CHALLENGING EXCLUSION:
A CRITIQUE OF THE LEGAL BARRIERS FACED BY
ETHNO-RACIAL PSYCHIATRIC CONSUMER/SURVIVORS IN
ONTARIO

by

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A thesis submitted in conformity with the requirements
for the degree of Master of Laws, Faculty of Law
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ABSTRACT

This thesis identifies and analyzes the legal barriers faced by ethno-racial psychiatric consumer/survivors in Ontario, through an analysis of the Consent and Capacity Board (CCB). I employ interdisciplinary research to test the hypothesis that factors such as race, ethnicity, culture, poverty and social exclusion are not fully addressed by the CCB. To critique the CCB, I developed a theoretical framework using the grounded theory approach, in combination with tenets of disability theory, critical race theory and intersectionality. I used the theoretical framework to analyze qualitative research involving twenty interviews of stakeholders including lawyers, psychiatrists, CCB adjudicators, mental health service providers and ethno-racial psychiatric consumer/survivors. The analysis revealed the procedural, systemic/structural and discretionary barriers within the CCB’s pre-hearing, hearing and post-hearing process. Barriers were the result of cultural misunderstandings, misdiagnosis, complex familial relationships, culturally inappropriate care, institutional racism, poverty, discrimination and the CCB’s “color blind approach.” I conclude with prioritized recommendations.
ACKNOWLEDGEMENTS

I wish to thank Professor Colleen Flood, my supervisor, for her patience, advice and support. She encouraged me to approach the study of mental health law from interdisciplinary and critical perspectives. I am grateful to Dr. Kwame McKenzie at the Centre for Addiction and Mental Health (CAMH) for helping me plan and execute this study. His guidance and mentorship enriched my understanding of cultural psychiatry and qualitative research. I thank the Canadian Institute of Health Research (CIHR) Training Program in Health Law and Policy for awarding me with a fellowship to pursue my academic goals, and the ARCH Disability Law Centre for fostering my commitment to mental health law.

My sincere gratitude goes to all of the stakeholders who participated in this study. They graciously offered their time and shared their personal experiences. Their contributions facilitated my understanding of the needs and concerns of ethno-racial psychiatric consumer/survivors before the Consent and Capacity Board (CCB) in Ontario.

Finally, I give a special thanks to my wonderful family and friends. Thank you Dad, Mom, Amar and Neil for your love, energy and beautiful optimism.
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CHAPTER 1
INTRODUCTION

The mental health of members from racialized communities cannot be understood in isolation from the intersecting social conditions and inequities of their lives. Ontario’s mental health system needs to challenge and transform these inequities through law reform and cultural empowerment. ¹

In our multi-racial society, the intersection of race, mental health and law cannot be ignored. As a lawyer of South Asian descent, my desire to pursue graduate work in the area of mental health law stems from my work experiences with the ARCH Disability Law Centre in Toronto, the University of Ottawa’s Community Legal Clinic, and life experiences with family and friends who are psychiatric consumer / survivors.² I have recognized that psychiatric consumer/survivors from ethno-racial communities may experience complex forms of racism, by virtue of their ethnicity, culture and society’s inherent prejudice towards them. 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.³ People from ethnic minorities are also more likely to experience mental health stigma and legal barriers than the majority

¹ Interview with a service provider on January 20, 2009.
² I will use the term “psychiatric consumer/survivors” to describe those who are recipients or former recipients of mental health and/or addiction services. Since there is no consensus on what the appropriate terminology should be to describe people with mental health problems, other terms that have been used include: psychiatric survivors, psychiatric disability, mental health disability and people with mental illness. Although it is grammatically incorrect, “psychiatric consumer/survivors” is the accepted term in the literature.
group. The legal barriers faced by ethno-racial psychiatric consumer/survivors are complex as a result of factors such as racism, poverty, unemployment, separation from family and community support, socio-cultural sources of stigma associated with mental health issues, differing values and understanding of mental health in general, misdiagnosis, mistrust of the mental health system and culturally inappropriate care. Consequently, they have been found to have higher rates of involuntary admission and a higher likelihood of misdiagnosis leading to involuntary admission in the civil mental health system.

Within this context, this thesis identifies and analyzes the legal barriers which are perceived to differentially affect psychiatric consumer/survivors from various ethno-racial communities in Ontario. I achieve this through an analysis of the Consent and Capacity Board (CCB) employing empirical and interdisciplinary research. I test the hypothesis that factors such as race, ethnicity, culture, poverty and social exclusion are not fully addressed by the CCB, thereby creating legal barriers for ethno-racial psychiatric consumer/survivors. This thesis applies a theoretical framework using the


grounded theory approach, in combination with disability theory, critical race theory and intersectionality to critique the jurisprudence, legislation and policies of the CCB. The legal analysis is informed by qualitative research involving interviews of stakeholders including lawyers, psychiatrists, CCB board members, mental health service providers and psychiatric consumer/survivors from various ethno-racial communities. The purpose of the thesis is to examine whether the law is formulated to address the needs of ethno-racial psychiatric consumer/survivors, and what approaches lawyers, psychiatrists, health-care professionals and service providers can use to address the cultural gap and barriers within the legal system.

This chapter introduces the study by articulating the rationale, terminology, methodology and overview of the thesis. The rationale describes why I chose to focus on the CCB, its mandate and the importance of the study. The terminology section explains key terms such as psychiatric consumer/survivor, legal barriers and ethno-racial. Lastly, I give an overview of the chapters and organizational structure of this thesis.

1.1 Rationale of the Study

Laws that impact psychiatric consumer/survivors affect the most fundamental aspects of their lives, including their liberty (such as involuntary hospitalizations), their housing (such as access to supportive housing) and their ability to participate fully in society without discrimination (such as not being discharged from work because of a

---

7 I have received ethics approval from the University of Toronto Research Ethics Board to conduct interviews involving lawyers, psychiatrists and service providers. In regard to psychiatric consumer/survivors themselves, I have received ethics approval at the Centre of Addiction and Mental Health. This process will be explained in Chapter Two.
psychiatric disability). Ontario’s Consent and Capacity Board (CCB) is an important administrative tribunal adjudicating issues arising from these laws. Specifically, the Board has the authority to adjudicate issues of “involuntary committal and community treatment orders under the Mental Health Act (MHA),\(^8\) consent and capacity issues in relation to treatment, admission to care facilities and personal assistance services under the Health Care Consent Act (HCCA),\(^9\) and management of property under both the Substitute Decisions Act (SDA)\(^10\) and the MHA.”\(^11\) The CCB also adjudicates matters that come under the Long Term Care Act,\(^12\) the Mandatory Blood Testing Act, 2006\(^13\) and the Personal Health Information Act.\(^14\)

The CCB has the difficult task of making decisions that must balance an individual’s civil rights, liberty and autonomy against the interests of the State.\(^15\) Since over 80% of the applications to the CCB involve a review of involuntary status or a person’s capacity to accept or refuse treatment,\(^16\) the Board must ensure that elements of safety, interests of the community, dignity and autonomy of the individual and the right

\(^9\) S.O. 1996, c.2.
\(^12\) S.O. 1994, c. 26.
\(^14\) S.O. 2004, c.3, Sched. A.
\(^15\) *Supra* note 11 at ix.
to have treatment when required are paramount to its decisions. As an adjudicative, expert tribunal, a CCB panel consists of a lawyer, a psychiatrist, and a member of the public. The Board has 151 appointed members, and it heard approximately 2606 cases in the last year.

I chose to analyze this particular tribunal because it hears cases which involve the “deprivation of an individual’s dignity”; it addresses human rights issues in an administrative context outside of the forensic mental health system and its wide jurisdiction in mental health law has an immense impact upon ethno-racial psychiatric consumer/survivors. Thus, an intersectional analysis of the CCB’s polices, jurisprudence and legislation is necessary to ensure that barriers faced by psychiatric consumer/survivors from various ethno-racial communities are identified, analyzed and better dealt with.

In Canada, despite its relevance, the literature and statistics on ethnicity and mental health are scarce. Although there are studies which acknowledge that people from ethno-racial communities are at a higher risk for having mental health issues, there is a dearth of progressive legal literature on the experiences of psychiatric consumer/survivors.

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17 *Ibid* at 2.
consumer/survivors from ethno-racial communities.\textsuperscript{22} This is significant as racialized groups now make up over 13\% of the Canadian population. It is estimated that approximately 57\% of Canada’s racialized population will live in Ontario by 2017.\textsuperscript{23} In Toronto specifically, the primary research site for this study, 43\% of the population belongs to a “visible minority.”\textsuperscript{24} Consequently, a critical, interdisciplinary study such as this one is needed to recognize how the realities of mental disability, race, poverty and class intersect. The value of this research lies in contributing to successful advocacy for psychiatric consumer/survivors from various ethno-racial communities. The qualitative data and legal analysis are used to inform law reform initiatives and policy recommendations. I intend to take the knowledge that results from this study back into the community to ensure that the stakeholders interviewed, the CCB itself and others can benefit from it. I hope this study can contribute to the evolving discourse that challenges the traditional assumptions and the paternalism inherent in the application of Ontario’s mental health laws.


1.2 Terminology

The conceptualization of legal barriers includes three components: 1) procedural barriers, 2) systemic/structural barriers and 3) discretionary barriers. An exact characterization of what these categories include is not given at this early stage as it is the goal of this thesis to identify the relevant issues and themes through legal research, qualitative interviews and analysis.²⁵ Procedural barriers include a discussion surrounding language and communication barriers in the pre-CCB hearing and CCB hearing process. The systemic/structural barriers refer to a discussion surrounding the prevailing dominance of the medical model of disability in the CCB’s jurisprudence, the lack of culturally-specific clinical support within the psychiatric system, and how racial discrimination and social exclusion in the civil mental health system impact the experiences of ethno-racial psychiatric consumer/survivors who come before the CCB. Lastly, the discretionary barriers refer to the extent to which factors such as race, culture, and ethnicity are considered within the CCB’s jurisprudence, legislation and policies, and the judicial mechanisms used by the CCB to ensure that cultural stereotypes are not inculcated.

In this thesis, ethno-racial communities refer to Canadians of non-European background or heritage including those who are Canadian born and those who have come to Canada as immigrants or refugees.²⁶ The study does not include a discussion of

²⁵ However, I have included examples of the types of issues anticipated.

Aboriginal peoples since contextual and historical factors affecting the discrimination faced by Aboriginal peoples are distinct from ethno-racial communities. Although ethnicity is an abstract term, for the purposes of this thesis, its definition “involves sharing of a common culture, which may be based on a combination of factors such as language, religion, national identity, customs, social and/or political position within a country’s social system.”

This thesis uses the term psychiatric consumer/survivors to describe those who are recipients or former recipients of psychiatric and/or addiction services. There is no consensus on appropriate terminology and it is a contested issue. Other terms that are used include “people with mental illness,” “mental health disability” and “psychiatric disability.” However, I use the term psychiatric consumer/survivor because of its relevance to a critique of the CCB and in an attempt to be as inclusive as possible.

1.3. Overview of the Thesis

There are three main chapters in addition to this one.

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28 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 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, “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.
i) **Chapter Two: Methodology** I review the relevant literature needed to explain the methodological approach and theoretical underpinnings of this thesis. The grounded theory approach is informed by a combination of disability theory, critical race theory and intersectionality. This theoretical framework is used to inform the research design, interview guide, the interview process, the ethical considerations and the data analysis procedure.

ii) **Chapter Three: Legal Analysis and Findings** I highlight the emergent themes from the qualitative interviews to assess the legal barriers that psychiatric consumer/survivors from various ethno-racial communities face. The theoretical framework conceptualized in Chapter Two has been applied to these findings and to the legal analysis of the jurisprudence, legislation and policies of the CCB. This chapter examines whether the law is formulated to address the needs of ethno-racial psychiatric consumer/survivors and analyzes the influence that race and culture may have had on the CCB’s cases and policies.

iii) **Chapter Four: Conclusion and Recommendations** This chapter includes the summary, conclusions and recommendations that have been drawn from the qualitative research and legal analysis. These can be used to understand and challenge the exclusion faced by ethno-racial psychiatric consumer/survivors within the legal system and the mental health system.
CHAPTER 2
METHODOLOGY

There has been little Canadian academic scholarship addressing the intersection of mental health, race and the law. I develop a theoretical framework in this chapter that helps to frame thinking about these intersections. I assume the importance of taking an interdisciplinary approach to this topic and as such the theoretical framework uses the grounded theory approach, a research method in qualitative methodology, in combination with disability theory, critical race theory and intersectionality. First, I describe the rationale for using a qualitative methodology. Subsequently, I highlight the relevant themes of the theories, which are used to identify and critique the legal barriers perceived to differentially affect psychiatric consumer/survivors from ethno-racial communities who appear before the CCB. These themes are used to inform the qualitative component of the thesis, including the interview guide, the interview process, and the data analysis procedure. As I outline the models of disablement, I argue that not one model of disability fits perfectly to a critique of the CCB. Since the social model of disability is more relevant to the critique, the discussion of the medical and economic models are limited and they are primarily used to contrast with the social model of disability. Lastly, in the section on procedures, I describe the inclusion criteria for the

29 “Grounded theory is a method of conducting qualitative research that focuses on creating conceptual frameworks or theories through building inductive analysis from data.” Antony Bryant and Kathy Charmaz (eds), The Sage Handbook of Grounded Theory (London: Sage, 2007) at 608.
interviews and the semi-structured interview techniques employed throughout the data collection stage of research.

2.1 Theoretical Framework

2.1.1 Rationale for Using a Qualitative Methodology

Qualitative methodology provides a tool for collecting and analyzing data based on the participants’ views and their perception of the problem. Harley and Muhit argue that qualitative research methods should be used for disability research when investigating a minimally-studied research area, when target populations are vulnerable and when policy recommendations are required. Using qualitative research methods enables the researcher to gain a “holistic” and integrated understanding of the context under study. When studying the CCB, the aim is to understand the legal barriers faced by psychiatric consumer/survivors from various ethno-racial communities. As described in chapter one, a comprehensive understanding of the role that factors such as race, ethnicity and culture have upon the CCB’s jurisprudence is lacking. Thus, I use qualitative methodology, specifically the grounded theory approach, because it provides a process of rigorous inquiry into how these social factors impact the CCB’s work.

31 Ibid. at 108-109.
32 Ibid.
2.1.2 Grounded Theory

Grounded theory enables the researcher to develop a “general and abstract theory grounded in the views of the participants.”\textsuperscript{33} The researcher inductively derives a theory by systematically collecting interview data and analyzing the data using various methods to explore social processes.\textsuperscript{34} Grounded theory is advantageous since it allows the researcher to “1) build rather than only test theory; 2) give the research process the rigor necessary to make the theory good science; 3) help the analyst to break through the biases and assumptions brought to, and that can develop during the research process; 4) provide the grounding, build the density, and develop the sensitivity, tightly woven explanatory theory that closely approximates the reality it represents.”\textsuperscript{35} Using grounded theory enables me to explore the CCB’s work through the perceptions of a variety of different stakeholders, the goal being to develop on this basis policy recommendations that are “grounded in the data.”\textsuperscript{36}

As Glaser and Strauss argue, the process of generating grounded theory is a “way of arriving at theory suited to its supposed uses.”\textsuperscript{37} The hypotheses and concepts arise from the data during the course of the research, while the source of certain ideas may

\textsuperscript{33} Ibid. at 105.

\textsuperscript{34} Anselm L. Strauss and Juliet M. Corbin, Basics of Qualitative Research: Grounded Theory Procedures and Techniques (London: Sage, 1990) at 23.

\textsuperscript{35} Ibid. at 57.

\textsuperscript{36} Supra note 30 at 106.

come from theories and models outside of the data itself.\(^\text{38}\) 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.”\(^\text{39}\) There is an underlying assumption that legal norms and structures can be changed because reality is socially constructed.\(^\text{40}\) While the grounded theory approach is flexible in nature, this approach also consists of explicit guidelines to analyze qualitative data. These are described in the section on procedures. I use these guidelines, along with certain tenets of disability theory, critical race theory and intersectionality described below, to critique the CCB.

2.1.3 The Models of Disablement

Disability scholarship attempts to explain how disability is influenced by the complex circumstances surrounding one’s health condition, personal and external social factors.\(^\text{41}\) A theoretical discussion of the various models of disability theory including the social model, the biomedical model and the economic model, along with critical race theory and intersectionality, are put forth to contextualize the analysis throughout the thesis and to acknowledge the multiple

\(^{38}\) *Ibid.* at 45. As Glaser and Strauss argue, “Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges.”


\(^{40}\) *Ibid.* at 244.

\(^{41}\) *Supra* note 30 at 107.
and intersecting grounds of discrimination. Since there is not one unifying theory of disability, relevant elements of each model are described. However, I argue that the social model of disability is most relevant to critiquing the CCB, thereby limiting the discussion of the economic and biomedical models.

### 2.1.4 The Social Model of Disability

Contemporary disability theorists such as Dianne Pothier, Susan Wendell, Lennard Davis and Jerome Bickenbach argue that people with disabilities experience inequality as a result of social factors. This social model suggests that the social environment creates barriers for people with disabilities to participate in society. The model relies on the assumption that “disability is not inherent in the individual,” and that there is something in society that needs to be fixed to address the social consequences of impairments.

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Social constructionists argue that society has perceived a negative attitude about disability using essentialist assumptions about what a normal body or mind should constitute. As Dianne Pothier argues:

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.\(^\text{45}\)

There are limitations to this theory. As Susan Wendell argues, 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.\(^\text{46}\) Moreover, the relationship between the psychiatric consumer/survivor movement and the disability movement is complex and contested. The social model of disability has not been fully embraced by psychiatric consumer/survivors because of the fear that a monolithic theory or set of ideas may subordinate them similar to the illness model of psychiatry.\(^\text{47}\) Thus, this study explores the possibility of using the social model of disability in order to apply it to psychiatric consumer/survivors.

\(^{45}\) Dianne Pothier, \textit{supra} note 43 at 526.

\(^{46}\) Susan Wendell, “Toward a Feminist Theory of Disability” in Debra Shogan, \textit{Reader in Feminist Ethics} (Toronto: Canadian Scholars’ Press, 1993) at 260. This critique has also been put forth by Tom Shakespeare, \textit{Disability Rights and Wrongs} (London: Routledge, 1996).

\(^{47}\) \textit{Ibid.} (Susan Wendell) at 213.
In order to explore the relevance of using a social model for psychiatric consumer/survivors, it is important to note the differences between the approaches of the disability movement and that of the psychiatric consumer/survivor movement. 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.\(^{48}\)

In contrast, Barnes and Mercer characterize the psychiatric consumer/survivor movement by a partnership model with four characteristics:

1. There has been strong pressure for [psychiatric consumer/survivors’] involvement to be in mental health service based initiatives.
2. Most of the efforts and energy of [psychiatric consumer/survivors] who become involved has been focused on reforming traditional mental health services.
3. Much of the involvement of [psychiatric consumer/survivors] has been related to the service, policy and practice system…
4. Much of the funded activity of [psychiatric consumer/survivors] has been in non-user controlled voluntary and statutory organizations.\(^{49}\)

The social model emphasizes that a person may have no functional limitations aside from those imposed by societal prejudice, stigma and stereotype.\(^{50}\) In light of this,


\(^{49}\) *Ibid.* (Peter Beresford) at 212.
the social model has provoked interest amongst the psychiatric consumer/survivor movement because it may be able to highlight issues of personal experience and social oppression. 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.\textsuperscript{51}

When applied to mental health, the model rejects the value of psychiatric diagnosis within the medical model and emphasizes the “socially constructed nature of impairment.”\textsuperscript{52} Thus, this model is especially relevant to understand the role that race, ethnicity, religion, immigrant/refugee status, language, sexual orientation, class, gender and disability plays on the CCB’s jurisprudence. This will be highlighted in the legal analysis to emphasize how cultural and racial issues are largely peripheral to the dominance of the medical model\textsuperscript{53} within the CCB’s jurisprudence.

\begin{flushright}
\textsuperscript{50} Jerome E. Bickenbach, \textit{supra} note 43 at 92.
\textsuperscript{52} \textit{Supra} note 49 at 218.
\textsuperscript{53} Carol Thomas and Mairian Corker, “A Journey Around the Social Model” in Marian Corker and Tom Shakespeare, \textit{Disability/Postmodernity: Embodying Disability Theory} (London: The Cromwell Press, 2002) at 19. Although the social model has also been critiqued for not directly incorporating other oppressions such as racism and sexism, critical race theory and intersectionality will be used in this study to highlight the relevant areas.
2.1.5 The Bio-Medical Model of Disability

The bio-medical model of disability focuses on the physical or mental impairments of the individual and places an emphasis on clinical diagnosis and medical intervention.\(^\text{54}\) Within this model, clinicians are viewed as “experts” and there is a focus on “prevention, cure, containment of disease pain management, rehabilitation and palliative care.”\(^\text{55}\) For the purposes of this thesis, the bio-medical model is akin to the illness model of psychiatry. In the illness model, psychiatric consumer/survivors’ problems related to “thinking, emotional reaction, feelings, fears, anxieties, depressions, etc. are conceptualized in terms of illness, dealt with - treated - with a variety of interventions aimed at ‘cure’ or ‘alleviation of symptoms (of illness).’”\(^\text{56}\) There is an implicit assumption that psychiatric consumer/survivors should accept that they are ill and treatment should take place within a hospital by medically-trained professionals.\(^\text{57}\) Mental illness is seen as a biochemical imbalance. Social relationships and cultural factors are secondary and often irrelevant to treatment.\(^\text{58}\)

Proponents of the social model argue that the medical model of disability has not been “selected through a neutral or disinterested process,” but rather “through an

\(^{54}\) Jerome E. Bickenbach, *supra* note 43 at 92.

\(^{55}\) Jerome E. Bickenbach, *supra* note 43 at 92.


\(^{58}\) *Ibid.*
The illness model of psychiatry has been critiqued within the profession itself by psychiatrists such as Thomas Szasz⁶⁰ and Ronald David Laing⁶¹ who argue that the concept of mental illness and psychiatric treatment is a form of “social control.”⁶² Szasz argues that involuntary detention poses a greater form of social control than prison because “it entails far greater deprivation of rights than does incarceration in prison, a penalty carefully circumscribed by constitutional guarantees and judicial safeguards.”⁶³ Although the medical profession does not readily accept these views, the critique has put pressure on the discipline of psychiatry to become sensitive to social issues such as racism and other barriers to care faced by psychiatric consumer/survivors.⁶⁴

The critique of the bio-medical model highlights the problem of subjective bias within psychiatric diagnosis.⁶⁵ For instance, the literature reveals that there is higher

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⁶² Supra note 60 at 48.


⁶⁴ Kamaldeep Bhui and Dinesh Bhugra, Culture and Mental Health (Oxford: Edward Arnold Publishers, 2007) at 227. Some of the barriers to care include “inadequate numbers of trained and acceptable mental health workers; limited awareness of mental disorders; and reliance on ethno-specific social agencies that are not designed to provide specialized mental health care.”

⁶⁵ Aaron Dhir, supra note 22 at 104.
probability of misdiagnosis in situations where the psychiatrist and patient have evident cultural and social differences. Suman Fernando argues that other dangers the medical model carries for psychiatric consumer/survivors from racialized communities 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.”

In regard to the CCB, the bio-medical model forms the basis of what the legislation and policies of the CCB are based upon. The psychiatrist may be inclined to “achieve a good clinical outcome” which may be in conflict with the psychiatric consumer/survivor’s own values and the lawyer advocating on behalf of him or her. Since a psychiatrist is also an adjudicator on the panel of the CCB, lawyers have argued that it may be questionable whether a “rights analysis may be corrupted by a paternalistic ‘for their good approach.’” These concerns are further complicated by factors such as race, ethnicity and culture.

67 Supra note 56 at 35.
68 Interview with a lawyer on November 17, 2008. This argument will be further explored in the next chapter.
71 Interview with a lawyer on December 5, 2008.
I will use these arguments and concerns regarding the biomedical model of disability, along with the elements of the theories highlighted throughout this chapter to critique the CCB’s work. Examples of the cultural influence upon capacity assessments leading up to the CCB hearing, the psychiatrists’ reports and the therapeutic relationship between the psychiatrist and the psychiatric consumer/survivor will be discussed. By highlighting the tension between the social model of disability and the medical model of disability, I argue that the CCB must balance the “uncontrollable and immutable” reality of psychiatric consumer/survivors’ limitations along with the cultural realities that continue to create barriers for ethno-racial psychiatric consumer/survivors.  

2.1.6 The Economic Model of Disability

The economic model of disability views someone with a disability as one “who embodies an economic cost that must be factored into society-wide economic policy decisions.” The economic efficiency of the individual is determined by the individual’s capacity to contribute to the labor market. This is valued against the potential societal cost of accommodating the person in order for him/her to participate and integrate into society. Policy makers use this model to apply a cost-benefit analysis when entitling disabled workers to vocational rehabilitation, disability accommodations and welfare benefits.

72 Ibid.
73 Jerome E. Bickenbach, supra note 43 at 13.
74 Jerome E. Bickenbach, supra note 43 at 104-105.
An economic model appears to have underpinned decision-making in immigration cases involving persons with disabilities that were excluded under the excessive demand criteria under s. 38 (1) (c) of the Immigration and Refugee Act. Specifically, s. 38 (1) c) of IRPA states that a foreign national may be medically inadmissible to Canada and denied a visa (or refused entry at the border) based on his or her medical condition if he or she “might reasonably be expected to cause excessive demand on health or social services.”

According to the regulations, the excessive demand is determined by seeing if the “anticipated costs” would exceed the “costs of health and social services for the average Canadian over a period of five consecutive years…” or “would add to existing waiting lists for those services and would increase the rate or mortality and morbidity in Canada by denying or delaying access to those services to Canadian citizens or permanent residents.” This regulation has been problematic in cases such as Chesters v. Canada.

75 Immigration and Refugee Protection Act, S.C. 2001, c. 27 [IRPA].
76 IRPA, S.C. 2001, c. 27, s. 38 (1). Under section 1 of the Immigration and Refugee Protection Regulations, "excessive demand" means (a) a demand on health services or social services for which the anticipated costs would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years immediately following the most recent medical examination required by these Regulations, unless there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years; or (b) a demand on health services or social services that would add to existing waiting lists and would increase the rate of mortality and morbidity in Canada as a result of the denial or delay in the provision of those services to Canadian citizens or permanent residents. Immigration and Refugee Protect Act Regulations, S.O.R./2002-227, s.1 [IRPR].
77 Under IRPR, S.O.R./2002-227, s. 30 (1): Those who have to have a medical examination include: a) foreign nations and family members applying for a PR visa (b), foreign nations seeking to work in Canada in area where protection of public health essential (c) foreign nations seeking to renew work or study permit and have resided for 6 months in an area the Minister determines has a higher incidence of serious
Although these cases did not directly involve psychiatric consumer/survivors, they are important to point out because they highlight the problems underpinning the economic model.

For instance, in Chesters, the reasoning behind the case suggested that a “disability itself” should be seen as enough to prevent one from immigrating to Canada, reinforcing the attitude that immigrants and refugees with disabilities are a “burden,” and will have “excessive demands” on the health and social services. Scholars have argued that this economic model is especially problematic because it purports to able-bodied assumptions which view the disabled as “non productive” members of society, with the assumption that they cannot contribute to the mainstream work environment. As Bickenbach remarks,

[i]t is ironic that though the economic transformation of disablement, in conjunction with other developments in rehabilitation and social welfare programming, created aspects of disablement policy that were not there before, it also fundamentally distorted disablement

communicable diseases (d) refugees.

79 [2005] 2 S.C.R. 706 [Hilewitz and DeJong].
80 Ibid.
by focusing exclusively on the economic problem posed by workers with limited repertoires of productive capacities. Disablement became, in order words, a supply-side labour-market issue, nothing more or nor less.\textsuperscript{83}

This model is not central to a critique of the CCB. However, its theoretical underpinnings are useful because of its focus on the impairment of the individual, which is similar to the bio-medical model of disability.\textsuperscript{84} Also, the economic model of disability will be used in the section on recommendations because it seeks reform at the structural and policy levels.\textsuperscript{85}

\textbf{2.1.7 Critical Race Theory}

Using tools of constructionism, critical race theorists exemplify how race, difference and identity are relational categories that are distinct from purely descriptive or inherent categories.\textsuperscript{86} Critical race theory is essential to the project of deconstructing the impact that race can have within the legal context. The theory can help in explaining how institutional and social practices contribute to discriminatory experiences for psychiatric consumer/survivors before the CCB. Since disability should not be seen as an isolated phenomenon, critical race theory is especially relevant in highlighting the fact that there may be additional barriers ethno-racial psychiatric consumer/survivors face as a result of

\begin{thebibliography}{99}
\bibitem{83} Jerome E. Bickenbach, \textit{supra} note 43 at 126.
\bibitem{84} Jerome E. Bickenbach, \textit{supra} note 43 at 104-105
\bibitem{85} Jerome E. Bickenbach, \textit{supra} note 43 at 104-105.
\bibitem{86} Susan Williams, “Feminist Legal Epistemologies” (1993) 8 Berkeley Women’s Law Journal 63 at 64.
\end{thebibliography}
their linguistic, racial and ethnic background. Therefore, critical race theory is used in this thesis to question the “neutrality” and “objectivity” of the CCB’s jurisprudence, policies and legislation.

Critical race theory is relevant to a critique of disability discourse because the unmarked disability identity is often modeled on a white Euro-American disability experience. As Fellows and Razack argue, “the systems of domination that position white, middle-class, heterosexual, nondisabled men at the centre continue to operate among all other groups, limiting in various ways what [marginal groups] know and feel about one another.” The intersection of race and disability has not been readily explored. But, parallels can be drawn. As contemporary theorists of disability and race argue, the “impairment of disability,” along with what “constitutes a racial category is socially constructed.”

It is important to note that the Canadian research about the incidences of disability amongst various racial and ethnic lines is limited, with the exception of the identification of disability among Aboriginal peoples in Canada. Little research has been conducted


regarding other racial groups.\textsuperscript{90} Groups that have brought a critical race component to their research include the Ethno Racial People with Disabilities Coalition of Ontario, the ARCH Disability Law Centre as well as the Association Multi Ethnique L’intergration des Personnes Handicapees du Quebec.\textsuperscript{91} However, this research is not primarily on psychiatric consumer/survivors.

Critical race theory recognizes law “as both a product and a promoter of racism”\textsuperscript{92} because it may be used by the “more powerful to oppress the less powerful in society and to maintain the existing political, social and economic status quo.”\textsuperscript{93} Critical race theorist Carol Aylward identifies six dominant themes of critical race theory in the Canadian context.

1. The need to move beyond existing rights analysis.

2. An acknowledgement and analysis of the centrality of racism and not just the White supremacy form of racism but also the systemic and subtle forms that have the effect of subordinating people of colour.

3. A total rejection of the “colour-blind” approach to law, which ignores the fact that Blacks and Whites have not been and are not similarly situated with regard to legal doctrines, rules, principles and practices.

4. A contextual analysis which positions the experiences of oppressed peoples at its centre.

5. A deconstruction which asks the question: How does this legal doctrine, rule, principle, policy or practice subordinate the interests of Black people and other people of colour?

\textsuperscript{90} Ibid. at 6.
\textsuperscript{91} Ibid. at 6.
\textsuperscript{92} Mari Matsuda, \textit{Where is Your Body? And Other Essays on Race, Gender and the Law} (Boston, MA: Beacon, 1996) at 22.
6. A reconstruction which understands the duality of law, recognizing both its contribution to the subordination of Blacks and other people of colour and its transformative power.\(^9^4\)

In this thesis, the themes given above are used to ensure that contextual analyses of the experiences of ethno-racial psychiatric consumer/survivors who appear before the CCB are fully examined.

2.1.8 Intersectionality

This thesis employs intersectionality as an analytical tool, along with the grounded theory approach, models of disablement and critical race theory. The concept of intersectionality is defined as “intersectional oppression that arises out of the combination of various oppressions which together produce something unique and distinct from any one form of discrimination, standing alone.”\(^9^5\) In a legal context, intersectional analysis enables one to consider the historical, social and political context, which contributes to the experiences and barriers an individual may face. Adjudicators may treat “race, colour, ethnic origin, ancestry, and place of origin as a single category.”\(^9^6\) This is problematic because these social categories must be seen to operate relationally and they cannot stand alone as additive categories.\(^9^7\)


\(^{96}\) *Ibid.* at 10.

\(^{97}\) *Supra* note 87 at 3.
Specifically, an intersectional analysis has been used in human rights jurisprudence to ensure that adjudicators understand the complexity of the intersecting oppressions and identities that result in discrimination. 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.

For instance, in *Radek v. Henderson Development (Canada) Ltd.*, an intersectional approach is used by the British Columbia Human Rights Tribunal to examine the intersections between the grounds of race, gender, disability and class. The reasoning of the case illustrates the tribunal’s willingness to understand that Radek’s experience of discrimination was complex and unique because of the “multiple facets” of her identity.

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100 “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
The intersectionality paradigm is used in this thesis to highlight the multiple levels of discrimination experienced by ethno-racial psychiatric consumer/survivors. In regard to the CCB specifically, intersectionality will be used to question whether the experiences of psychiatric consumer/survivors from ethno-racial communities are “qualitatively different” as result of a combination of their intersecting identities.\(^{101}\)

It is important to note the limitations of using an intersectional analysis. Since qualitative research can only attempt to study a few intersections at once, intersectionality is best employed in research that is aimed at “small sample sizes and in-depth data gathering techniques.”\(^{102}\) The researcher must also be cautious not to generalize the findings and perpetuate negative stereotypes when studying intersections such as race, culture and ethnicity.\(^{103}\)


\(^{103}\) Ibid.
2.2 Procedures

2.2.1 Participants: Inclusion Criteria and Recruitment

For the qualitative component of this thesis, the grounded theory approach and relevant elements of the theories, which I described above in the theoretical framework, is used to analyze the data obtained from twenty personal interviews. I have conducted interviews with five members of each of the following stakeholders: lawyers, psychiatrists, mental health service providers, CCB adjudicators\(^{104}\) and psychiatric consumer/survivors from various ethno-racial communities. These stakeholders were chosen because of their role in the CCB legal process and/or the wider mental system.

The following inclusion criteria are used for the lawyers, psychiatrists and mental health service providers:

1. Licensed lawyers, psychiatrists and mental health service providers in Ontario.\(^{105}\)
2. Experience working with psychiatric consumer/survivors from ethno-racial communities.

The potential participants from these stakeholder groups 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,”

\(^{104}\) The CCB adjudicators are included amongst the lawyer, psychiatrist and service provider categories.

\(^{105}\) Although mental health service providers may not be licensed, they should be qualified to work with psychiatric consumer/survivors in Ontario.
which involves requesting initial contacts to refer to their peers. Appendix B is an example of the initial script that was used to contact participants. Throughout the research process, I also attended a number of CCB hearings and I joined the mental health legal committee, which enabled me to fully understand the nuances of the legal proceedings.

The inclusion criteria for psychiatric consumer/survivors from various ethno-racial communities are:

1. Psychiatric consumer survivor from an ethno-racial community in Ontario.
2. Has been through a CCB hearing within the last three years (2006-2009).
3. Over the age of 18 years
4. Considered capable by their doctor or caseworker of participating in the interview process.
5. Main diagnosis: mental health.

It is important to note that the Centre of Addiction and Mental Health (CAMH) was the site chosen to interview psychiatric consumer/survivors because it is a University of Toronto-affiliated teaching hospital and it was more accessible. In light of the stringent ethics procedures at CAMH, I contacted doctors and caseworkers to arrange interviews

\[\text{Supra note 29 at 605.}\]

\[A\] committee comprised of lawyers advocating on behalf of psychiatric consumer/survivors in Ontario.

\[\text{The exclusion criteria was: 1) substitute decision maker 2) on a community treatment order 3) not considered stable by their team.}\]

\[\text{Findings may have varied if I had interviewed ethno-racial psychiatric consumer/survivors in other hospital settings.}\]
with psychiatric consumer/survivors. Appendix A is an example of the contact script that was used.

### 2.2.2 Interview Process

Semi-standardized interview guides were used throughout the data collection procedure, which are provided in Appendices C to G. This approach to interviewing ensures some structure to presenting the questions, and also enables respondents to react to the open-ended questions in a flexible interviewing style.\(^{110}\) The interview guide includes approximately twenty questions that were modified during the interview depending on the aspects that were relevant to focus upon. When creating the interview guide, the questions were derived from informal discussions with lawyers practising mental health law, advice from my supervisors, my own personal experiences advocating on behalf of psychiatric consumer/survivors from various ethno-racial communities and relevant literature, which is referred to in the forthcoming chapter.

After the potential participants were contacted and agreed to participate, they were interviewed in a location of their choosing in Toronto as long as it was private and the conversation could not be overheard. One participant was interviewed over the phone as he resided in Ottawa and meeting in person was not feasible.\(^{111}\) During the interview, a recording device was used so that the interviews could be transcribed and analyzed in

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\(^{111}\) Interview with a CCB adjudicator on January 30, 2009.
more detail afterwards. The interviews were approximately forty-five minutes to one hour long.

2.2.3 Informed Consent Process

In order to receive ethics approval for conducting these interviews, I had to go through two separate ethics approval processes. The process through the Research Ethics Board (REB) at the University of Toronto was relatively straightforward. There were few amendments to be made, and I received approval within two months of my submission.\footnote{I submitted the forms on September 11, 2009 and I received approval on October 24, 2009.} In contrast, the ethics process through CAMH’s REB was more complicated since the interviews involved psychiatric consumer/survivors, a vulnerable population. Thus, it took three submissions with amendments before I received a final approval at CAMH’s REB.\footnote{I submitted the CAMH forms on December 2, 2009 and I received final approval on March 19, 2009. I would not have been able to even have access to CAMH without the assistance and support of my supervisor at CAMH, Dr. Kwame McKenzie.}

Before beginning the interviews, I outlined the objectives of my research, addressed issues of confidentiality, reviewed the consent form and invited participants to ask questions if necessary. As per the guidelines through the Research Ethics Board at the University of Toronto and at CAMH, a written consent form was used. These are attached in Appendices H and I. Regarding privacy, all the informants’ data was kept anonymous for the purposes of this study. Informants are identified in this thesis only with reference to their stakeholder name (i.e. lawyer, psychiatrist, service provider, CCB adjudicator or psychiatric consumer/survivor).
2.2.4 Analysis of the Interviews

The analysis of the data is divided into three steps. First, I wrote down a preliminary interpretation of the data. This consisted of notes, and ideas highlighted during the interview, which were later used in the legal analysis. Second, I transcribed each interview in order to fully immerse myself into the data and ensure that connections between them could be drawn. Third, I was able to analyze the information according to Glaser and Strauss’ constant comparative method,\footnote{Supra note 37 at 105. 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 simultaneously throughout the analysis and each provides continuous development to its successive stage until the analysis is terminated.”} and the elements of the theories described in the theoretical framework of this chapter.

Specifically, Glaser and Strauss’ constant comparative method involved comparing and contrasting ideas within a transcribed interview to another. The result of this comparison – referred to as “coding” was written in the margin of each interview. This process enabled me to recognize the categories and sub-categories (themes) emerging from the data.\footnote{Ibid.} Although the preliminary categories of “procedural barriers,” “systemic/structural barriers,” and “discretionary barriers,” were used, other themes emerged during the coding process. The relevant tenets of the theories within the theoretical framework described in this chapter were used to analyze the data from different perspectives. It is important to note that the analysis was an evolutionary
process. As outlined by the grounded theory approach, there was constant re-visitation to the data so that the categories and findings were refined.\textsuperscript{116}

2.3 Conclusion

In this chapter, I have developed a theoretical framework that uses the grounded theory approach, in combination with tenets of disability theory, critical race theory and intersectionality. This theoretical framework is used to analyze the qualitative data and inform the legal analysis of the CCB. I have argued that the social model of disability is more relevant to critiquing the CCB than the economic and medical models. In the section on procedures, I describe the inclusion criteria and recruitment process for the participants, the interview process, the informed consent process and the data analysis procedures. The findings and interpretations emerging from the analysis are presented in the forthcoming chapter.

CHAPTER 3
LEGAL ANALYSIS AND FINDINGS

This chapter identifies and analyzes the legal barriers perceived to differentially affect psychiatric consumer/survivors from various ethno-racial communities who appear before the CCB. I use the theoretical framework developed in the previous chapter to analyze the qualitative interviews. The results are organized into three major sections of “Procedural Barriers,” “Systemic/Structural Barriers,” and “Discretionary Barriers.” The themes and issues that emerge within these categories are drawn following a thorough analysis of the interviews and the relevant literature. My claim that the CCB fails to adequately take into account race, ethnicity, culture, poverty and social exclusion within its processes and jurisprudence is strengthened by empirical evidence. As many of the CCB’s decisions are not written, and there is a dearth of literature examining these issues, this empirical research is an important contribution to the literature. The themes that emerge challenge the medical model of disability through an analysis of the diverse social realities which marginalize psychiatric consumer/survivors from ethno-racial communities.117

117 However, in light of the limited scope of this thesis, these findings are not conclusive statements and they are grounded in the views of the respondents. The semi-standardized interview guides used throughout the data collection procedure are provided in Appendices C to G.
3.1 Procedural Barriers

3.1.1 The Context

Since neither the CCB nor CAMH keep statistics on the ethnic break-up of its clientele, a preliminary point of inquiry for this thesis was to ascertain the particular ethnic backgrounds of psychiatric consumer/survivors appearing before the CCB. The majority of respondents indicated that ethno-racial psychiatric consumer/survivors appearing before the CCB were generally from Punjabi, Tamil, Arab, Vietnamese, Caribbean, Cambodian and Chinese communities.

Respondents indicated that the types of legal cases involving psychiatric consumer/survivors from ethno-racial communities most often concerned involuntary status, treatment incapacity, and financial incapacity. However, more empirical research should be conducted given the lack of statistics available. As one respondent

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118 There are no statistics available on the ethnic backgrounds of psychiatric consumer/survivors appearing before the CCB. In this regard, the extent of information available is very limited. The statistics that are available include CAMH’s patient profile, which unfortunately does not document the ethnicity of patients. For instance, 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 “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, 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.

119 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

120 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
argued, “It is difficult to try and improve the CCB in regard to diversity issues or hold it accountable when there is no data available on racialized clients, in terms of statistics.”

3.1.2 Conception of Mental Health Amongst Ethno-Racial Communities

Cultural and religious factors often influence how mental health is perceived amongst ethno-racial communities. As suggested by Branka Agic, the “cultural meaning of mental illness defines how people receive health promotion messages, what is considered to be a mental health problem and what kind of help is preferred.” For this thesis, I inquired into this area in order to contextualize the experiences of ethno-racial psychiatric consumer/survivors before the CCB. The question posed to respondents was: “How is mental health/disability is perceived differently amongst various ethno-racial communities?” Respondents found this question difficult to answer because perceptions of mental health could vary tremendously amongst different cultures and even amongst certain families. For instance, a service provider emphasized how Somali communities often viewed mental illness as a “gift from God.”

121 Interview with a service provider on January 20, 2009.
123 Ibid. at 5.
124 This question is found in Appendices C to G. The question posed to ethno-racial psychiatric consumer/survivors was: “How is mental health viewed in your community?”
125 As respondents indicated, culture is not static, and it is amorphous and changing.
126 Interview with a service provider on January 20, 2009.
As she explained,

When you are dealing with a community who thinks it is like a gift, and that is why the person is behaving differently from the rest of the population – you cannot discount that idea, but on the other hand, you have to deal with how that idea is affecting the person’s life, functioning and how it is disabling that person.” 127

In contrast, a few respondents felt that individuals from ethno-racial communities present symptoms of mental illness in the form of somatic complaints (making no distinction between the body and mind) because it is perceived to be more acceptable. 128

3.1.3 Stigma

Indeed, these cultural conceptions are influenced by the severe stigma associated with mental illness amongst ethno-racial communities. For instance, a consumer/survivor felt “it is a double stigma.” 129 As a psychiatrist explained,

The stigma is both ways – so people from diverse groups are stigmatized two times because you are not only stigmatized by people outside, but also by yourself – from internal stigma. When you have self-stigma, you don’t fight for your rights because it infiltrates inside.” 130

127 Interview with a service provider on January 20, 2009.
128 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009; Supra note 122.
129 Interview with a psychiatric consumer/survivor on May 13, 2009.
130 Interview with a psychiatrist on November 5, 2008.
As a result of varied understandings of the causes and treatments of mental illness, the stigma of mental illness amongst ethno-racial communities extends to the family and the entire community more than in mainstream society.\textsuperscript{131} As a lawyer suggested, “North American cultures are not free from stigma either. But, the individualistic culture promotes more freedom in talking and dealing with it.”\textsuperscript{132}

### 3.1.4 Culture-Bound Syndromes

Respondents emphasized that the Western definitions of mental illness could not be applied homogenously to ethno-racial communities.\textsuperscript{133} For instance, a psychiatrist suggested, “We call certain things mental health which is not mental health in other cultures. We define things differently.”\textsuperscript{134} A consumer/survivor argued, “How can someone say what is normal in my culture is not normal in another? Where does cultural sensitivity begin and psychiatric symptoms start?”\textsuperscript{135}

Research indicates that although the symptoms of mental illness are similar across cultures, its manifestations and how people interpret the symptoms often vary with race, ethnicity, and culture.\textsuperscript{136} Specifically, the World Health Organization lists twelve frequently culture-bound syndromes in the ICD-10 (International Classification of

\begin{itemize}
  \item \textsuperscript{131} Interview with a psychiatrist on November 5, 2008. This will be analyzed further in the section on “Systemic/Structural Barriers.”
  \item \textsuperscript{132} Interview with a lawyer on December 5, 2008.
  \item \textsuperscript{133} Interview with a service provider from November 2008 until May 2009.
  \item \textsuperscript{134} Interview with a psychiatrist on November 5, 2008.
  \item \textsuperscript{135} Interview with a psychiatric consumer/survivor on January 19, 2009.
\end{itemize}
The classification of culture-bound syndromes challenges the standard psychiatric classifications within the illness model of psychiatry. Although these syndromes may not arise in cultures outside of Western society, respondents referred to these because they highlight the fact that there is “no such thing as a culture free syndrome – all disease classifications have to exist in a cultural context” and psychiatrists need to make culturally appropriate diagnoses.

Psychiatric consumer/survivors interviewed felt that it was important for the CCB, lawyers, psychiatrists and service providers to understand the different cultural approaches to dealing with mental health crises. For instance, a majority of respondents made reference to the well-known WHO studies which found that long-

137 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, supra note 64 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.

138 Cheryl Ritenbaugh, “Obesity as a Culture Bound Syndrome” (1982) 6:4 Culture, Medicine and Psychiatry 347 at 347. According to Rittenbaugh, the following four criteria should be used to define a culture bound syndrome: 1) It cannot be understood apart from its specific cultural or subcultural context; 2) the aetiology summarizes and symbolizes core meanings and behavioural norms of that culture; 3) diagnosis relies on culture specific technology as well as ideology; 4) successful treatment is accomplished only by participants in that culture.


140 Data derived from interviews with consumer/survivors on April 8, 2009 and May 13, 2009.

term outcomes for recovery from schizophrenia were better in developing countries than developed countries.\textsuperscript{142} Explanations of the findings suggest that the more benign outcomes in developing countries are a result of the following four factors:

1. Cultural belief systems that externalize causality, freeing the patient and family of blame;

2. Expectancies of temporary aberration and speedy recovery, which avoid self-devaluation and preserve social acceptance;

3. Greater opportunities for social reintegration and normalized world roles in agrarian economies; and

4. Extended kinship networks to buffer the effects of illness on the patient and their caregivers.\textsuperscript{143}

Respondents referred to these studies to make the argument that community integration, family support and alternative therapies instead of pharmacological treatment could have a role in the recovery of mental illness.\textsuperscript{144}

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\textsuperscript{142} Ibid.; Data derived from interviews conducted with lawyers from November 2008 until May 2009.
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\textsuperscript{144} Interview with a service provider on January 20, 2009.
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3.2 The Pre-Hearing Process

3.2.1 Perception of Inaccessibility

A common view expressed by respondents is that cultural factors inhibit some ethno-racial psychiatric consumer/survivors from taking part in the CCB hearing process.\textsuperscript{145} The process of receiving rights advice under s.15 of the MHA is straightforward. Specifically, a 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 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.”\textsuperscript{146} In Ontario’s major hospitals (including CAMH), a rights adviser is supposed to explain to the person the importance of the medical finding of incapacity and the option to make an application to the CCB to review the finding.\textsuperscript{147} If the person agrees, the rights adviser often assists in making the legal aid application and contacts the lawyer of the person’s choosing.\textsuperscript{148}

At a general level, the respondents expressed that this process worked “fairly well” to ensure that those interested in applying for legal aid had assistance.\textsuperscript{149}

\begin{footnotesize}
\begin{itemize}
\item Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and consumer/survivors from November 2008 until May 2009.
\item s. 15 Reg. 741 to MHA, R.S.O. 1990, c. M.7.; \textit{Supra} note 11 at at 6, 9 and 311.
\item \textit{Supra} note 11 at 6, 9 and 311.
\item Interview with a service provider on January 13, 2009
\item Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
\end{itemize}
\end{footnotesize}
instance, one respondent commented that Legal Aid Ontario (LAO) was flexible in recognizing that refugees, regardless of their status, were provided a lawyer if they were involuntarily detained. During the rights advice process, interpretation services are also available for those who do not speak English.

Respondents emphasized that, the fact that the applicants made the decision to participate in the CCB process was a barrier itself because “a lot of people from ethno-racial communities don’t really want to use the system or they don’t really understand it.” Psychiatric consumer/survivors from ethno-racial communities may have a different understanding of the mental health system and their civil rights. The idea of contesting their doctor’s decision was intimidating and unfamiliar because of the “trust” bestowed upon the doctor. The majority of lawyers reported that the type of legalese and language used to convey the “rights information” actually deterred psychiatric consumer/survivors from ethno-racial communities from participating in CCB hearings. For example, a consumer/survivor stated: “I didn’t understand…what is the

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150 Interview with a lawyer on November 17, 2008. Although refugees are not usually allowed legal aid, this lawyer suggested that clients are not denied legal aid eligibility on that basis.

151 Respondents express that the quality of interpretation is questionable and this will be further explored within this chapter.

152 Interview with a psychiatrist on Feb. 11, 2009; Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

153 Interview with a psychiatrist on November 5, 2008.

154 Data derived from interviews conducted with lawyers from November 2008 until May 2009.

155 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
point of a process that just tells me I am crazy anyways? Others expressed the view that the process “sounded scary” and “difficult” because the hearing was in opposition to their doctor, whom they trusted.\textsuperscript{157}

The notion of “medical treatment” in certain cultures may be fundamentally different. As a psychiatrist suggested;

In some cultures, they never go to the hospital until they die. So if the patient doesn’t see the hospital as somewhere they can get treatment, but instead as a jail then they fight it. And, if you say, you go to a hearing to be against the doctor, they may wonder, why should I go against my doctor?\textsuperscript{158}

The concept of appealing a doctor’s decision is unfamiliar and the “adversarial system is a real setback.”\textsuperscript{159} For some ethno-racial psychiatric consumer/survivors, it is not just an issue of civil rights or individual freedom because of strong cultural norms and conflicting family values. For instance, the families of some South Asian, Chinese or African psychiatric consumer/survivors may view all treatment recommended by physicians as necessary, thereby advocating that the person stays in hospital against the person’s wishes.\textsuperscript{160} Thus, culturally derived beliefs influence why psychiatric

\begin{flushend}
\textsuperscript{156} Interview with a psychiatric consumer/survivor on May 13, 2009
\textsuperscript{157} Interview with a psychiatric consumer/survivor on April 8, 2009
\textsuperscript{158} Interview with a psychiatrist on November 5, 2008.
\textsuperscript{159} Interview with a psychiatrist on February 11, 2009.
\textsuperscript{160} Interview with a psychiatrist on February 11, 2009; Interview with a psychiatrist on November 5, 2008.
consumer/survivors from ethno-racial communities continue to underutilize the CCB process.\textsuperscript{161}

### 3.2.2 Access to Counsel

I inquired into whether legal assistance was easily accessible for psychiatric consumer/survivors from ethno-racial communities. Overall, respondents felt that the system was well set up for ensuring that legal services were available.\textsuperscript{162} As previously explained, the rights adviser is able to assist people with completing the legal aid applications. However, respondents did express concerns about the extent to which lawyers were able to understand, represent and meet the needs of psychiatric consumer/survivors from ethno-racial communities. Specifically, lawyers indicated a barrier in the pre-hearing process was that they could not specify what language they spoke or which ethnic-background they belonged to on the “list of lawyers” used by the rights advisers.\textsuperscript{163} This is unfortunate because “clients pick their lawyer randomly” and there is a “problem of getting a lawyer who actually understands the client and their culture.”\textsuperscript{164} It can be especially daunting for those who do not speak English and would

\textsuperscript{161} Interview with a psychiatrist on February 11, 2009. This is in comparison to the majority culture.

\textsuperscript{162} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

\textsuperscript{163} Data derived from interviews conducted with lawyers from November 2008 until May 2009.

\textsuperscript{164} Interview with a service provider (rights adviser) on January 13, 2009; Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
prefer a lawyer from their own background who may have a better understanding of their cultural context and can speak the same language as their client.\footnote{Interview with a lawyer on December 5, 2008; Interview with a lawyer on November 17, 2008. Although they may try to pick a lawyer with a familiar last name, there is no guarantee that the lawyer will speak the same language as the consumer/survivor.}

Respondents believed that lawyers were often unable to recognize that a cultural issue was relevant to the hearing.\footnote{Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.} For instance, a lawyer argued that “We are often not trained to understand what the significance of a particular cultural act might mean if a client is from a diverse community – like from a Korean or from an Indo-Muslim community.”\footnote{Interview with a lawyer on December 5, 2008.} She suggested, “It is not that lawyers are not open. I think the concern is we often don’t recognize there is a cultural issue that is creating an issue before the CCB.”\footnote{Interview with a lawyer on December 5, 2008.} In this regard, lawyers have yet to develop a sophisticated understanding of how to incorporate the varied cultural backgrounds of psychiatric consumer/survivors in their challenge before the CCB. This comes up frequently in cases involving refugees who have come from oppressive regimes.\footnote{Interview with a lawyer on November 17, 2008.} Respondents were also concerned that there was a lack of diversity of counsel amongst lawyers in the mental health bar.\footnote{Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.}

Overall, the respondents’ views were consistent with Micheal Perlin’s claim that lawyers can be equally responsible as psychiatrists and adjudicators for the cultural
incompetence and the lack of rights realization in mental health law.\textsuperscript{171} Perlin attributes this to “sanism” which is defined 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...”\textsuperscript{172} 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.”\textsuperscript{173} Lawyers advocating for psychiatric consumer/survivors may be responsible for endorsing a paternalistic approach rather than an instruction-based advocacy model. This “gate keeper mentality” is complicated in CCB proceedings where dynamics of culture and ethnicity come into play.\textsuperscript{174}

Specifically, lawyers representing psychiatric consumer/survivors from various ethno-racial communities often grapple with cultural conflicts with the family of their clients, who have put faith in the advice of the psychiatrist and mental health system, in opposition to the client’s wishes.\textsuperscript{175} Respondents perceived these conflicts to occur more

\textsuperscript{171} Interview with a lawyer on March 5, 2008; 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.

\textsuperscript{172} Michael Perlin, supra note 171 at 74.

\textsuperscript{173} Interview with a supra note 171 at 74.

\textsuperscript{174} Interview with a lawyer on March 5, 2009.

\textsuperscript{175} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
amongst some ethno-racial communities because of the reverence placed upon the psychiatrist, and the acceptance of the inherent paternalism within the system. Family members wanted their loved ones to stay in the hospital, instead of having to face the stigma associated with mental illness in the community.\textsuperscript{176}

As a lawyer argued,

> Despite what the families say, the hospital may not always be the best place for the client and he or she may do better in the community. As advocates, we have to realize that the best way to approach your client is to be instruction based, regardless of what these instructions entail. We cannot be a gatekeeper for their concerns.\textsuperscript{177}

Similarly, a consumer/survivor stated, “I just wanted my lawyer to listen to me and not to my family.”\textsuperscript{178}

\textsuperscript{176} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009; These views are consistent with research that suggests, “persons in collectivist cultures, on the other hand, are enculturated in a shared set of mutual responsibilities. They may expect and accept the paternalism of other persons whose position dictates both obligation and authority.” Harriet P. Lefley, supra note 143 at 240; Joan G. Miller, “Cultural Diversity in the Morality of Caring: Individually-Oriented Versus Duty-Based Interpersonal Moral Codes” (1994) 28:1 Cross-Cultural Research 3.

\textsuperscript{177} In this quote, the lawyer was referring to the clients’ concerns when she said, “we cannot be a gatekeeper for their concerns.” Interview with a lawyer on November 17, 2008.

\textsuperscript{178} Interview with a psychiatric consumer/survivor on April 8, 2009. In contrast, a psychiatrist argued, “when you are successful as the patient’s lawyer, you may actually get the patient into a worse situation especially for the families. Because there is no one advocating for the family. So this patient may be violent at home but not violent in the hospital, so of course they will be discharged – so if there is no treatment arranged for the community situation, this can lead to tragedies.” Interview with a psychiatrist on November 5, 2008.
3.2.3 Psychiatrists’ Capacity Assessments

Respondents believe that psychiatrists’ capacity assessments prior to the CCB hearing failed to properly acknowledge the importance of culture, ethnicity and other socio-cultural factors. A common perception amongst those I interviewed was that cultural barriers and language discrepancies between the psychiatrist and ethno-racial psychiatric consumer/survivors led to incorrect capacity assessments. Cultural and racial stereotypes cause under-diagnosis or over-diagnosis. For instance, one psychiatrist suggested,

If African patients are uttering to the sky, we may diagnose them as being psychotic, but really they may be chanting. In these cases, we over-diagnose. But, in other cases – we can under-diagnose. With Chinese patients who are very quiet and don’t say

\[\text{\textsuperscript{179}}\] Data derived from interviews conducted with lawyers, psychiatrists, service providers CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009. Sections 15 (1) and 15 (1.1) in the MHA, R.S.O. 1990, c. M.7. set out the criteria for 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 Webers, [1994] O.J. No. 2767 (Gen.Div.). Specifically, s. 15 (1) Application for Psychiatric Assessment reads –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.
much. They are totally psychotic in their head and they don’t tell you. And we think okay- they can go home.\textsuperscript{180}

In some cases, respondents felt that religious and spiritual beliefs were inaccurately perceived as indicia of mental illness.\textsuperscript{181}

As the literature indicates, psychological distress is expressed differently across cultures depending on “culturally pervasive norms, generative themes, and health concerns.”\textsuperscript{182} Respondents indicate that it is imperative that psychiatrists understand not only the psychiatric symptoms of ethno-racial psychiatric consumer/survivors, but also their social history, their culturally embedded idioms of distress and their cultural standards of normality and abnormality.\textsuperscript{183} However, in light of the time restraints and lack of resources, the majority of psychiatrists felt that it was difficult to address cultural issues in capacity assessments.\textsuperscript{184} As one psychiatrist argued, “When patients talk about cultural issues, some psychiatrists don’t pay attention because they are not symptoms to be treated, and medication cannot take them away.”\textsuperscript{185} Thus, although psychiatrists are

\textsuperscript{180} Interview with a psychiatrist on November 5, 2008.

\textsuperscript{181} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.


\textsuperscript{183} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

\textsuperscript{184} Data derived from interviews conducted with psychiatrists from November 2008 until May 2009.

\textsuperscript{185} Interview with a psychiatrist on January 12, 2009.
trained to be culturally aware, respondents expressed strong concern that the cultural explanations for illness are not always factored into the assessments.  

3.3 Language/Communication Barriers

Respondents clearly felt that there were significant language and communication barriers for psychiatric consumer/survivors from various ethno-racial communities throughout the pre-hearing, hearing and post-hearing CCB process. Generally, respondents indicated that language was a greater challenge for those from Hong Kong, Chinese, Vietnamese or Korean communities than for those from South Asian or Middle Eastern communities, because those from the latter communities frequently had a greater facility in English.

3.3.1 Pre-Hearing: Language/Communication Barriers Within the Hospital

In 2007-2008, CAMH indicated that there were 2000 requests for interpretation services in approximately 50 different languages. Although psychiatrists and service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009; These views are consistent with the research presented in Paula Chaplan and Lisa Cosgrove, eds., Bias in Psychiatric Diagnosis (New York: Rowman and Littlefield, 2004).

Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

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, supra note 118.
providers interviewed believed that CAMH did have the “best interpretation” services available in the Toronto area, a number of barriers were identified in the pre-hearing stage. For instance, respondents felt that ethno-racial psychiatric consumer/survivors often had misunderstandings within the hospital because interpreters were not always available on the unit and generally only staff were able to request interpreters. This can be especially traumatic for ethno-racial psychiatric consumer/survivors who are being prescribed medications that they have concerns about and feel they need to communicate with their treatment provider. As a consumer/survivor expressed, “I have never understood what my medications were…and I have been on medications for almost thirty years.” Another lawyer argued, “If you are unable to communicate with staff, and you are standing outside the nursing station speaking in another language, and they don’t understand you, to me, that is a safety issue.”

190 However, it is important to note that different hospitals have different resources for interpreters. Respondents suggested that some hospitals in Ontario did not have a mandate for interpretation and using volunteers; Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

191 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

192 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

193 Interview with a psychiatric consumer/survivor on April 8, 2009.

194 Interview with a lawyer on November 17, 2008.
For instance, in *S.A. (Re)*,\(^{195}\) the attending physician in the emergency room had fundamentally misunderstood S.A. because of language and communication problems. In this case, the applicant was Arabic and there was no interpreter available for him in the emergency room. As a result, S.A. was involuntarily detained and he remained in hospital unnecessarily for the week prior to his CCB hearing. Since the applicant had limited English skills, the attending physician and treatment team misconstrued his failure to eat “normal” meals to support a finding of involuntary status. Despite the hospital’s position, the CCB was not persuaded by the limited evidence of mental disorder-induced serious physical impairment. The CCB reasoned that, “there were almost no objective signs at the time [of the applicant’s incapacity], and which may have emanated from at least a limited capacity on the part of the applicant to describe his history and that nicety which is required in the face of lack of any such signs.”\(^{196}\) The case illustrates the unfortunate impact that language and communication barriers within the hospital have upon ethno-racial psychiatric consumer/survivors.\(^{197}\) Appropriate cultural and interpreters services could have prevented S.A. and others the agony of staying in the hospital and being required to undergo a CCB hearing.\(^{198}\)

### 3.3.2 Pre-Hearing: Language/Communication Barriers During Lawyer/Client Meetings

The CCB does not provide interpreters for the pre-hearing meetings between the lawyer and his or her client. As previously explained, lawyers are not able to indicate

\(^{195}\) *S.A. (Re)*, 2007 CanLII 37457 (ON C.C.B.); TO-07-1551.


\(^{197}\) Interview with a lawyer on November 17, 2008.

\(^{198}\) Interview with a lawyer on November 17, 2008.
which language they speak on LAO’s “list of lawyers.”\textsuperscript{199} Since some of the ethno-racial psychiatric consumer/survivors do not speak English, interpreters are needed. Although legal aid will pay for interpreters during these meetings, lawyers interviewed felt that it was a “cumbersome” and “unreliable process” to arrange the interpreters.\textsuperscript{200} Specifically, lawyers have to arrange an interpreter within the seven day period of when the CCB hearing is supposed to take place. Often, rights advisers call the lawyer when only six days are remaining. Lawyers have to figure out if interpreters are needed, and then call LAO. Instead of arranging the interpreters for the lawyers, LAO has an “internal list” of interpreters through the Ministry of Attorney General, which it refuses to distribute to its lawyers. LAO reads out five names at a time to the lawyer on the phone. The lawyers are responsible for calling the interpreters and scheduling meetings within six days. As a lawyer explained, interpreters are often unable to work on such short notice and they refuse to work at legal aid rates. Consequently, some lawyers go without interpreters relying on the minimal English the client is able to understand.\textsuperscript{201} Thus, the barriers to communication remain because of the procedural inefficiencies of the system.

\textsuperscript{199} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

\textsuperscript{200} Data derived from interviews conducted with lawyers from November 2008 until May 2009.

\textsuperscript{201} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009; In some cases, lawyers may ask the interpreter to come a half an hour before the hearing if the CCB has scheduled them in advance (Interview with lawyer on November 17, 2008).
3.3.3 Pre-Hearing: Language/Communication Barriers During the Psychiatrists’ Capacity Assessments

The majority of respondents reported that psychiatrists would not use interpreters for the capacity assessments if ethno-racial psychiatric consumer/survivors appeared to have some knowledge of English. In these cases, “They cannot fully express what they want to say.” Since the psychiatrists are not often trained to work with interpreters, the assessments can take twice as long if an interpreter is involved. As a psychiatrist explained, “Although we have been trying to train psychiatrists to use interpreters more, we don’t make use of them enough because it makes the process more complicated. So, the reports vary a lot between those that are English speaking and non-speaking.”

In light of the language barriers, obtaining collaborative information from the families and understanding the full cultural context of the ethno-racial psychiatric consumer/survivors’ experience is difficult. As cultural psychiatry suggests, recognizing the culturally embedded idioms of distress or explanatory models of distress rest on the ethno-racial psychiatric consumer/survivor’s ability to communicate. In this regard, a psychiatrist argued that “language barriers create a higher potential for misclassification, misdiagnosis or mismanagement in the capacity assessments.”

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202 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

203 Interview with a psychiatrist on November 5, 2008.

204 Interview with a psychiatrist on January 12, 2009.

205 Interview with a psychiatrist on January 25, 2009; Juan E. Mezzich and Giovanni Caracci (eds), supra note 182.

206 Interview with a psychiatrist on January 25, 2009.
3.3.4 During the Hearing: Language/Communication Barriers

According to the CCB, interpreters were used for 62 hearings from January 2008 to December 2008, and for 29 hearings from January 2009 to July 2009. Respondents felt that the quality of interpretation during the CCB hearing was generally “okay.” However, respondents indicated that there were cases where the subjective bias of the interpreter was problematic during the CCB hearing. Specifically, a service provider referred to a case where a South Korean client was given an interpreter who was North Korean and wearing a nationalist symbol. The service provider believed that the client was obviously uncomfortable and tense during the hearing. She stated, “I really questioned whether the interpreter was putting in his own interpretation or not.”

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207 Email from CCB registrar on July 10, 2009. Interpreters were used for 44 hearings from April 2006 to December 2006 and for 51 hearings from January 2007 to December 2007.

208 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009. Section 18 of the CCB’s Rules of Practice indicates that the Board is responsible for arranging an interpreter for the hearing. 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>; accessed 23 November 2009.

209 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

210 Interview with a service provider on January 13, 2009.

211 Interview with a service provider on January 13, 2009.
were also other anecdotal accounts that were provided to me about interpreters who did not have the relevant expertise to properly translate medical evidence.\textsuperscript{212}

Overall, respondents felt that “cultural interpretation” was a barrier.\textsuperscript{213} As a psychiatrist explained:

I think interpreters can translate word for word, but translating a personal cultural experience is difficult for somebody even from the same country - but a different generation or different class. This requires an expertise that is sometimes beyond the average interpreter. It may take somebody who has more experience understanding the cultural context of the person.\textsuperscript{214}

In this regard, the lawyers interviewed felt that the lack of cultural interpretation during the hearing made it difficult to convey the ethno-racial psychiatric consumer/survivor’s story.\textsuperscript{215}

Although CCB adjudicators felt that they tried their best to stay away from medical jargon and legalese throughout the hearing process,\textsuperscript{216} three ethno-racial consumer/survivors interviewed indicated that they had trouble understanding the

\begin{itemize}
\item \textsuperscript{212} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
\item \textsuperscript{213} Data derived from interviews conducted with lawyers, psychiatrists, service providers CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
\item \textsuperscript{214} Interview with a psychiatrist on January 25, 2009.
\item \textsuperscript{215} Data derived from interviews conducted with lawyers November 2008 until May 2009.
\item \textsuperscript{216} Data derived from interviews conducted with CCB adjudicators from November 2008 until May 2009.
\end{itemize}
hearing, even when language was not an issue. Also, the majority of lawyers interviewed suggested ethno-racial psychiatric consumer/survivors’ accent, body language and demeanor might have contributed to the communication barriers.

### 3.4.5 Post Hearing: Language/Communication Barriers

Since the CCB’s written decisions and reasons are given in English, the CCB itself does not ensure that there is an interpreter or translator available for the person to understand the reasons for the decision. Respondents indicated this was the most significant language and communication barrier after the CCB hearing. As a CCB adjudicator expressed,

> It has never been stated as a requirement for anyone to translate or interpret the reasons for a decision. That is a hole in the system. We should be ensuring that our whole process is understandable, which includes the decision and the reasons for the decision.

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217 Data derived from interviews conducted with psychiatric consumer/survivors from November 2008 until May 2009.

218 Data derived from interviews conducted with lawyers from November 2008 until May 2009.

219 The Board renders its decisions within one day of the hearing. Most of the reasons for the decision are not written. Parties may request written reasons for the decision. This is supposed to be provided to the party within two days of the request. Data derived from interviews conducted with lawyers, psychiatrists, service providers CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

220 Data derived from interviews conducted with lawyers, psychiatrists, service providers CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

221 Interview with a CCB adjudicator on February 17, 2009.
3.4 During the Hearing

3.4.1 Perceptions of Comfort

I inquired into whether psychiatric consumer/survivors from ethno-racial communities were comfortable during the hearing and about their ability to participate in the hearing. A couple of themes emerged from the respondents’ views. Procedural barriers that affected the comfort of ethno-racial psychiatric consumer/survivors included the length of the hearings, the family’s involvement in the hearing and the adversarial nature of the hearings.\(^{222}\)

With regard to the length of the hearing, the CCB was flexible and there were no limits on how long hearings would last. Respondents suggested that hearings could last as long as seven hours and some continued on for almost two days or more. However, since a goal of the legislation includes “a fair and speedy resolution of the matters,”\(^{223}\) all of the psychiatric consumer/survivors interviewed felt that the hearings were too long. As a consumer/survivor argued, “As someone new to the mental health system in Canada, a seven hour hearing was too much. They should have warned me.”\(^{224}\)

\(^{222}\) Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

\(^{223}\) Interview with a CCB adjudicator on January 30, 2009.

\(^{224}\) Interview with a psychiatric consumer/survivor on May 13, 2009. The timing of the hearing was problematic for a psychiatric consumer/survivors who felt uncomfortable and tired because the hearing was so early in the morning.
Despite the length of the hearing, the CCB was perceived to be accommodating to the needs of ethno-racial psychiatric consumer/survivors during the hearing in certain respects.\textsuperscript{225} For instance, respondents felt that there were enough breaks given throughout the long hearings. Also, as per CCB’s rule 12.1, the hearings were held in the hospital where the psychiatric consumer/survivor was staying to ensure accessibility and convenience.\textsuperscript{226}

In general, respondents felt that ethno-racial psychiatric consumer/survivors had trouble answering questions put to them as part of a CCB hearing because of their language, cultural misunderstanding and lack of education.\textsuperscript{227} Specifically, respondents gave anecdotal accounts of this occurring in cases where recent immigrants were

\textsuperscript{225} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009. In contrast, psychiatrists interviewed complained that the process was unaccommodating for them. As a psychiatrist explained, “Hearings are way too long because they can drag on for two or three days! We have to book appointments weeks in advance. So to cancel a day’s office means how many phone calls, rescheduling people, and some people really need you.” Consequently, psychiatrists indicated that many of their colleagues try to avoid the CCB hearings as much as possible. Interview with a psychiatrist on February 11, 2009.

\textsuperscript{226} Supra note 11 at 554. As Hiltz and Szigeti explain, “The Board is a traveling tribunal and most of its hearings are held in the hospital, psychiatric facility or nursing home where the applicant is located. However, there are a number of applications which concern individuals residing in the community (for example, CTOs, financial capacity hearings under the SDA). While applicants may not want to return to a hospital where they have been held against their will in order to attend a hearing, there are competing considerations of physicians’ schedules and logistics of producing an original clinical record of a patient or former patient outside of the facility which controls and owns those records. The Board does have access to hearing rooms at its Toronto head office and will make hearing rooms available elsewhere across the province where necessary. Sometimes a neutral setting is itself helpful to facilitate the conduct of the proceedings.”

\textsuperscript{227} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
frightened they would “lose their immigration status” during the CCB hearings. Thus, they were much more apprehensive to willingly give information during the hearings.\footnote{Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.}

Another factor that affected the comfort of ethno-racial psychiatric consumer/survivors was the family’s role in the hearing. The majority of respondents felt that family support enhanced the comfort levels of those involved.\footnote{Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.} However, a few respondents felt that some cases involving family members created unnecessary discomfort and tension in the hearing. As a consumer/survivor explained, “My sister came as a hostile witness…in that she didn’t represent me and she wanted me to stay in the hospital.”\footnote{Interview with a psychiatric consumer/survivor on April 8, 2009.} Other cases required intervention by the CCB itself. For instance, a CCB adjudicator recalled a case where a young Pakistani woman could not speak freely in the presence of her father in the room. As the CCB adjudicator, she grappled with whether she should ask the applicant’s lawyer to seek an order excluding witnesses or not. She suggested that the “CCB should have the expertise and confidence to deal with these issues properly – especially because we are not going to get it all laid out and explained to us.”\footnote{Interview with a CCB adjudicator on Feb. 17, 2009.}
3.4.2 Adversarial/Therapeutic Relationship Compromised

The CCB’s proceedings are intended to be informal and not “overly adversarial.” However, in practice, the hearings can become adversarial as a result of the CCB’s adjudicative function, which requires its adjudicators to only make a finding of incapacity if there is “clear and cogent evidence to support it.” The adversarial nature of the hearing is influenced by procedural objections, legal technicalities and the nature of the evidence and the number of witnesses brought forth by the parties.

In light of this, I inquired into what impact the adversarial nature of the hearings had on ethno-racial psychiatric consumer/survivors. The majority of respondents felt that the increasingly adversarial hearings had compromised the therapeutic relationship between the psychiatrist and the ethno-racial psychiatric consumer/survivor. For instance, a lawyer recalled a case where the psychiatrist had attempted to cross-examine a young Somali psychiatric consumer/survivor in the hearing. As a result of the psychiatrist’s aggressiveness, along with other cultural and language barriers, the hearing

232 Supra note 11 at 555.
233 Starson v. Swayze, 1999 CanLII 15052 (Ont. S.C.) at para 17; It is important to note that the CCB has both inquisitorial and adjudicative functions, Supra note 11 at 555; In Starson v. Swayze, Justice Malloy supports the view that the CCB is adjudicative in nature. In order to make this argument, he compares the CCB to other disciplinary tribunals in paras 15-17.
234 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009. As argued by Hiltz and Szigeti, “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 to the Board.” Supra note 11 at 555.
235 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
was counter-therapeutic for the woman.\footnote{Interview with a lawyer on March 5, 2009.} Similarly, a consumer/survivor argued, “After the hearing, I really didn’t like my doctor. So, I didn’t stay with him a long time after because of that...”\footnote{Interview with a psychiatric consumer/survivor on April 8, 2009.} As a CCB adjudicator explained,

Physicians feel that their therapeutic relationship with the client gets compromised because the lawyer for the client pitches them against the doctor. And so this doctor who has been working very hard to gain the trust and confidence of this person, all of a sudden is being cast as the villan, which can have harmful consequences for their relationship going forward. The lawyer and the applicant might not see each other again after the hearing, but the doctor and the applicant have to continue to work together.. we hope – toward the common goal of better mental health for that person and that can be compromised.\footnote{Interview with a CCB adjudicator on Feb. 17, 2009.}

In a cultural context, the adversarial system is a set-back for ethno-racial psychiatric consumer/survivors because of their general mistrust of the mental health system and the language barriers they face.\footnote{Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.} For instance, the consumer/survivors interviewed felt the formality of the proceedings, the questions posed and the nature of the evidence presented caused them discomfort and confusion.\footnote{Data derived from interviews conducted with psychiatric consumer/survivors from November 2008 until May 2009.} Also, lawyers felt the ethno-racial individual’s credibility (whether the applicant or family member) was
questioned as a result of intangible qualities such as eye contact, mannerisms, body language and accent.\textsuperscript{241}

Indeed, CCB adjudicators indicate that the “CCB summary form” has reduced the disruption in hearings and it has been a positive step for all parties to the CCB.\textsuperscript{242} The CCB summary enables the psychiatrist to fill out the evidence that they have in order to meet the legal test. The hearing becomes more “streamlined, focused and shorter,” because traumatic events and the “litany of episodes that led to the mental health crisis” do not have to be repeated by the psychiatrist in front of the ethno-racial psychiatric consumer/survivor.\textsuperscript{243}

Despite the improvements with the “CCB summary,” the majority of psychiatrists felt strongly that the adversarial model was not ideal for CCB hearings and should be changed to a mandatory mediation model.\textsuperscript{244} This issue highlighted the tension between

\textsuperscript{241} Data derived from interviews conducted with lawyers from November 2008 until May 2009.

\textsuperscript{242} Data derived from interviews conducted with CCB adjudicators from November 2008 until May 2009.

\textsuperscript{243} Interview with a CCB adjudicator on Feb. 17, 2009.

\textsuperscript{244} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009. At present the CCB only uses mediation as “part of the proceeding and not part of the hearing.” Specifically, section 15 of the Rules of Practice, supra note 208 state:

15.1 Mediation, which is part of the proceeding but not a part of the hearing, may be held for the purpose of attempting to reach a settlement of any or all of the issues, or at least their simplification; 15.2 The Board may arrange for mediation only if all the parties consent to participate in the process. Any party can, at any time during the mediation, request an end to the mediation process. If such a request is made, mediation ends and a hearing will take place, if appropriate; 15.3 Mediation will not be held unless the party who is the subject of the application has legal representation; 15.4 Mediation shall be conducted by a person designated by the chair to sit as a mediator; 15.5 If a member of the Board presides over a mediation, that member shall not participate in the hearing unless all parties consent; 15.6 Mediation shall not be open to the public; 15.7 After mediation, all documents shall be returned to the party who provided them. Documents created or statements made for the sole purpose of mediation are not part of the record and are not admissible in a hearing unless all parties consent. Discussions held at mediation are privileged and may
the medical and rights-based perspectives. In general, those who favored the medical perspective argued that lawyers had made the process too adversarial and legalistic by complicating hearings with procedural objections and other technicalities.\textsuperscript{245} These views are consistent with the illness model of psychiatry. For instance, Gray, O’Reilly and Clements argue that psychiatrists find it difficult to “embrace a process that appears to them to ignore the patient’s best interests.”\textsuperscript{246}

In contrast, the majority of lawyers felt that the adversarial hearings and more importantly certain protective procedures during the process were in their clients’ liberty interests.\textsuperscript{247} Other models such as mediation may not ensure the robust level of due process required. As the former vice-chair of the CCB suggests,

\begin{quote}
The approach of the Board to the procedural rights of psychiatric patients is therefore critical. To give little or no weight to procedural rights diminishes not only the process but the person. Are the rights of psychiatric patients to due process somehow lessened or diminished by a compromised mental state? To the contrary, such rights should be strictly enforced and protected. How “just” can it be to detain an individual suffering from mental disorder yet to deny or ignore the right of the individual to due process? If this is acceptable, why have legislation setting out due process or a Board to determine whether the process was complied with?\textsuperscript{248}
\end{quote}

\begin{figure}

\begin{itemize}
\item[\textsuperscript{245}] Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
\item[\textsuperscript{246}] \textit{Supra} note 69 at 26.
\item[\textsuperscript{247}] Data derived from interviews conducted with lawyers from November 2008 until May 2009.
\end{itemize}

\end{figure}
3.5 Systemic/Structural Barriers

This section gives an overview of the systemic/structural barriers experienced by ethno-racial psychiatric consumer/survivors. I argue that these underlying systemic and structural barriers influence the extent to which the CCB can address the needs of ethno-racial communities in its processes and jurisprudence. As a respondent explained, “When you analyze each stage of the CCB’s process, you will find many systemic barriers. That is why, to put it bluntly, you are up the creek without a paddle.” Change at the CCB level will need to address these underlying barriers, which are a result of the intersecting oppressions faced by ethno-racial communities, the lack of alternative and culturally appropriate treatment options within the wider mental health system and the lack of ethno-specific mental health services in Ontario.

3.5.1 Intersecting Oppressions

Studies confirm the impact that intersecting oppressions such as poverty, class, race, gender orientation have upon the mental health prospects of members from ethno-

Aaron Dhir, “The Maelstrom of Civil Commitment in Ontario: Using Examinations Conducted During Periods of Unlawful Detention to Form the Basis of Subsequent Involuntary Detention Under Ontario’s Mental Health Act” (2003) 24:2 Health L. Canada 9 at 16. As a lawyer explained, “it serves our client to have a more formal process, that we object to evidence that is not admissible.. that we enforce a formal process as much as possible and raise procedural issues if we see them.” Interview with a lawyer on November 17, 2008.

249 Interview with a service provider on January 19, 2009.
racial communities. As respondents indicated, the social, historical and political context of discrimination faced by ethno-racial psychiatric consumer/survivors had to be understood by the CCB and the mental health system. For instance, a service provider argued,

Poverty is more widespread amongst ethno-racial communities. The CCB and the wider mental health system need to do a lot of work to break the stigma and understand how these communities can keep on living in the cycle of poverty, which overlaps with their mental health diagnoses, as well as the lack of resources and the lack of opportunity that they may have to employment, and to access health care and treatment.

Intersecting with poverty, another significant systemic/structural barrier identified by respondents was racism. Racism, manifested in individual acts and institutional processes, can lead to barriers to care and increased likelihood of developing mental illnesses for individuals from ethno-racial communities. Specifically, literature indicates that victims of discrimination, whether racial discrimination or some other form, are twice as likely of developing psychosis. Canadian research suggests that perceived

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251 Interview with a service provider on January 28, 2009.

252 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

racial discrimination has been linked to depression amongst Koreans in Toronto\textsuperscript{254} and Southeast Asian refugees in Canada.\textsuperscript{255} This is important to recognize since a 2005 Canadian survey indicated that approximately one in six had been victim of racism.\textsuperscript{256}

The mental health system frequently “mirrors systemic discrimination” by not acknowledging how racism and other oppressions affect ethno-racial psychiatric consumer/survivors.\textsuperscript{257} Respondents gave anecdotal evidence of how misdiagnosis could occur as a result of the institutional racism.\textsuperscript{258} For instance, a psychiatrist believed “ethno-racial patients are more likely to be given the schizophrenia label because of racist stereotypes within the institution.”\textsuperscript{259} As Dr. Jaswant Guzder argues:

[Ethno-racial psychiatric consumer/survivors] often have to contend with a collusion of professional blind spots, beginning with our institutional stance that is unwelcoming or that denies cultural axis issues. If an institution doesn’t facilitate the building of a therapeutic alliance that takes into account both a person’s experiential cultural map and previous racism encounters, this clinical setting is taking an approach that reflects overt racism or an implicit racism related to

\textsuperscript{256} Supra note 254.
\textsuperscript{257} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009; Avril Roberts, “Challenging Borders and Barriers: Cultural Competence Must Embrace Anti-Oppression Frameworks” (2008) 11.3 CrossCurrents 16 at 16.
\textsuperscript{258} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
\textsuperscript{259} Interview with a psychiatrist on January 12, 2009.
ignorance lack of acknowledgement or sheer oversight, a situation that constitutes institutional racism.\textsuperscript{260} 

The CCB must address the institutional racism and the systemic causes of discrimination faced by ethno-racial psychiatric consumer/survivors within its jurisprudence, policies and processes. Without understanding these contemporary struggles of oppression, specific measures to effect change cannot occur.\textsuperscript{261} Specifically, ethno-racial psychiatric consumer/survivors found it frustrating that the CCB did not want to hear about their experiences of discrimination in the hospital, whether racial or otherwise.\textsuperscript{262} As a lawyer explained,

\begin{quote}
If someone has applied to the Consent and Capacity board, the doctor isn’t supposed to go ahead with the treatment unless the board has confirmed the decision of incapacity. In some cases, especially where there are cultural and language barriers, doctors go ahead with treatment. If you raise this at a hearing, the Board will say.. ‘I am not here to hear this type of information, maybe you have a civil action, maybe you want to complain to the College of Physicians and Surgeons, our only mandate is to say whether you are capable or not. The fact that your rights related to your capacity were violated and you faced racial discrimination in the hospital is not relevant to what we are here to decide and so I am not going to hear any evidence about that.’\textsuperscript{263}
\end{quote}

\textsuperscript{260} Avril Roberts, \textit{supra} note 257.

\textsuperscript{261} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009. As one psychiatrist expressed, “if you translate that to the CCB - the CCB may change to some extent which may have an influence of the system, but if the ward doesn’t change it is still a problem. That is where the change would be most beneficial. A lot of things happen in the hospital ward, people work there for a whole shift of eight hours, patients stay there 24 hours..there is a subculture there, like a little society there and that is where change has to occur I think.” Interview with a psychiatrist on November 5, 2008.

\textsuperscript{262} Data derived from interviews conducted with psychiatric consumer/survivors from November 2008 until May 2009.

\textsuperscript{263} Interview with a lawyer on November 17, 2008; \textit{Supra} note 11 at 176. Under s. 18, 33 (1), (2) and (3) of the HCCA, S.O. 1996, c.2., “treatment cannot commence if before
Evidence such as this highlights the unfortunate reality that the CCB does not fully address rights violations and systemic discrimination experienced by ethno-racial psychiatric consumer/survivors. To minimize or ignore these experiences may lead to further marginalization for ethno-racial psychiatric consumer/survivors because the discrimination may have contributed to their mental health crisis.

3.5.2 Alternative and Culturally Appropriate Treatment Options

In cases involving treatment incapacity, applicants wish to “retain the right to refuse the recommended treatment.” 264 The CCB has a limited jurisdiction to address the type of medications being proposed because “the refusal of treatment is often equated with the lack of capacity to consent to treatment.” 265 As a result, the CCB’s role in these cases is to determine whether the person is capable or not of consenting to the treatment.  

Once treatment has begun, the health practitioner is informed that the person found incapable intends to apply or has applied to the Board for a review of the finding or to appoint a representative for purposes of making the decision on his or her behalf, or another person intends to apply or has applied to be appointed by the Board to make the decision. The physician may, however continue to administer treatment to the incapable prior to the finding of incapacity being made or before it came to the health practitioner’s attention that a hearing of these issues may come before the Board. Once a person has indicated an intent to the Board, however, treatment may only commence in the following circumstances: 1) once 48 hours have elapsed since the health practitioner was informed of the intended application but no application has been made; 2) if the application to the Board has been withdrawn; 3) when the Board has rendered a decision in the matter and no party has indicated an intention to appeal the Board’s decision; 4) where a party has indicated an intention to appeal but the time for filing the appeal (seven days) has elapsed without the appeal being filed; or 5) when the appeal from the Board’s decision has been finally disposed of.”

264 Supra note 11 at 176.

treatment.\footnote{Under s. 2 of the HCCA, S.O. 1996, c.2., “treatment includes a course of treatment, plan of treatment or community treatment plan.” Under s. 33.7 of the MHA, R.S.O. 1990, c. M.7., the Community Treatment Order is based on the Community Treatment Plan in s. 33.1 (4)(b) of the MHA.} This was confirmed in \textit{Starson v. Swayze}, where the Supreme Court found that “the legislative mandate of the Board is to adjudicate solely upon a patient’s capacity. The Board’s conception of the patient’s best interests is irrelevant to that determination…”\footnote{\textit{Starson v. Swayze}, [2003] S.C.J. No. 33, [2003] 1 S.C.R. 722 (S.C.C.) at para. 76.}

Within this context, I inquired into whether the proposed treatment options for ethno-racial psychiatric consumer/survivors were culturally appropriate. Since the CCB itself cannot consider whether treatment plans are culturally appropriate,\footnote{As a CCB adjudicator explained, “Since it is beyond our mandate, we do not consider whether treatment plans are culturally appropriate because that is decided by the health practitioner before the hearing. Perhaps, there may be room for this when the Board is reviewing Community Treatment Orders.” Interview with a CCB adjudicator on January 30, 2009. Similarly, a lawyer argued that: “The Board can only be as open in terms of possibilities in terms of the system. If the system doesn’t afford a range of things, then the Board is locked into this.” Interview with a lawyer on December 5, 2008.} respondents believed the lack of culturally appropriate treatment options within the mental health system fundamentally affected how ethno-racial psychiatric consumer/survivors’ cases were determined before the CCB.

Respondents argued that there were “no alternatives within the mental health system” because the predominant medical view was that mental illnesses such as
schizophrenia, bipolar disorder and depression should be treated with pharmacological drugs. For instance, a lawyer argued,

I guess what bothers me is that there is a degree of forcing coercion within the system that the CCB has come to accept. If you are incapable and the board confirms this, then you will receive medication by injection, you will be held down by security guards and receive that medication because that is determined to be in your ‘best interests.’ And there is an acceptance that that is what will happen. And that seems to me something that we should naturally be repulsed by...because it is such a violent intervention. Not only the act of holding someone down, injecting them and restraining them, but the actual act of injecting them with neuroleptic medication that will put them in a chemical prison. I use these words because over time I have learned from people that this is their experience.

The lack of alternatives within the mental health system is further complicated by research called “ethnic physopharmacology,” which indicates that the side effects and responses to psychiatric medication can vary amongst ethnic-racial groups. For instance, data indicate that African groups have a higher likelihood of experiencing episodes of neuroleptic toxicity from taking neuroleptic drugs, and may have more severe side effects than Caucasians when being treated with the regular dosages of lithium. Data also suggest people of East Asian origin have a higher likelihood of

269 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
270 Interview with a lawyer on December 5, 2008.
272 Ibid.
developing side effects from anti-depressants.\textsuperscript{274} In treatment incapacity cases, the CCB may not be sufficiently aware of these varied cultural and racial responses to medications, and thereby assume ethno-racial psychiatric consumer/survivors are refusing or unable to consent to certain medications for other reasons.\textsuperscript{275}

In general, respondents’ views were consistent with proponents of the social model of disability who argue that “psychiatric medication should be considered as one of the several treatment approaches that must be undertaken in order to address mental health concerns.”\textsuperscript{276} Alternative and complementary medicines, many of which are culturally derived such as megavitamin therapy, acupuncture, homeopathy, light therapy and naturopathy, should be considered viable options for treating mental illness. Respondents suggested that ethno-racial psychiatric consumer/survivors would be more willing to consent/comply with recommended treatment if they had such options.\textsuperscript{277} For instance, a few respondents made reference to Dr. Abram Hoffer’s work. Dr. Hoffer was devoted to helping schizophrenic patients cope with their illness through the use of complementary and alternative medicines. Through his research, Dr. Hoffer discovered

\begin{footnotesize}
\footnote{\textsuperscript{274} Ibid.}
\footnote{\textsuperscript{275} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.}
\footnote{\textsuperscript{276} Erin Elizabeth Fitzpatrick, “Lessons from Starson on Consent and Capacity,” (2006) Vol. 26:4 Health L. Canada 74 at 81; Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.}
\footnote{\textsuperscript{277} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.}
\end{footnotesize}
how nutrition, Vitamin B3 (niacin) and Vitamin C could reduce the symptoms of schizophrenia and decrease relapses.\textsuperscript{278}

\subsection*{3.5.3 Lack of Ethno-Specific Mental Health Services}

The lack of ethno-specific mental health services in Ontario was identified as a significant systemic and structural barrier for ethno-racial psychiatric consumer/survivors.\textsuperscript{279} As one psychiatrist argued, “the lack of ethno-specific services within the hospital results in no accountability for mental health amongst diverse groups.”\textsuperscript{280} Although respondents felt that the CAMH’s psychiatrists and treatments teams were becoming more racially diverse, anti-oppression policies and accountability mechanisms for ethno-specific mental health services have not been fully developed within the hospital setting.\textsuperscript{281} As a service provider suggested,

We have to go beyond the idea that incorporating ‘race’ on a superficial and token level is enough. Service providers and treatment teams need to understand the underlying issues of racism and marginalization through an anti-oppression lens. Since one person’s psychiatric symptoms are another person’s cultural comfort zone, we have to recognize how our own social location affects our ability to care for those from ethno-racial communities.\textsuperscript{282}

\begin{itemize}
\item \textsuperscript{279} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
\item \textsuperscript{280} Interview with a psychiatrist on November 5, 2008.
\item \textsuperscript{281} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
\item \textsuperscript{282} Interview with a service provider on January 28, 2009.
\end{itemize}
Within the community, respondents indicated that the resources for ethno-specific mental health services were insufficient. For instance, ethno-specific mental health agencies in Toronto such as Hong Fook Mental Health Association and Across Boundaries: An Ethno-Racial Mental Health Centre are well known and rapidly growing. As a consumer/survivor recalled from his experience at Across Boundaries, “it was great to see someone like me who had made it, trying to help me too.” More resources for these and other ethno-specific mental health agencies are needed, especially in the Greater Toronto Area.

3.6 Discretionary Barriers

This section analyzes the extent to which factors such as race, culture, and ethnicity are considered within the CCB’s jurisprudence, legislation and policies. As a result of the aforementioned procedural and systemic barriers, the CCB has the difficult role to instill justice, fairness and human rights for ethno-racial communities in involuntary status, treatment incapacity, and financial incapacity cases. I use the empirical evidence to argue that the CCB must be more attentive to factors such as race, culture and ethnicity through its discretionary powers. I highlight cases where a “color-blind approach” was adopted and as a consequence the CCB did not further explore discrimination faced by the ethno-racial psychiatric consumer/survivor.

283 Interview with a psychiatric consumer/survivor on April 8, 2009.
3.6.1 Color-Blind Approach

This theme arose from questions posed to respondents on how the CCB exercises discretion where factors such as race, ethnicity, and culture became an issue. Overall, respondents felt that the CCB gives little recognition to these nuanced issues.\(^{284}\) There is a growing concern that the CCB may not acknowledge cultural misunderstandings when reviewing the evidence presented by the psychiatrist or health practitioner.\(^{285}\) As a CCB adjudicator explained,

> Board members generally have an uneasiness dealing with cultural issues. I think a lot of it goes back to the question of confidence of our members. We need to keep working on members feeling comfortable with these racial and cultural issues and feeling confident to deal with them … feeling empowered that we are qualified members to address these issues as opposed to shying away from them and thinking that we are going to offend someone. I think there is a general shyness about these issues which need to be gotten rid of.”\(^{286}\)

This “uneasiness” results in the CCB adopting a “color-blind” approach (the omission of a racial or cultural analysis).\(^{287}\) More, specifically, respondents identified problems with the CCB’s limited jurisdiction and the gap in the legislation.\(^{288}\) The

\(^{284}\) Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

\(^{285}\) Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

\(^{286}\) Interview with a CCB adjudicator on February 17, 2009.

\(^{287}\) Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009; Supra note 94 at 32.

\(^{288}\) Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009. As a lawyer explained, “there are significant complaints about the discretionary
legislation does not specify how the CCB should account for racial or cultural factors. In this lacuna, the CCB adjudicators have taken a relatively narrow interpretation of their mandate, which is focused on analyzing whether the medical evidence fulfills the criteria of the legislation.\(^{289}\) In my inquiry on this issue, the majority of respondents felt that CCB adjudicators should go beyond this narrow interpretation and use their discretionary powers to address racial and cultural factors.\(^{290}\)

In this regard, respondents believed that the CCB did not sufficiently explore contextual cultural factors, which might have impacted the individual’s understanding of their mental illness and treatment. This was the perception in cases such as \(L; \text{ File TO-}\)

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\(^{289}\) Data derived from interviews conducted with lawyers, psychiatrists, service providers CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009. For instance, the CCB reviews the medical evidence for involuntary detention. Section 20 (5) of the MHA states: The attending physician shall complete a certificate of involuntary admission or a certificate of renewal if, after examining the patient, he or she is of the opinion both, (a) that the patient is suffering from mental disorder of a nature or quality that likely will result in, (i) serious bodily harm to the patient, (ii) serious bodily harm to another person, or (iii) serious physical impairment of the patient, unless the patient remains in the custody of a psychiatric facility; and (b) that the patient is not suitable for admission or continuation as an informal or voluntary patient. R.S.O. 1990, c. M.7, s. 20 (5); 2000, c. 9, s. 7 (3, 4).

\(^{290}\) Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
because race is merely mentioned in the evidence and its impact is not analyzed. In \textit{L; File TO-06-1167 (Re)}, the psychiatrist notes that L, the ethno-racial psychiatric consumer/survivor, has “bizarre thoughts about her race.” However, these “thoughts” are not explained. Similarly, in \textit{B.; File TO-05-6467 (Re)}, it states that “Mr. B believes he is in hospital because of his race,” and the role of race is omitted within the CCB’s analysis.

The CCB’s color-blind approach is also problematic in cases where the discrimination, whether racial or otherwise, was the precursor to the deterioration of mental health for ethno-racial psychiatric consumer/survivors. For instance, a lawyer referred to a case where the client’s experience of racial discrimination in the hospital caused him to go on a hunger strike, which led to his deterioration of mental health. As the lawyer explained,

The board traditionally has been disinterested in the precursor to the behavior. And if you talk about racial discrimination and you suffer from paranoid schizophrenia, then they think you are being paranoid. So, if you already have

\begin{itemize}
\item \textsuperscript{291} [2006] O.C.C.B.D. No. 148 at para 10.
\item \textsuperscript{292} [2005] O.C.C.B.D. No.211 at para. 17.
\item \textsuperscript{293} It is important to note that CCB decisions, (where reasons are given) do not generally state the ethnicity of the applicant.
\item \textsuperscript{294} \textit{Supra} note 291. Race is mentioned in the evidence as follows: “Dr. Kluckach, staff psychiatrist, noted that her presentation was somewhat consistent with a mood disorder, with a past history of depression He noted that her [effect] was such that she might have some hypomanic presentation in addition to her somewhat bizarre thoughts about her race and her bizarre behaviour.”
\item \textsuperscript{295} \textit{Supra} note 292. In this case, it states: “Dr. Wong said Mr. B believes he is in hospital because of his race. Dr. Wong said Mr. B believes Dr. Wong is racist. He said he does not need to rebut this type of belief.”
\end{itemize}
the label of suffering from a mental disorder, then your complaints about your
treatment in your hospital are discounted as are most of your complaints
because you have a mental health problem. It is not to say that the board is
racist, it is the evidence that is gathered is only analyzed from a medical
perspective. 296

During the hearing, the majority of lawyers felt that the CCB rarely posed
questions about an individual’s ethnic background and the cultural factors at play.
Intangible qualities such as a racialized person’s demeanor, eye contact and mannerisms
influenced the CCB’s perception of that particular individual’s credibility. 297A lawyer
referred to a case where she argued that the Board perceived the applicant’s mother, the
substitute decision maker, to be less credible because she had a heavy accent. The lawyer
argued,

What I do see of more regularly at the Board is a discounting…because it is a
quality that you cannot really ascribe to..it is difficult to describe, but when you
have a mom who is truly emotional about their child and they are crying and
they speak with an accent. I get the impression often when I am before the
Board that they are discounted as an emotional parent who is caught in emotions
of their child being unwell and can’t reason the decision. 298

Cases such as these became complicated when explicit conflicts arose between
the ethno-racial family member or ethno-racial psychiatric consumer/survivor and the
psychiatrist. Specifically, a lawyer argued, “I am never successful at a capacity hearing
unless the ethno-racial client acknowledges that they have the diagnosis that the doctor is

296 Interview with a lawyer on December 5, 2008.
297 Data derived from interviews conducted with lawyers from November 2008 until May
2009.
298 Interview with a lawyer on December 5, 2008.
saying that they have.” Indeed, a number of respondents referred to cases where conflicts arose because of cultural expectations related to the care of aging parents. In these cases, the alternative care arrangements or treatments proposed by ethno-racial family members and their cultural norms were not considered. A lawyer felt,

If the family members don’t go along with what the doctor says, they are often marginalized. And when the substitute decision maker is from a racialized community, I think that marginalization is greater. Cultural evidence such that. ‘You never put your parent in a nursing home in Chinese culture’ will generally not be considered by the Board.

Respondents also believed that the CCB’s color-blind approach might lead to cultural misunderstandings. This was most apparent in cases where the ethno-racial psychiatric consumer/survivor was involuntarily detained for risk of harm to another person. A lawyer perceived this in the following case:

There are some cultures where people will say ‘I will kill you,’ and the client may say – yeah but in my culture I don’t mean that as a threat – it is a phrase, I say that all the time. I have one client where his son came to the hearing and said ‘yeah – I say that in our culture all the time…I say it to my kids, you know we just say that I will kill you.’ That family was Phillipino and amongst Phillipino males there is kind of macho culture. It is something that you have to understand. But, the board didn’t really seem to buy that. They seemed to assess it from the point of view of the ‘average, reasonable person in Canada.’ They didn’t really seem to buy that type of cultural argument.

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299 Interview with a lawyer on November 17, 2008.
300 Data derived from interviews conducted with lawyers from November 2008 until May 2009.
301 Interview with a lawyer on December 5, 2008.
302 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
303 Interview with a lawyer on November 17, 2008.
Proponents of critical race theory argue against using a colour-blind approach in legal cases. As Lopez argues,

In order to get beyond racism, 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.

On the other hand, a few CCB adjudicators felt that having race, culture and ethnicity as factors in decision making could create varying standards for ethno-racial psychiatric consumer/survivors and other psychiatric consumer/survivors. 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?

These contrasting views indicate why the color-blind approach is contentious and the difficult task CCB adjudicators have when considering how to address racial and cultural factors in their adjudication. However, I argue that the color-blind approach, adopted by the CCB in the aforementioned cases, was problematic. If these discretionary decisions had taken contextual cultural perspectives into account, there might have been a different or better outcome for the ethno-racial psychiatric consumer/survivor.


305 Interview with a CCB adjudicator on February 17, 2009.
3.6.2 Membership of the Board

The extent to which the CCB addresses issues specific to ethno-racial psychiatric consumer/survivors is a function of its membership and their competence. In this regard, I inquired into how “diversity” amongst the CCB’s membership was perceived. The majority of respondents believed that the CCB’s membership was not culturally diverse. Although the CCB composition has improved, there is no policy within the CCB’s mandate to ensure diversity amongst its adjudicators. As a CCB adjudicator explained,

> It is not terrible, but it is not great. There has been a real effort made in the last few years to recruit and appoint people who reflect the province of Ontario better than just white people. When I joined it was mostly white men, now there are quite a few white men, quite a few white women and a few members of racialized groups, but not as many as we should have. It is something that we need to continue to work on. First of all, when you get people who come from a culture that is not the majority culture, they inherently have an expertise in this area. And those of us that don’t, we are lacking in confidence, we feel that we are lacking in skills and knowledge, we don’t really know how to approach ethno-racial applicants. So, to have colleagues that can show us and teach us is one important thing that we need to work on.

In general, respondents argued that CCB adjudicators’ ethnicity, socio-economic background, gender, values and experiences impacted their discretionary decisions. Although difficult to ascertain, respondents referred to cases where ethno-racial psychiatric consumer/survivors felt at ease with adjudicators with diverse backgrounds.

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306 Supra note 16 at 4. According to its annual report of 2007/2008, the CCB had 151 appointed members consisting of 51 lawyers, 54 psychiatrists and 46 Public Members.

307 Interview with a CCB adjudicator on Feb. 17, 2009.
and perspectives.\textsuperscript{308} For instance, in \textit{E.R.; File TO-04-1115 (Re)},\textsuperscript{309} Mr. R, an African-Canadian man appearing before the board asked that “some members of the panel constituted to hear his application be of African Canadian descent.”\textsuperscript{310} The CCB denied this request in order to ensure the proceeding was cost-effective, efficient and timely. Moreover, the CCB argued the following,

…to place such a request in the framework of a special need that ought to be accommodated is to imply that persons of different race or ethnicity are ipso facto biased, or are for some other unspoken reason incompetent to deal with the particular matter. What is particularly disturbing is the underlying assumption that a member of the Board may be found unsuitable to hear a given matter simply on account of his or her race or ethnic background. That premise is unacceptable and, in our opinion, the accommodation of such requests when appointing panels to deal with applications would undermine the integrity of the entire Board.\textsuperscript{311}

Despite the CCB’s denial of the request for an ethno-racial adjudicator in this case, respondents gave anecdotal evidence of the positive impact that a diverse composition of the CCB has upon ethno-racial psychiatric consumer/survivors in proceedings.\textsuperscript{312} These views were consistent with literature suggesting “the more perspectives and backgrounds included in public decision making, the more qualitatively

\begin{itemize}
\item \textsuperscript{308} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
\item \textsuperscript{309} [2004] O.C.C.B.D. No. 185.
\item \textsuperscript{310} \textit{Ibid.} at para. 4.
\item \textsuperscript{311} \textit{Ibid.}
\item \textsuperscript{312} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
\end{itemize}
enhanced that the decision making in the aggregate will become and the more legitimate it will be viewed by those affected.”

It is important to note that respondents’ perception of “diversity” went beyond race and ethnicity. Respondents emphasized that it is not necessary that CCB adjudicators be from ethno-racial communities, if they are competent and sensitive when approaching cultural issues. They should have an understanding of how their own assumptions, underlying prejudices, privilege and social context impact their perspectives and decision-making abilities.

Overall, respondents felt that the level of deference given to the various Board members within proceedings was problematic. For instance, psychiatrist or lawyer members were often accorded a higher level of discretionary deference than the community members. As a lawyer explained,

Typically, the community member is the weakest member of the panel. There is a role for the community member, there are supposed to express concerns not only safety concerns, but policy related concerns. I would think a community member is the one who should be concerned about the stigma of mental illness and how certain decisions would affect this person’s long term well being in the community. But, usually they go along with the psychiatrist member or lawyer member. Although one or two take their own point of view, I have the sense that community members are kind of intimidated by the other members of the panel and they defer to them for whatever decisions they are making. If there is a three member panel on an


314 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

315 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
involuntary issue, it is kind of sad because you don’t have someone there who is predisposed to think about the patient’s point of view.\textsuperscript{316}

Lastly, I inquired into whether CCB adjudicators are being trained to address culturally specific issues. In this regard, the CCB adjudicators reported that the CCB had a half-day workshop on diversity and cultural awareness for its members in November 2008.\textsuperscript{317} The CCB also has a working group on cultural diversity issues. Since the working group’s final report is in progress, the expected completion date is unsure.\textsuperscript{318}

3.7 Conclusion

The findings presented in this chapter strengthen my claim that the CCB fails to adequately address how diverse social realities affect ethno-racial psychiatric consumer/survivors. Using the theoretical framework developed in Chapter 2, I identified and critiqued the procedural, systemic/structural and discretionary barriers faced by ethno-racial psychiatric consumer/survivors who had appeared before the CCB.\textsuperscript{319}

The procedural barriers that were identified recognize how cultural conceptions, misunderstandings and stigma associated with mental illness amongst various ethno-racial communities inhibited some ethno-racial psychiatric consumer/survivors from

\textsuperscript{316} Interview with a lawyer on November 17, 2008.
\textsuperscript{317} Interview with a CCB adjudicator on February 17, 2009.
\textsuperscript{318} Interview with a CCB adjudicator on February 17, 2009.
\textsuperscript{319} Due to the limitations of this study, it is not possible to make conclusive statements from the empirical evidence.
taking part in the CCB process.\(^{320}\) Ethno-racial psychiatric consumer/survivors faced barriers accessing lawyers who were able to understand how to incorporate cultural issues within the CCB challenge, and psychiatrists who acknowledged the importance of race, culture, ethnicity and other factors within the pre-hearing capacity assessments. Significant language and communication barriers were identified throughout the pre-hearing (within hospital, pre-counsel meetings and psychiatrists’ capacity assessments) and the post-hearing CCB process.\(^{321}\)

An analysis of the systemic/structural barriers was critical to understand how intersecting oppressions such as institutional racism, discrimination and poverty affect the mental health prospects of ethno-racial psychiatric consumer/survivors. The lack of consideration given to alternative and culturally appropriate treatment plans within the mental health system and the lack of ethno-specific mental health services creates further disparities for ethno-racial communities.\(^{322}\) Lastly, the section on discretionary barriers identified tensions arising from the CCB’s adoption of a color-blind approach in treatment incapacity, involuntary detention and long-term care cases complicated by

\(^{320}\) Interview with a psychiatrist on Feb. 11, 2009; Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

\(^{321}\) Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

\(^{322}\) Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
racial, cultural and other social issues. Given the complexity of these cases, the lack of
diversity amongst the CCB’s membership revealed challenges for all parties involved. 323

The CCB must attempt to erode these barriers through law reform, public education and advocacy. The next chapter will present recommendations suggested by stakeholders on how the complexities of mental health, race, culture and other social factors can be fully addressed by the CCB.

323 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
CHAPTER 4
CONCLUSION AND RECOMMENDATIONS

Ethno-racial psychiatric consumer/survivors face complex forms of discrimination as a result of the culture specific stigmatization of mental health disabilities, institutional racism and culturally inappropriate care.\textsuperscript{324} To challenge this exclusion, we must strive to understand their diverse needs, perspectives and conceptions of mental health. Since the CCB has an immense impact on the civil rights, liberty and dignity of ethno-racial psychiatric consumer/survivors who appear before it, I chose to analyze this particular tribunal for this study. In this chapter, I give an overview of the purpose, findings and conclusions of the study, along with recommendations, suggested by the stakeholders I interviewed, to address the cultural gap and barriers within the legal system.

This study identified and analyzed the procedural, systemic/structural and discretionary barriers faced by ethno-racial psychiatric consumer/survivors through an analysis of the Consent and Capacity Board (CCB). My hypothesis was that the CCB fails to adequately address issues of race, ethnicity, culture, poverty and social exclusion within its processes and jurisprudence. As I described in Chapter One, I was motivated to pursue this study given the dearth of progressive legal literature on the experience of ethno-racial psychiatric consumer/survivors in the civil mental health system. In Chapter Two, I developed a theoretical framework, which blends the grounded theory approach, with tenets of disability theory, critical race theory and intersectionality. I used the

\textsuperscript{324} \textit{Supra} note 5.
theoretical framework to analyze qualitative research involving twenty interviews of stakeholders including lawyers, psychiatrists, CCB adjudicators, mental health service providers, and ethno-racial psychiatric consumer/survivors.

Limitations of this study include its sample size and location. Despite the limitations, a strength of the study is the respondents’ level of candor and the quality of information provided vis-à-vis their particular experiences that is not otherwise accessible. Respondents openly expressed their views, beliefs, perceptions and attitudes of and towards the CCB pre-hearing, hearing and post-hearings procedures, along with their experiences with the mental health system.

Using the grounded theory approach, along with the theories described in Chapter Two, I analyzed the interviews and from this analysis emerged data-derived themes and sub-categories. These findings were embedded within an analysis of the relevant literature and presented in Chapter Three. The findings confirmed the validity of my hypothesis. In particular, there were procedural barriers identified within the rights advice system, the pre-hearing lawyer meetings, the psychiatrists’ capacity assessments, the hearing process and the post-hearing process. Respondents perceived how barriers were the result of cultural misunderstandings, misdiagnosis, complex familial conflicts and culturally inappropriate care. Although the rights advice system worked “fairly well,” respondents felt that ethno-racial psychiatric consumer/survivors were more likely to underutilize the CCB process because of its adversarial nature, the initial perceptions of

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325 The interviews were conducted primarily in Toronto and the findings of this study might have varied if there were interviews done 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.
inaccessibility, language and communications issues. 326 In the pre-hearing stage, lawyers were frustrated by the procedural inefficiencies of obtaining an interpreter, and by the fact that their language abilities were not specified on Legal Aid Ontario’s lists. 327 The majority of respondents felt that racial stereotypes and language discrepancies between the psychiatrist and ethno-racial psychiatric consumer/survivor led to incorrect capacity assessments.328

Throughout the CCB’s processes, significant language and communication barriers were identified. 329 This was analyzed in S.A. (Re)330 where the attending physician fundamentally misunderstood S.A. (who spoke Arabic) because there was no interpreter available in the emergency room and thereby involuntarily detained him. 331 Within the CCB’s hearings, subjective biases of the interpreter, the lack of cultural interpretation available and the adversarial nature of the hearings were all viewed as problematic on the part of those interviewed. Indeed, it is of significant concern that the

326 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
327 Data derived from interviews conducted with lawyers from November 2008 until May 2009.
328 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
329 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
330 S.A. (Re), supra note 195.
331 S.A. (Re), supra note 195 at para 22.
CCB itself does not ensure that there is an interpreter or translator available for the ethno-racial psychiatric consumer/survivors to understand the reasons for a decision.  

In analyzing the systemic and structural barriers, I reveal how institutional racism, systemic discrimination and poverty jeopardize the mental health of ethno-racial psychiatric consumer/survivors, and often contribute to their negative experiences within the mental health system. The lack of consideration given to alternative and culturally appropriate treatment plans within the mental health system, and the CCB’s limited jurisdiction impacts the extent to which the CCB can address the treatment concerns of ethno-racial psychiatric consumer/survivors. This was particularly problematic in cases where ethno-racial psychiatric consumer/survivors wanted alternative treatments such as megavitamin therapy, acupuncture, homeopathy, light therapy, and

332 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

333 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

334 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
The lack of ethno-specific mental health services within the hospital and the communities perpetuated these disparities.

The section on discretionary barriers highlighted cases where the CCB’s “color-blind” approach (the omission of a racial or cultural analysis) was contentious. The majority of respondents believed that CCB adjudicators should use their discretionary powers to be more attentive to factors such as race, culture and ethnicity in treatment incapacity, involuntary detention and long-term care cases. However, there were contrasting views, and the following questions arose: Should varying standards of discretion be used for ethno-racial psychiatric consumer/survivors who appear before the CCB? To what extent should race and culture factor into an adjudicator’s decision? Lastly, the majority of respondents indicated that the CCB’s lack of diversity amongst its membership affected the extent to which issues specific to ethno-racial psychiatric consumer/survivors could be addressed.

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335 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

336 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

337 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

338 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.
To address the barriers identified and critiqued, change is needed within the mental health system itself, the CCB, and amongst the individuals working within these institutions. The stakeholders I interviewed provide the recommendations given below. Although all of the recommendations have merit, I have prioritized and presented them according to those requiring precedence.

4.1 Recommendations

i) Legislative Reform

1. There should be legislative reform to increase the CCB’s mandate and jurisdiction, in order to address whether treatment options are culturally appropriate and whether psychiatric consumer/survivors’ treatment within the hospital is fair.

2. The Mental Health Act should include a section recognizing that factors such as race, culture and ethnicity must be considered where appropriate.

ii) Education

3. There should be more education campaigns and workshops aimed at increasing awareness about mental health issues in various ethno-racial communities in Ontario.

4. Educational resources should be available for all stakeholders about how mental health is perceived amongst various ethno-racial communities, and how culture

I recognize that these recommendations are broad in nature.

I identify and give an explanation of some of the top priorities in the next section.
impacts the interpretation of psychiatric symptoms. Educational resources should also be available on alternative and culturally appropriate treatment options.

iii) Research and Evaluation

5. The Ontario Ministry of Health and Long-Term Care should create an office that monitors how responsive the mental health system is towards ethno-racial psychiatric consumer/survivors.

6. The Mental Health Commission of Canada\textsuperscript{341} should fund research aimed at eroding the barriers faced by ethno-racial psychiatric consumer/survivors within the legal system.

7. An evaluation assessment tool, consisting of a set of valid and reliable indicators, should be created to scrutinize the application of Ontario’s mental health laws in order to address cultural considerations for ethno-racial psychiatric consumer/survivors.

\textsuperscript{341} The Mental Health Commission is a non-profit organization that is funded by the Government of Canada. It is a national body and it was “created to focus national attention on mental health issues and to work to improve the health and social outcomes of people living with mental illness.” Currently, the Commission has four key initiatives. These include: a mental health strategy, an anti-stigma campaign, homelessness research demonstration projects and a knowledge exchange centre. Mental Health Commission of Canada, “Out of the Shadows Forever,” online: Mental Health Commission of Canada <http://www.mentalhealthcommission.ca/English/Pages/default.aspx>; accessed 12 July 2009.
iv) Training

8. CCB adjudicators should have a duty to inquire into culturally specific issues, and assess the evidence keeping cultural, racial and other social factors in mind. Training should ensure that adjudicators are competent and comfortable when addressing these issues.

9. The CCB should invite ethno-racial psychiatric consumer/survivors to speak about their experiences in the hospital and in CCB hearings, at regional and provincial meetings.

10. There should be anti-racism training for CCB adjudicators, lawyers, psychiatrists, and treatment teams within the hospital.

11. Lawyers should be trained on how to recognize if cultural, racial and other social issues are relevant to an ethno-racial psychiatric consumer/survivor’s case, and how to incorporate these issues into their arguments before the CCB. Legal Aid Ontario’s refugee law resources may be of assistance.

12. A consultation-liason model should be implemented, to ensure that service providers who specialize in providing care for ethno-racial communities can provide education, training and support to staff within the hospitals.

v) Communication and Language

13. Cultural interpreters, along with language interpreters should be used throughout the CCB’s pre-hearing, hearing and post-hearing CCB process.

14. The CCB should ensure that the reasons for its decisions are available in different languages, or interpreters are available for those who need them.

15. The rights advisors’ lists should specify the particular language abilities of each Legal Aid Ontario lawyer.
16. Legal Aid Ontario should devise a more efficient method of providing interpretation services during pre-hearing meetings.

17. During the capacity assessments, psychiatrists should use cultural consultants,\textsuperscript{342} if necessary, to avoid misdiagnosis, miscommunication, and biases.

\textbf{vi) Membership}

18. The diversity of the CCB’s adjudicators should be increased. The CCB should include psychiatric consumer/survivors, some of whom are racialized, amongst its membership.

19. Legal Aid Ontario should make an effort to culturally diversify the lawyers on the CCB panel.

\textbf{vii) Funding}

20. There should be more financial resources available for Legal Aid Ontario lawyers on the CCB panel.

21. There should be more financial resources for ethno-racial mental health agencies such as Hong Fook Mental Health Association and Across Boundaries: An Ethno-Racial Mental Health Centre.

\textbf{4.2 Priorities}

Within these recommendations, I prioritize three areas, which will require an ongoing commitment by all stakeholders, to challenge the discrimination faced by ethno-

\textsuperscript{342} “Such consultants would ideally be familiar with both the patient’s cultural norms and basic psychiatric assessment skills. They are distinguished from an interpreter, as they are familiar with systems issues, and can often serve as a liason between the staff and the patient.” Juan E. Mezzich and Giovanni Caracci (eds), \textit{supra} note 182 at at 140.
racial psychiatric consumer/survivors. First, legislative reform is necessary to increase the CCB’s mandate and jurisdiction. The CCB should have the authority to adjudicate matters of particular importance to ethno-racial psychiatric consumer/survivors, such as whether treatment options are culturally appropriate and whether their treatment within the hospital is fair. As I argued in Chapter Three, there are significant complaints about the CCB’s mandate and limited jurisdiction. Ethno-racial psychiatric consumer/survivors were frustrated that the CCB did not want to hear about their experiences of discrimination in the hospital, whether racial or otherwise.\textsuperscript{343} Legislative reform will help ensure CCB adjudicators have legislative direction to address the cultural and racial dimensions at play within a case and ethno-racial psychiatric consumer/survivors’ experiences of systemic discrimination. Additionally, since the CCB is currently governed by a variety of statutes, consolidating the statutes into one may facilitate CCB adjudicators’ understanding of the legislation and help alleviate some of the procedural barriers identified within this study.\textsuperscript{344}

Secondly, I argue that education initiatives must include more grassroots and broad-based community education programs within ethno-racial communities. These

\textsuperscript{343} Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009.

\textsuperscript{344} This was recommended by the Chair of the CCB, Justice Edward F. Ormston. He argued, “The legislation that governs the Board is a hodgepodge of a variety of statutes that should be consolidated into one.” Justice Edward F. Ormston, “The Role and Function of the Consent and Capacity Board in the Mental Health System – Issues and Trends,” in Psychiatric Patient Advocate Office, \textit{Honouring the Past, Shaping the Future: 25th Anniversary Report} (Toronto: Queen’s Printer, 2008) at 225.
programs should aim at increasing awareness and countering the internalized stigma about mental health amongst ethno-racial communities. Ideally, these programs should be initiated by ethno-racial psychiatric consumer/survivors, with the support of service providers, health care practitioners, community legal workers and CCB adjudicators. The educational resources should include plain language fact sheets about mental health, the CCB process and other issues such as “informed consent,” “community treatment orders,” and alternate treatment options. These must be available in several different languages. By creating partnerships between the CCB, ethno-racial communities and other stakeholders, the recommendations proposed for anti-racism training will be easier to implement.

As the study indicates, there is a need for continuous evaluation, research and monitoring of the mental health system’s responsiveness to ethno-racial psychiatric consumer/survivors. The CCB, the Ontario Ministry of Health and Long-Term Care and the Mental Health Commission and other stakeholders should collaborate their research efforts. Research projects should employ multidisciplinary perspectives and approaches. Statistics should be kept on the number of ethno-racial psychiatric consumer/survivors using mental health services in Ontario, and the number of ethno-racial psychiatric consumer/survivors appearing before the CCB. Since health care professionals are constantly being encouraged to make mental health services more culturally sensitive, periodic evaluation reviews must occur to identify effective intervention strategies and treatment options for ethno-racial psychiatric consumer/survivors. In order to hold the
CCB accountable, indicators and valid assessment scales should be created and used to identify cultural gaps within Ontario’s mental health laws. 345

4.3 Concluding Remarks

In our increasingly multi-racial society, the exclusion faced by ethno-racial psychiatric consumer/survivors can no longer be ignored. I hope that the findings and recommendations from this study can contribute to successful advocacy for ethno-racial psychiatric consumer/survivors. However, I recognize that there are no easy answers or simple solutions, and the recommendations presented above are only the beginning. The future challenge for the CCB will be to collaborate with all the stakeholders, and to build upon the existing training and mentoring programs used for adjudicators. On the systemic level, decision makers must recognize the importance of funding ethno-specific mental health research and services, and we must all continue to question the institutional racism and stereotypical assumptions within society. As Rani Srivastava argues, “It is only when we embrace the difference, and deal with forces that impose conformity that we will discover cultures and the true value of diversity.”346

345 Currently, it is important to note the MHA mandates the reviews of Community Treatment Orders every five years. Although not aimed at evaluating culturally sensitivity, section 33.9 (1) states: “The Minister shall establish a process to review the following matters: 1. The reasons that community treatment orders were or were not used during the review period; 2. The effectiveness of community treatment orders during the review period; 3. Methods used to evaluate the outcome of any treatment used under community treatment order. According to s. 33.9 (4), the “Minister shall make available to the public for inspection the written report of the person conducting each review.” (MHA, R.S.O. 1990, c. M.7., s. 33.9).

BIBLIOGRAPHY

LEGISLATION


Immigration and Refugee Protection Act, S.C. 2001, c. 27.


Personal Health Information Act, S.O. 2004, c.3, Sched. A.


JURISPRUDENCE

B.; File TO-05-6467 (Re), [2005] O.C.C.B.D. No.211.


S.A. (Re), 2007 CanLII 37457 (ON C.C.B.); TO-07-1551.


SECONDARY MATERIAL: MONOGRAPHS

Across Boundaries. A Guide to Anti-Racist Organizational Change in the Health Mental Health Sector (Toronto: Across Boundaries, 1997).


Bickenbach, Jerome E. Physical Disability and Social Policy (Toronto: University of Toronto Press, 1993).


Mezzich, Juan E. and Giovanni Caracci (eds). *Cultural Formulation: A Reader for Psychiatric Diagnosis* (Maryland: Rowman and Littlefield Publishing Group, 2008).


SECONDARY MATERIAL: ARTICLES


Perlin, Michael. "'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.


SECONDARY MATERIAL: REPORTS


Scadding Court Community Centre. *Final Report: Perspectives on Disability in 3 Cultural Communities: Downtown Toronto, Canada* (Toronto: Canadian Centre on Disability Studies, 2005).


OTHER MATERIAL


Szigeti, Anita. "Representing a Client who has a Mental Health Issue before the Consent and Capacity Board" October, 2007 [unpublished].
APPENDIX A

Telephone/In-Person/E-Mail Script for Initial Contact with Psychiatric Consumer/Survivors

Hello. My name is Ruby Dhand and I am a graduate student at the University of Toronto, Faculty of Law. For my master’s thesis, I am conducting a study involving interviews with psychiatric consumer/survivors from various ethno-racial communities. Specifically, the purpose of this research is to investigate the experience of psychiatric consumer/survivors from various ethno-racial communities with the Consent and Capacity Board (CCB).

You are being invited to voluntarily participate in individual interviews concerning your experience with the Consent and Capacity Board. Your agreement to contribute to my study would be greatly appreciated. If you agree to participate in my study, I will interview you in person at the location of your choosing. The interview will last approximately one hour and I will be asking questions regarding your experience as a client before the Consent and Capacity Board. With your consent, the interview will be audio-taped. Since the participation in this research is voluntary, you have the right to withdraw from the study, decline to answer any questions or discontinue with the interview at any time with no negative consequences to your treatment.

In order to ensure anonymity and confidentiality, only a general summary of your personal information related to your ethnicity and educational background will be presented. If you wish, you may indicate that you do not want this information presented, and no negative consequences will ensue.

I wish to thank you in advance for your time.

Sincerely,

Ruby Dhand
APPENDIX B

Telephone/In-Person/E-Mail Script for Initial Contact with CCB Adjudicators, Lawyers, Service Providers and Psychiatrists

Hello. My name is Ruby Dhand and I am a graduate student at the University of Toronto, Faculty of Law. For my master’s thesis, I am conducting a study involving interviews with lawyers, service providers, health-care professionals and psychiatrists who have served psychiatric consumer/survivors from various ethno-racial communities. Specifically, the purpose of this research is to analyze the types of discrimination faced by psychiatric consumer/survivors from various ethno-racial communities in Ontario, through the narrow perspective of the Consent and Capacity Board (CCB).

Your name was given to me by [fill in the individual who suggested contacting this potential participant, if applicable] who suggested that you could give me some insight into this study. Given your expertise and experience, I would really appreciate if I could interview you. If you agree to participate in my study, I will interview you in person at the location of your choosing. The interview will last approximately one hour and I will be asking questions regarding your experience serving psychiatric consumer/survivors from various ethno-racial groups who are appearing or have appeared before the Consent and Capacity Board. I will ask you to discuss the challenges that you may have encountered with this clientele. With your consent, the interview will be audio-taped. Since the participation in this research is voluntary, you have the right to withdraw from the study, decline to answer any questions or discontinue with the interview at any time with no negative consequences.

In order to ensure anonymity and confidentiality, only a general summary of your personal information related to your education history and current employment will be presented, along with other demographic information if necessary. If you wish, you may indicate that you do not want this information presented, and no negative consequences will ensue.

I do not foresee that you should experience any risks when participating in this study since you will be discussing the type of work you are involved in and the type of clients you serve. Since little academic attention has been given to this area of study, the value of participating in this research lies in contributing to successful advocacy for psychiatric consumer/survivors from various ethno-racial communities and an opportunity for providing law reform and policy recommendations. I intend to take the knowledge that will result from this study back into the community to ensure that other stakeholders, lawyers, service providers and/or health care professionals and psychiatrists can benefit from it.
I wish to thank you in advance for your time. If you have any questions or if you would like further information about my study, please do not hesitate to contact me by phone at (647) 344-3396 or email at rubydhand41@gmail.com.

Sincerely,

Ruby Dhand
APPENDIX C

Semi-Standardized Interview Guide for Psychiatric Consumer/Survivors

* This will be used as a topic guide as the interview is semi-structured. The headings and questions may vary according to the time and comfort of the participant.

Introduction

Which ethno-cultural or ethno-racial community do you identify with?
Have you had a hearing, if so when?
Was it a CCB hearing?
Do you know what the hearing was for?

The CCB Process

What legal problems have you had?
Was it easy for you to find a lawyer?
Did you learn about the Consent and Capacity Board’s procedures before your hearing?
Were you able to talk to a rights adviser before the hearing?
Did you clearly understand your rights?
Did you have a lawyer at the hearing?
If so, do you think your lawyer did a good job?
If you had a lawyer, how many times were you able to meet with your lawyer before the hearing?

The Hearing

Can you describe your experience at the Consent and Capacity Board? (i.e. – What happened during the hearing? Was it a good or bad experience?)
What was the outcome of your hearing?
Did you feel comfortable at the hearing? (i.e. – Did you know what was going on? Did you feel welcome and at ease or nervous or frightened?)
If you were asked questions, did you feel that you were given a chance to express yourself without being hurried or interrupted?
Were you informed that you could ask for breaks as necessary?

If you had an interpreter, did she/he interpret only the questions that were directed to you or the full hearing?

If you used an interpreter, were the questions addressed to you and not the interpreter?

Did you feel that the Consent and Capacity Board took account of how factors such as race, ethnicity, religion, culture may have played a role in your situation?

Do you think the psychiatrist provided a good assessment of your situation?

Do you think the psychiatrist represented your situation fairly?

Did the psychiatrist take into account of any cultural factors that may have influenced your condition?

Did you have a service provider who was assisting you? Did he/she do a good job?

Were you able to bring your family to the hearing?

**After the Hearing**

After the hearing, did you fully understand the Consent and Capacity Board’s decision?

If not, were you able to get someone to help you understand?

How is mental health viewed in your community?

Do you feel that you are able to access culturally sensitive mental health services?

Do you have any recommendations how the Consent and Capacity Board can improve the process?
APPENDIX D

Semi-Standardized Interview Guide for Lawyers

What is the name of your law firm/legal clinic/organization?
What area of law do you specialize in?
How many years have you been practising in your field?
What is your experience with the Consent and Capacity Board?

What kind of experience do you have working with psychiatric consumer/survivors from various ethno-racial groups?
Generally speaking, which ethno-racial communities do your clients come from?
Is legal assistance easily accessible for this clientele?

What legal concerns have you heard from these clients (concerns such as 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.)?
Do these clients generally have positive or negative experiences at the Consent and Capacity Board?
What legal barriers do these clients face?

Have you seen situations where any of the following factors such as race, ethnicity, religion, immigrant/refugee status, language, sexual orientation, class, gender and/or disability have been a barrier for these clients?
How does the Consent and Capacity Board address these legal barriers?
How does the Consent and Capacity Board address issues of race, ethnicity, religion, immigrant/refugee status, language, sexual orientation, class, gender and disability?
Are these clients accommodated well at the Consent and Capacity Board?
What is the process for obtaining accommodation at the Consent and Capacity Board?
How is mental health/disability viewed differently amongst the various ethno-racial communities you work with?
Does the stigma and perceptions vary?
How do legal approaches to interpreting and dealing with clients who are psychiatric consumer/survivors compare to the cultural and/or medical approaches?

Are there common themes of exclusion?

What are the strategies or approaches that lawyers/service providers or the CCB can use to understand and challenge the barriers that these clients face?

Can you suggest any specific law reform initiatives and/or policy recommendations?
APPENDIX E

Semi-Standardized Interview Guide for Service-Providers

What is the name of your agency/organization?
What is your position title/what is your profession?
How many years have you been practising in your field?

What is the mandate of your agency/organization? What kind of services do you provide?
What kind of experience do you have working with psychiatric consumer/survivors from various ethno-racial groups?
Which ethno-racial communities does your organization have the most contact with?
How are your services culturally sensitive?
Are legal services easily accessible for clients who are psychiatric consumer/survivors from various ethno-racial groups?
Are there lawyers who serve these communities in your organization? If not, where do you refer to these clients for legal advice?
What legal concerns have you heard from these clients (concerns such as the 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.)?
Do these clients generally have positive or negative experiences at the Consent and Capacity Board?

What legal barriers do these clients face?
Have you seen situations where any of the following factors such as race, ethnicity, religion, immigrant/refugee status, language, sexual orientation, class, gender and/or disability have been a barrier for these clients?
How does the Consent and Capacity Board address these legal barriers?
How does the Consent and Capacity Board address issues of race, ethnicity, religion, immigrant/refugee status, language, sexual orientation, class, gender and disability?
Are these clients accommodated well at the Consent and Capacity Board?
How is mental health/disability viewed differently amongst the various ethno-racial communities you work with?

Does the stigma and perceptions vary?

How do legal approaches to interpreting and dealing with clients who are psychiatric consumer/survivors compare to the cultural and/or medical approaches?

Are there common themes of exclusion?

What are the strategies or approaches that lawyers/service providers or the CCB can use to understand and challenge the barriers that these clients face?

Can you suggest any specific law reform initiatives and/or policy recommendations?
APPENDIX F

Semi-Standardized Interview Guide for Psychiatrists

What is your position title/what is your profession?
Where do you work?
How many years have you been practising in your field?
What kind of educational training have you received?

What kind of services do you provide?
What kind of experience do you have working with psychiatric consumer/survivors from various ethno-racial groups?
Generally speaking, which ethno-racial communities do your clients come from?

What is your experience with clients who have had legal concerns?
What legal concerns have you heard from these clients (detained 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.)?

Have you ever been involved in a proceeding before the Consent and Capacity Board?
How do the cases involving psychiatric consumer/survivors from ethno-racial communities differ from others?
What challenges do these clients pose for a psychiatrist appearing before the Consent and Capacity Board?
How does culture/race impact the assessment of a client’s capacity?

Do these clients generally have positive or negative experiences at the Consent and Capacity Board?
What legal barriers do these clients face?
Have you seen situations where factors such as race, ethnicity, religion, immigrant/refugee status, language, sexual orientation, class, gender and/or disability have been a barrier for this clientele?
How does the Consent and Capacity Board address these legal barriers?
How does the Consent and Capacity Board address issues such as race, ethnicity, religion, immigrant/refugee status, language, sexual orientation, class, gender and disability?
Are these clients accommodated well at the Consent and Capacity Board?
How is mental health/disability viewed differently amongst the various ethno-racial communities you work with?
Does the stigma and perceptions vary?
How do legal approaches to interpreting and dealing with clients who are psychiatric consumer/survivors compare to the cultural approaches and/or medical approaches?
Are there common themes of exclusion?
What are the strategies or approaches that lawyers/service providers or the CCB can use to understand and challenge the barriers that these clients face?
What do you need to increase your capacity to deliver mental health services to these clients?
Can you suggest any specific law reform initiatives and/or policy recommendations?
APPENDIX G

Semi-Standardized Interview Guide for CCB Adjudicators

Can you describe your job?
What is your profession?
How many years have you been practising in your field?

What kind of experience do you have working with psychiatric consumer/survivors from various ethno-racial communities?
Generally speaking, which ethno-racial communities do clients before the CCB come from?
Is legal assistance easily accessible for this clientele?
What legal concerns have you heard from these clients (concerns such as 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.)?

Do these clients generally have positive or negative experiences at the Consent and Capacity Board?
What barriers to justice do these clients face?
Have you seen situations where any of the following factors such as race, ethnicity, religion, immigrant/refugee status, language, sexual orientation, class, gender and/or disability have been a barrier for these clients?
How does the Consent and Capacity Board address issues of race, ethnicity, religion, immigrant/refugee status, language, sexual orientation, class, gender and disability?

Are these clients accommodated well at the Consent and Capacity Board?
What is the process for obtaining accommodation at the Consent and Capacity Board?
What kind of training have the members of the CCB received?
Is there any specific training for addressing the needs of clients from various ethno-racial communities?

Are board members able to ensure cultural considerations are taken into account in the decisions (ie - alternative treatment plans – culturally appropriate treatment options, etc)?
How is mental health/disability viewed differently amongst the various ethno-racial communities you work with?

Does the stigma and perceptions vary?

How do legal approaches to interpreting and dealing with clients who are psychiatric consumer/survivors compare to the cultural approaches and/or medical approaches?

Are there common themes of exclusion?

What are the strategies or approaches that lawyers/service providers or the CCB can use to understand and challenge the barriers that these clients face?

Can you suggest any specific law reform initiatives and/or policy recommendations?
APPENDIX H

Consent Form for Psychiatric Consumer/Survivors

This research is being conducted by Ruby Dhand as part of her Master of Law at the Faculty of Law, University of Toronto. It is called, “Challenging Exclusion: A Critique of the Legal Barriers Faced by Psychiatric Consumers/Survivors from Ethno-Racial Communities in Ontario.” The purpose of this research is to investigate the experience of psychiatric consumer/survivors from various ethno-racial communities with the Consent and Capacity Board (CCB).

Process

By being a participant in this study, you will take part in a semi-standardized interview for approximately one hour. The researcher will be asking questions regarding your experience as a client before the Consent and Capacity Board. 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 Colleen Flood (Faculty of Law) 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.
APPENDIX I

Consent Form for CCB adjudicators, Lawyers, Service Providers and Psychiatrists

This research is being conducted by Ruby Dhand as part of her Master of Law at the Faculty of Law, University of Toronto. The purpose of this research is to analyze the types of discrimination faced by psychiatric consumer/survivors from various ethno-racial communities in Ontario, through the narrow perspective of the Consent and Capacity Board (CCB).

Given your experience of working with psychiatric consumer/survivors from various ethno-racial communities, the researcher has contacted you to be a participant in this study. By being a participant in this study, you will take part in a semi-standardized interview for approximately one hour. The researcher will be asking questions regarding your experience serving psychiatric consumer/survivors from various ethno-racial groups who are appearing or have appeared before the Consent and Capacity Board. I will ask you to discuss the challenges that you may have encountered with this clientele. 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 only people who will have access to the information will be the researcher, Ruby Dhand, and her supervisors, Professor Colleen Flood (Faculty of Law) and Dr. Kwame McKenzie (Centre for Addiction and Mental Health).

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 education history and current employment will be presented, along with other demographic information if necessary. 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 locked filing cabinet. 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. 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.

I do not foresee that you should experience any risks when participating in this study since you will be discussing the type of work you are involved in and the type of clients you serve. Since little academic attention has been given to this area of study, the value of participating in this research lies in contributing to successful advocacy for psychiatric consumer/survivors from various ethno-racial communities and an opportunity for providing law reform and policy recommendations. I intend to take the knowledge that will result from this study back into the community to ensure that other stakeholders, lawyers, service providers and/or health care professionals and psychiatrists can benefit from it.
If you have any questions about your rights as a participant, you may contact the Research Ethics Review Office by e-mail (ethics.review@utoronto.ca) or phone (416-946-3273).

If you have any questions about the procedures, or any aspect of the study, please feel free to call the researcher, Ruby Dhand, at 647-344-3396.

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