing of the extent to which the client's treatment is culturally appropriate;

- Client's relationship with his or her case-worker;
- Client's access to culturally appropriate treatment and care when on a CTO;

Religious Accommodation

Are the client's religious accommodation requests being met?

Consider factors such as:

- Client's need for religious accommodation;
- Client's ability to access spirituality services;
- Client's ability to practice his or her religion freely within the hospital and the community;
- CCB's role;
- Client's ability to bring forward the religious accommodation requests to the CCB, the Ontario Human Rights Tribunal or the Psychiatric Patient Advocate Office;
- Client's religious observance and beliefs;

V. Post-Hearing

Are there resources and support available for the client to appeal his or her CCB decision?

Consider factors such as:

- Resources and support available for the client to make applications before the Ontario Human Rights Tribunal;
- Client's access to legal advice and resources on his or her immigration status;
- Client's lawyer's consideration of using the CCB's reconsideration mechanism (Rule 31);

VI. Human Rights and Social Supports

Is the client able to stay with dignity in the hospital?

Consider factors such as:

- Client's comfort level;
- Client's experience of seclusion and restraint;
- Client's lawyer's ability to assist the client in making human rights complaints;
- Client's ability to access organizations such as the CAMH Empowerment Council, the Human Rights Legal Support Centre, Across Boundaries, Hong Fook Mental Health Association, and the Ethno-Racial People with Disabilities Coalition of Ontario;
- Funding available for the client to make a human rights complaint;
- Client's experience of racism within the CCB's pre-hearing, hearing and post-hearing processes;
- Client's experience of racism within the hospital;
- Cultural programming available for the client within the hospital;
- Client's access to treatment staff from diverse communities;
- Client's experience of comfort in a long-term care facility;
- Client's experience of poverty in the community;
- Client's access to adequate social supports including adequate housing, community and ethno-specific supports;
- Client's need for individualized social supports vs mainstream ones;
- Client's access individualized ethno-specific social supports;
- *Ontario Human Rights Code*;
- *United Nations Convention on the Rights of Persons with Disabilities*;
- Client access to varied food options;
- Client's comfort level sharing a room with a member of the opposite sex;

VII. Administrative Justice, Law Reform and Legislative Reform

In the CCB's review of the client's involuntary committal, financial capacity, treatment capacity or a CTO status, were relevant cultural considerations taken into account?

Consider factors such as:

- Viability of Ontario's mental health laws to include criteria for considerations of culture, race, ethnicity, class, religion, gender, disability, and other social factors;
- Transparency of CCB's appointment process;
- Credibility of CCB's appointment process;
- Viability of legislative reform;
- Ongoing systemic advocacy along with legislative reform;

VIII. Research Initiatives, Education and Training

Is there funding available to support research on the experiences of ethno-racial people with mental health disabilities in Ontario's civil mental system?

Consider factors such as:

- Availability of statistics on the number of ethno-racial clients appearing before the CCB;
- Available statistics on the number of ethno-racial clients entering the psychiatric hospital;
- Informed consent process for the client;
- Research on how ethnopharmacology may impact diagnosis, involuntary medication and treatment plans of the client;
- Research available on the effectiveness of using other models of justice for the client;

- Evaluation research on the quality of ethno-specific services in Ontario;
- Impact on research on direct systemic advocacy on behalf of the client;
- Classes on cultural sensitivity/cultural competency or health equity in the mainstream medical education curriculum;
- Cultural sensitivity/ cultural competency or health equity requirements within the continuous legal education and continuous medical education requirements;
- Education for practitioners on how to challenge the institutional racism within the civil mental health system;
- Ongoing cultural sensitivity, diversity, anti-racism or anti-oppression training for practitioners;
- Mandatory training regarding cultural and intersectional issues for CCB adjudicators;
- Guest speakers from ethno-racial communities, experienced lawyers, and those specializing in providing ethno-specific mental health services in the CCB's training;

APPENDIX B

Semi-Standardized Interview Guide

i) Ethno-Racial People with Mental Health Disabilities

*These questions will only be used as a topic guide as the interview is semi-structured. The headings and questions will vary according to the time, comfort level and occupation and/or role of the participant in the study.

Screening Inclusion Questions:

What ethno-racial community do you identify with?

Have you been on a form that has kept you in hospital? (yes/no)

Did you have a hearing? (yes/no)

When was your last hearing?

I want to know a little about what happened before your last hearing:

Were you given the form and your rights on paper by the ward?

Can you read English?

If no, was the form translated?

Were you able to talk to a rights adviser before your hearing?

Was it clear to you?

Did you need an interpreter?

Did you have an interpreter?

Was there anything you did not understand?

I now want to ask you about your lawyer:

Did you have a lawyer?

If so, how many times did you meet with your lawyer before the hearing?

Did the lawyer represent your views as you wished?

Do you think your lawyer did a good job?

Was there anything that you think could have been done better?

I now want to ask you a little about what happened when you went to the hearing:

How was your experience before the Consent and Capacity Board?

What happened at the hearing?

How long was the hearing?

Were you able to take breaks?

Could you understand what was being said?

Do you think you needed an interpreter?

Do you think your case was understood by the Board?

If not, why?

Was it a problem with the board understanding you?

Was it a problem with your lawyer understanding you?

Was it a problem with your lawyer getting the board to understand?

Were there any cultural factors that you think should have been taken into account?

Were these factors taken into account in your opinion?

If they were not, do you think this was because:

(i.e.) The cultural issues you thought were important were not presented to the board

(i.e.) You could not get your lawyer to understand the cultural issues

(i.e.) Your lawyer could not get the board to understand cultural issues

(i.e.) The board did not seem to think the cultural issues were important

I want to ask a few questions about your psychiatrist:

Do you think, looking back, the psychiatrist did a good job representing your situation?

If no, what were the problems? (i.e. – Prompts: Disagree with diagnosis, disagree with treatment, got some of the history wrong, did not understand how social factors such as housing were important, did not understand how social factors such as relationships and family were important, did not understand how cultural factors were important to you)

Are there factors such as race, ethnicity, religion, culture, immigrant/ refugee status etc. relevant to your case?

Were these factors addressed by practitioners involved in your case (lawyers, service providers, psychiatrists, adjudicators)?

Lastly I want to find out what happened after the hearing:

How long after the hearing did you get the decision?

Did you get it on paper or verbally?

If it was on paper, do you have any problems reading English?

Did you understand the legal decision?

Were there things you did not understand?

Did someone talk to you about the decision?

Who did you speak to? For instance, did you speak to your lawyer or service provider about the decision?

Did you have an interpreter?

If not, do you think an interpreter would have been useful?

When you left the hospital, did you go on a CTO (community treatment order) ?

Do you have any recommendations for how the CCB (Consent and Capacity Board) hearings can be improved?

ii) Semi-Standardized Interview Guide for Practitioners

* This includes: lawyers who practice in the area of mental health law, health care professionals including psychiatrists, nurses and social workers, service providers such as front-line case workers at mental health agencies and adjudicators, government advisors and academics.

Legislative Framework

What legal concerns generally affect ethno-racial people with mental health disabilities in the civil mental health system (ie. detention in the hospitals, community treatment orders, interaction with police, substitute decision makers, right to interpreters, rights advice, medication, abuse or neglect in hospital facilities etc.)?

What are specific human rights considerations pertaining to ethno-racial people with mental health disabilities in the civil mental health system?

What types of experiences (positive or negative) do ethno-racial people with mental health disabilities have in cases involving:

- a) Voluntary and Involuntary admission procedures
- b) Consent and Capacity Issues
- c) Admission to Long Term Care Facilities
- d) Substitute Decision Making

e) Community Treatment Orders

f) Management of Property

g) Personal Care

h) Privacy and Confidentiality of Medical Information

Language

Is language interpretation easily accessible during the pre-hearing, hearing and post-hearing processes?

Is rights information accessible in various languages?

Are forms regularly translated for those who do not speak English?

Capacity Assessments

What factors are taken into account in the determination of a mental disorder?

Are translators readily available during the capacity assessments?

Rights within Mental Health Facilities

How can ethno-racial people with mental health disabilities access culturally appropriate services within the hospital?

How can ethno-racial people with mental health disabilities access culturally appropriate care within the wider mental health system? Are there effective provisions or mechanisms within the law for this?

What types of mechanisms are available to ensure there is sensitivity to diversity within the hospital and in the community?

What type of diversity training does staff within your profession receive?

Review Board

How does the Consent and Capacity Board's adjudication of cases involving ethno-racial people with mental health disabilities take into account factors such as culture, race, class, religion, immigrant/refugee status, age, sexual orientation, gender and/or disability etc?

Does the Consent and Capacity Board operate expeditiously and efficiently?

How can mental health laws infuse cultural factors within its content and implementation without inculcating stereotypes?

Recommendations

What are strategies or approaches that you can suggest to ensure equitable outcomes for ethno-racial people with mental health disabilities interacting with Ontario's civil mental health laws?

Can you suggest any specific law reform initiatives and/or policy recommendations?

APPENDIX C

Consent Form

This research is being conducted by Ruby Dhand as part of her Doctorate of Law program at Osgoode Hall Law School, York University. The purpose of this research is to develop a Cultural Analysis Tool (CAT). The CAT will consist of specific thematic questions that can serve as a cultural and equity analysis instrument for practitioners to use in the implementation of Ontario's civil mental health laws.

Process

By being a participant in this study, you will take part in a semi-standardized interview for approximately forty-five minutes. The researcher will be asking questions to address how issues of culture and equity pertaining to ethno-racial people with mental health disabilities can be incorporated into the implementation of Ontario's civil mental health laws and processes. You are not obliged to discuss anything in this interview that you are not comfortable with disclosing.

With your permission, the discussion will be tape-recorded. Tapes and transcripts will be kept confidential. The data will be stored on computerized files which will be secured by a password protected server. The only people who will have access to the information will be the researcher, Ruby Dhand, and her supervisors, Professor Roxanne Mykitiuk (Osgoode Hall Law School) and Dr. Kwame McKenzie (Centre for Addiction and Mental Health). It is your right to withdraw from the study, decline to answer any questions or discontinue with the interview at any time with no negative consequences.

After the Study

Since the research findings may be used for publication in journals and/or public presentations, stringent measures will be taken to ensure anonymity and confidentiality of the information. Each research participant will be identified by a code name/number. With your permission, only a general summary of your personal information related to

your ethnicity and education background will be presented. If you wish, you may indicate that you do not want this information presented, and no negative consequences will ensue.

All research material, when not being studied, will be stored in the CAMH Archive. If you would like to have a summary of the results from the study after the study is finished, please contact the researcher and she would be happy to share the study with you.

If you have any questions about your rights as a participant, you may contact Dr. Darby at the Research Ethics Review Office by phone at 416-535-8501 ext. 6876.

I, _____, have received and read a copy of this consent form. I understand the above information and I want to be a participant in this study.

Participant's Signature

Date