



# Challenging Involuntary Treatment and Confinement in Canada Through the United Nations Convention on the Rights of Persons with Disabilities (CRPD)

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**ABSTRACT** *The Convention on the Rights of Persons with Disabilities (CRPD) came into force in 2008. People with disabilities, including people with psychosocial disabilities, were instrumental to its development. Article 12 and Article 14 of the CRPD, which respectively affirm the universal legal capacity and right to liberty of persons with disabilities, were viewed as key victories by disability rights movements. These provisions are particularly important for people with psychosocial disabilities who are routinely subjected to human rights violations through psychiatric detainment and involuntary treatment authorized under domestic mental health legislation in many states. We aim to advance discourse surrounding the CRPD and its development by centring mad peoples' voices and individuals with lived experience through a literature review and interviews with key disability rights advocates. Using Canada as a case study, we critically examine the implementation of the CRPD and the need to align mental health acts with our international human rights obligations. We argue that forced psychiatric interventions violate the rights of persons with psychosocial disabilities and cause inherent harm. There is an urgent need to move towards new paradigms of care that promote the dignity and autonomy of people with psychosocial disabilities.*

**KEYWORDS** United Nations Convention on Rights of People with Disabilities; CRPD; human rights; rights for people with psychosocial disabilities; Canadian mental health law; supportive decision-making; non-coercive practices

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## Introduction

Social movements are critical to the advancement of human rights. They “agitate for the recognition of injustices as legal wrongs, and in which sectors of the population that have been oppressed rise up to assert themselves as protagonists who change the landscape of law along with the social, economic and cultural relationships in which law is grounded” (Minkowitz, 2012, p. 2). Activists and civil society groups played a central role in the drafting and adoption of the *United Nations (UN) Convention on the Rights of Persons with Disabilities* (CRPD) and continue to influence its implementation. Adopted by the UN in 2007, the CRPD constituted a landmark achievement for the rights of persons with disabilities and underscored a paradigm shift towards a human rights model of disability. Civil society groups played a pivotal role in solidifying the CRPD’s rights-based orientation and ensuring the inclusion of key provisions essential to addressing ongoing human rights violations against persons with disabilities.

Disability rights activists recognized the critical importance of *Article 12 – Equal Recognition Before the Law* and *Article 14 – Liberty and Security of the Person* for persons with psychosocial disabilities.<sup>1</sup> Forced psychiatry, a term used to describe coercive or non-consensual psychiatric intervention such as involuntary administration of treatment or detention in a psychiatric facility, routinely violate the human rights of people with psychosocial disabilities in the name of providing care (Burstow, 2019). By affirming the universal legal capacity of persons with disabilities and prohibiting the deprivation of a person’s liberty on the basis of disability, the CRPD provided a key moral and legal foundation for advocates to anchor their challenges to forced psychiatry and the legal regimes that underlie them. It further provided an opportunity to advance new paradigms of care that promote autonomy and dignity. However, aligning domestic mental health regimes with the CRPD has proven to be challenging – the paradigm shift called for by the CRPD has faced significant pushback.

The present paper aims to advance discourse regarding the CRPD and its relationship with domestic mental health regimes by centering the perspectives of people with lived experiences and disability rights activists involved in the psychiatric consumer/survivor’s movement. We conducted a literature review focused on work written by or with people with psychosocial disabilities involved in the disability rights movement. We also interviewed disability rights activists Mary O’Hagan and Susan L. Hardie, both of whom have lived experiences and have worked in the cross-disability and mental health sectors in various roles for over 30 years. O’Hagan participated in the CRPD negotiations as a member of the New Zealand delegation and was recently

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<sup>1</sup> We prefer to use the term “psychosocial disabilities” over terms like “mental illness” or “mental disorders” because this is the language this is used in the UN CRPD and is understood internationally.

appointed as the Executive Director of Lived Experience in the Department of Health in Victoria, Australia. Hardie is currently the Executive Director of Eviance, a community-based knowledge hub on cross-disability rights.

Centering on Canada, we contrast the intended goals of the CRPD with the current legislative reality of domestic mental health regimes and the continued use of forced psychiatry. In the first main section of this paper, we trace the historical significance of the CRPD and its development through a literature review and analysis of interviews with cross disability rights activists – O’Hagan and Hardie – who were active in the psychiatric consumer/survivor movement. In the second main section, we analyze Canadian provincial and territorial mental health legislation and their compliance with the CRPD, focusing specifically on involuntary treatment and psychiatric detention. We review competing interpretations of the CRPD, and arguments advanced for and against the dominant medical model of mental health “care.” In the third section, we build upon insights drawn by disability right activists to explore new paradigms of care implemented in Canada and elsewhere that comply with the CRPD.

## **Crafting the CRPD**

### *Disability in International Human Rights Law*

To appreciate the significance of the CRPD, it must be situated within the development of international human rights instruments and their historical representations of persons with disabilities. Bengt Lindqvist, the first UN Special Rapporteur on Disability of the Commission for Social Development and co-founder of Disability Rights Promotional International contends that the *Universal Declaration of Human Rights* by the United Nations in 1948 is one of the most important modern human events (Lindqvist, 2015, p.13). It contains the most widely accepted definition of human rights globally (Weissbrodt & Vega, 2010). This began the groundwork for the rights of people with disabilities. International treaties are often viewed as important tools in the modern world to protect the powerless from the powerful (Ignatieff, 2003).

Historically, people with disabilities have lacked access to rights enjoyed by non-disabled people. As society is often constructed from an able-bodied viewpoint, the needs of people with disabilities are often not considered (Quinn & Degener, 2002a, p. 23). As Quinn & Degener (2002a) remind us the task “of the international human rights system in this field [disability rights] is to make societies aware of the contradiction between their self-professed values and their application (or rather their non-application or misapplication) in the context of disability” (p. 23).

International treaties did not explicitly address the rights of people with disabilities until the 1970s and 1980s. Despite the UN adopting the *Declaration*

*on the Rights of Mentally Retarded* in 1971 and the *Declaration on the Rights of Disabled Persons* in 1975, both of which formally recognized the rights of people with disabilities (Rioux & Heath, 2014, p. 319), they were based largely on an individual/biomedical model of disability that frames disability as a personal tragedy and pathology that must be prevented, treated and cured (Barnes & Mercer, 2010). Consequently, “disabled persons have been depicted not as subjects of legal rights but as objects of welfare, health and charity programs” (Degener, 2000, p. 180). This understanding of disability has important implications for the human rights of persons with disabilities.

In the 1970’s and 1980’s disability activists became increasingly more vocal about their issues with the medical/individual model that dominated how people with disabilities were viewed and treated (Barnes & Mercer, 2010). This model emphasizes individual pathology and not social or environmental factors that contribute to disability. The by-product is “the underlying policy has been to segregate and exclude people with disabilities from mainstream society...because disabled persons were believed incapable of coping with both society at large and all or most major life activities” (Degener, 2000, p. 180). Disabled activists focused on how society was organized and how it contributed to restrictions of activities for people with disabilities (Barnes & Mercer, 2010). The Union of the Physically Impaired Against Segregation (UPIAS) created the social model to distinguish between impairment and disability (Barnes & Mercer, 2010). UPIAS defined impairment as “lacking part of or all of a limb, or having a defective limb, organism or mechanism of the body” (Oliver, 1990, p. 33). Disability, on the other hand, was defined as limited social inclusion and opportunity to participate in mainstream activities as compared able-bodied or sane persons (Oliver, 1990). UPIAS formulated a new social model of disability that positioned disability as socially constructed: the result of impairments interacting with structural barriers in their environment.

The social model of disability shifted thinking to inclusion and accessibility. This “paradigm shift from the medical to the social model of disability...reclassified [disability] as a human rights issue” (Degener, 2000, p.181). As Swain and French (2014) contend, “the human rights approach is the main international thrust for social change emanating from the social model of disability and the global challenge to the oppression of disabled people” (p. 50). To solidify this paradigm shift disability rights activists aimed to embed the social model and human rights models in human rights law. However, as with many important societal shifts, this required time and favourable political circumstances.

The United Nations (UN) International Year of Disabled Persons in 1981 and the International Decade of Disabled Persons from 1982-1992 (van Trigt, 2020, p. 206) helped to put disability rights issues on the global agenda. In 1982, the UN also established a World Programme of Action (WPA) Concerning Disabled Persons to develop a global strategy towards full participation of persons with disabilities in social life and national development

(UN Department of Economic and Social Affairs Disability, 1982). It was “during an expert meeting about the implementation of the WPA in 1987 in Stockholm, the idea of a convention emerged” (van Trigt, 2020, p. 207). While Italy and Sweden’s early attempts to advance such a convention were unsuccessful, the *Standard Rules on the Equalization of Opportunities for Persons with Disabilities* (Standard Rules) were created and adopted in 1993 (United Nations, 1993). They called for a UN Special Rapporteur on Disability “to monitor the implementation of the Rules” (United Nations, 1993, n.p.), which Bengt Lindqvist first held from 1994-2002. The Standard Rules called for States “to remove obstacles to equal participation” in society and “to involve disability NGOs as partners in this process” (Quinn & Degener, 2002b, p. 35). Thus, in the last three decades of the twentieth century the concept of disability rights emerged and established itself as a recurrent focus in international human rights discourse.

#### *Development of the CRPD*

Mary O’Hagan recounts a moment in 2001 when a significant shift in the creation of the convention occurred:

There was a guy from Mexico, who was a very well-connected guy, who had a disability of some sort. He managed to do something that a whole lot of people hadn’t been able to do. And that is to get the issue of the Convention on the agenda at the United Nations. (O’Hagan, personal communication, September 30, 2021)

That man from Mexico would be former Mexican Presidential candidate Gilberto Rincón Gallardo.

Beginning in the early 2000s Mexico started a strategic push towards an international disability convention. According to Andrés Balcázar de la Cruz (2020), Mexico was able to play this pivotal role because of the election of Mexican President Vicente Fox in 2000, who included disability rights as a key part of his platform. Fox supported the creation of an Office for Disability Matters, directed by a disabled person, Victor Hugo Flores. Flores worked with disability activist Maru (Maria Eugenia Antúnez Farrugia) and Ambassador Luis Alfonso de Alba to push for a UN disability rights convention (de la Cruz, 2020). Gallardo, who is also a person with a disability, attended the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance in September 2001 as the head of Mexican delegation, while Maru went around the same time to lobby the United Nations Third Committee in New York (de la Cruz, 2020). In December 2001, the UN general assembly accepted the recommendation from the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance, which included the creation of an Ad Hoc Committee to Create a UN Disability Convention. This in turn led to the issue of a disability convention being on the agenda of the general UN meetings in 2001. Prior to getting the issue on the agenda,

O'Hagan explains that she was part of a committee that met twice a year to help advise Bengt Lindqvist about how to monitor the Standard Rules from 1996 to 2001. O'Hagan explains that "we were always talking about a need for a convention on the rights of people with disabilities" (personal communication, September 30, 2021). She further explains that "after discussing for several years...suddenly the clouds parted, and the opportunity [for the convention] was there" (personal communication, September 30, 2021). She finishes by saying many disability rights activists "were pleasantly surprised. It is not often things happen a lot quicker than you expect. They usually take an indeterminable amount of time" (personal communication, September 30, 2021).

During the negotiation of the CRPD O'Hagan participated in its drafting at a meeting in New York in 2004. The CRPD was one of the first UN conventions that allowed the active participation of non-governmental organizations (NGO) and Disabled Persons Organizations or Organizations of Persons with Disabilities (DPO/OPD) in its formulation (O'Hagan, personal communication, 30 September 2021). This resulted in a diversity of representation of civil society groups in drafting the CRPD. O'Hagan described how this unique structure influenced the process of drafting the CRPD:

[Negotiations were] fraught and difficult and chaotic...as a result there were a lot of side meetings. Many decisions were made outside of the main meeting. Parties would meet and agree on wordings that would go through more easily. The striking thing about these meetings and sub-meetings was the role of the NGOs. (personal communication, September 30, 2021)

The role NGOs played in the drafting process was instrumental to the final wording of the present day CRPD. It enabled disability rights activists to play a central role in formulating key provisions.

In addition to cementing the social model of disability in the CRPD preamble (e.g., Article 5), the involvement of NGOs in the drafting of the Convention enabled activists to advance disability rights in a novel manner. Article 12, para. 2 of the CRPD challenged legal regimes that undermine the legal capacity of persons with disabilities by affirming they "enjoy legal capacity on equal basis with others in all areas of life" and calling for State Parties to provide access "to the support [persons with disabilities] may require in exercising their legal capacity." Similarly, Article 14 para. 1a & 1b affirmed persons with disabilities have the right to liberty and security of the person and that "the existence of a disability shall in no case justify a deprivation of liberty."

These articles of the CRPD were of critical importance to people with psychosocial disabilities whose rights are deprived through coercive psychiatric practices and substitute decision-making regimes. Mary O'Hagan noted, "[Article 12 and 14] were the real radical changes. Socioeconomic and political rights – they were kind of a restatement...the radical bit was the part about legal capacity and compulsory treatment" (personal communication,

September 30, 2021) Susan Hardie notes “I see Article 12 as essential to the entire CRPD – like the heart” (personal communication, September 30, 2021). People with disabilities may require different supports and resources to exercise their rights than their non-disabled peers but are no less entitled to exercising them.

They also proved to be the most contentious articles. Canada submitted a reservation to Article 12 affirming their intention to maintain substitute decision-making regimes “subject to appropriate and effective safeguards” (United Nations, n.d.), signaling their resistance to full implementation of the CRPD. Nonetheless, the CRPD provides an important international legal framework to challenge legal regimes and institutions that routinely violate the rights of persons with disabilities, including substitute decision-making models, while also challenging societal attitudes towards people with disabilities perpetuated under the dominant medical model.

### **Canadian Mental Health Regimes & Resistance to CRPD Compliance**

Disability rights groups have called for Canada to remove their reservation to Article 12 and reform legal regimes to ensure compliance with the CRPD (Inclusion Canada, 2022). A shadow report produced by Canadian users and survivors of psychiatry documents the lived experiences of people with psychosocial disabilities including the “nightmarish” effects of forcibly administered antipsychotic medication and other human rights violations endured while detained (Mad Canada Shadow Report, 2017). The report further details how all 13 of Canada’s provinces and territories enable involuntary treatment through substitute decision-makers as well as detention on the basis of psychosocial disability and thereby fail to comply with the CRPD. In particular, British Columbia’s mental health care system has been criticized for violating the rights of persons with psychosocial disabilities. A report published by the Community Legal Assistance Society, *Operating in Darkness: BC’s Mental Health Act Detention System*, details the use of restraints, seclusion, the removal of clothes and personal belongings and other indignities suffered by individuals detained under the *Mental Health Act* (Johnston, 2017). The report further identifies how detained individuals’ lack of access to legal services and insufficient institutional oversight enable human rights abuses.

Canada’s reservation to Article 12 and its limited implementation of the CRPD to date is supported by some medical experts who argue that abolishing substitute decision-making and other forced psychiatry practices would be detrimental to persons with psychosocial disabilities (Dufour et al., 2018; Gray et al., 2016). As both Susan Hardie and Mary O’Hagan remarked, there appears to be a lack of political willingness to modify these legal regimes and challenge the logic underlying. Hardie says:

I don't see the buy in from the government at all... When I was at the [Mental Health Commission of Canada] Justice Edward (Ted) Ormston led an innovative mental health and the law pilot project in three provinces to explore how to align mental health legislation and associated practices with the CRPD. The Final Project Report was clear "how to," but there was absolutely no commitment, nor political will, to implement the required actions to be signatories to CRPD in its entirety. (personal communication, December 18, 2021)

People with psychosocial disabilities and their allies seeking legal reform have often sought recourse through the courts. Various cases have been advanced in Canadian courts aiming to invalidate different provisions of provincial mental health regimes on the basis that they violate rights protected under the *Canadian Charter of Human Rights and Freedoms* (1982) (e.g., *McCorkell v. Riverview Hospital*, 1993). These legal challenges have led to mixed results. While there have been some cases that have circumscribed the use of forced psychiatry and affirmed the capacity of persons with psychosocial disabilities (e.g., *Fleming v. Reid*, 1991; *P.S. v. Ontario*, 2014; *Starson v. Swayze*, 2003), the courts have often found that the infringements upon individual rights authorized in mental health legislation are justified as a means of achieving legitimate public health and safety objectives (e.g., *Thompson v Ontario*, 2016). Dhand and Joffe (2020) argue, these types of Charter challenges should be interpreted in light of Canada's international human rights commitments under the CRPD.

However, as Hardie observed while working with lawyers in disability rights organizations on key court cases, "rarely has the CRPD been pulled into the arguments or cited" (personal communication, September 30, 2021). As a result, there has been minimal progress made towards abolishing substitute decision-making and psychiatric detainment in Canada and realizing the full ambition of the CRPD post-ratification. As Hardie notes "we have these structures that are keeping it the same" (personal communication, September 30, 2021) Further,

Canada consciously chose to keep the broken system, revealed by Senator Michael Kirby's *Out of the Shadow* report,<sup>2</sup> and was to begin remediation with Canada's first Mental Health Strategy in 2012, but the federal government chose to not fund the implementation of its own Strategy that was aligned with intersectionality and human rights, something the Committee of the Rights of Persons with Disabilities is requesting the federal government embrace... As a staff of MHCC [Mental Health commission of Canada] and Canadian citizen, it was my sense we failed all citizens in Canada for not addressing the 'broken mental health systems in our provinces and territories,' which continue to be aligned more for social control for the majority, with only a few privileged individuals accessing social care. (Hardie, personal communication, December 18, 2022)

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<sup>2</sup> See Kirby & Keon (2006).

The legal justifications for involuntary treatment and psychiatric detention can be distinguished: involuntary treatment is generally permitted on the basis that the individual lacks the capacity to consent and is authorized via a substitute decision-maker who provides substituted consent (*Starson v. Swayze*, 2003). In contrast, psychiatric detention of people with psychosocial disabilities is broadly justified on the basis of personal protection and public safety (Dhand & Joffe, 2020).

### *Substitute Decision-Making Regimes in Canada*

In *Starson v. Swayze* (2003) the Supreme Court of Canada established that treatment should only be imposed when a person is unable to understand the relevant factors and appreciate the likely consequence of their treatment refusal (para 10). When a person is deemed to lack capacity to make medical decisions, legal regimes authorize substitute decision-makers to consent on their behalf, which can vary greatly by jurisdiction. In some provinces, like Ontario and Alberta, the substitute decision-maker is a private actor such as a close friend or relative (Gray et al., 2016). In other jurisdictions, like British Columbia, Saskatchewan or Quebec, the substitute decision-maker may be an appointee of the State (e.g., an attending physician or a judge). In many cases, substitute decision-makers are required to make decisions in the “best interest” of the individual they represent. Some legal regimes also require the substitute decision-maker to respect the advanced instructions of the substitute. For example, if a person expressed while “capable” that they did not want antipsychotic medication under any circumstances a substitute decision-maker in Ontario would be bound to respect this decision. In other jurisdictions like Saskatchewan, the substitute decision-maker is obliged to consider the substitute’s capable wishes but can override them under certain conditions (Gray et al., 2016). Key features of substitute decision-making regimes across Canadian jurisdictions are summarized in the table below based on research by Gray et al. (2016).

*Table 1.* Substitute Decision-Making Regimes in Canada

<b>Jurisdiction</b>	<b>Substitute Decision-Maker</b>	<b>Best interests requirement</b>	<b>Adherence to advance directives or “capable wishes”</b>
BRITISH COLUMBIA	Director of Psychiatric Unit	Yes	Not specified
ALBERTA	Private Actor	Yes	Not specified
SASKATCHEWAN	Attending physician	Yes	Consideration only
MANITOBA	Private Actor	Modified*	Modified*
ONTARIO	Private Actor	Not specified	Yes
QUEBEC	Court	Yes	Not specified
NOVA SCOTIA	Private Actor		Consideration only
NEW BRUNSWICK	Specialized Tribunal	Yes	Consideration only
PRINCE EDWARD ISLAND	Private Actor	Yes	Not specified
NEWFOUNDLAND/LABRADOR	Attending physician	Yes	Not specified
YUKON	Private Actor	Not specified	Yes
NORTHWEST TERRITORIES/NUNAVUT	Private Actor	Not specified	Yes

(Source: Gray et al., 2016)

\*According to Gray et al. (2016), Manitoba has a “modified best interests” test, which means that the substitute decision-maker “must adhere to the patient’s previous capable wishes [unless doing so] would endanger the physical or mental health or safety of the patient or another person” (p. 224) in which case the decision should be made in the best interest of the substitute.

Substitute decision-making generally reflects a biomedical conceptualization of psychosocial disabilities rather than a social or human rights framework. Gray et al. (2016) argue that expanding physicians’ discretionary power to authorize involuntary psychiatric interventions would enable earlier access to treatment, shorter detention periods and improved health outcomes. This is contested by many psychiatric users/survivors (Mad Canada Shadow Report Group, 2017). Justifying non-consensual treatments because they are in the best interests of the patient undermines the autonomy of persons with psychosocial disabilities and deprives them of their legal agency protected by Article 12 of the CRPD.

Forced psychiatric treatment via substitute decision-making in Canada also stands in sharp contrast to a large body of Canadian jurisprudence protecting the right to bodily autonomy and medical self-determination, which includes the right to refuse treatment (e.g., *Malette v. Shulman*, 1990). Doctors are required to respect treatment refusal via advanced directive, even in emergency situations where a person is incapacitated, and treatment is deemed in their best interest (Mad Canada Shadow Report Group, 2017). Canadian courts have affirmed that these common law principles apply to persons with psychosocial disabilities too (*Fleming v. Reid*, 1991). Nonetheless, Canadian mental health legislation often does not require substitute-decision makers to respect advanced directives and frequently empowers them to override contemporaneous treatment refusal if it is in the substitute's best interest. Canadians with psychosocial disabilities do not enjoy access to medical self-determination equal to their non-disabled peers.

Additionally, the Committee on the Rights of Persons with Disabilities explains the conditional nature of capacity assessments and greater need for contextualization:

Mental capacity is not, as it is commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity. (Committee on the Right of Persons with Disabilities, 2014, para. 14)

The Committee clarifies that “perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity” (Committee on the Right of Persons with Disabilities, 2014, para. 13). Instead, the Committee calls for states to replace substitute decision-making regimes with supportive decision-making models. The law should prioritize representing the will of the individual to the greatest extent possible rather than supplanting it with substitute decision-makers and “objective” evaluations of what is in the individual's best interests.

### *Psychiatric Detention Regimes in Canada*

As Anand (1979) argues, involuntary psychiatric detention “represents the most significant deprivation of liberty without judicial processes that is sanctioned by our society” (p. 251) and is left “almost entirely to the discretion of psychiatrists” (p. 251). From Table 2 below, seven out of 13 Canadian jurisdictions have incorporated a deterioration as alternative to harm criterion into their mental health acts. This means a person may be detained even with no immediate safety risk identified (Gray et al. 2016). This lower threshold for detainment was unsuccessfully challenged in British Columbia and Ontario courts by two individuals, Joseph McCorkell and Karlene Thompson (Dhand & Joffe, 2020; *McCorkell v Riverview Hospital*, 1993; *Thompson v. Ontario*,

2016). The table below, copied from Gray et al.'s (2016) research, summarizes key criteria for psychiatric detainment in Canadian mental health acts.

Table 2. Criteria for Psychiatric Detainment in Canada

<b>Jurisdiction</b>	<b>Definition of harm</b>	<b>Deterioration as alternative to harm</b>	<b>Incapable of making treatment decision</b>
BRITISH COLUMBIA	Broad	Yes	No
ALBERTA	Broad	Yes	No
SASKATCHEWAN	Broad	Yes	Yes
MANITOBA	Broad	Yes	No
ONTARIO	Bodily	Yes (partial)	No for bodily harm. Yes for deterioration.
QUEBEC	Bodily	No	No
NOVA SCOTIA	Broad	Yes	Yes
NEW BRUNSWICK	Broad	No	No
PRINCE EDWARD ISLAND	Broad	No	No
NEWFOUNDLAND/LABRADOR	Broad	Yes	Yes
YUKON	Bodily	No	No
NORTHWEST TERRITORIES/NUNAVUT	Bodily	No	No

(Source: Gray et al., 2006)

Canadian mental health regimes clearly contravene Article 14 of the CRPD as the law permits the deprivation of liberty on the basis of people's disability. This explicit distinction "on the basis of disability" creates an inequality: a person without a diagnosed "mental disorder" who meets the other criteria outlined in the legislation, including risk of harming themselves or others, cannot be involuntarily detained. However, a person with a psychosocial disability who meets the legislative criteria of diagnosed mental disorder would be detainable. Section 15 of the *Canadian Charter of Human Rights and Freedoms* (Charter) (1982) protects the right to equality and prohibits discrimination on the basis of disability. The Charter thus provides a legal mechanism for challenging mental health legislation in Canadian courts in addition to Article 14 of the CRPD. However, legal scholars Dhand and Joffe (2020) observe there is a notable absence of Canadian jurisprudence challenging mental health laws on the basis of section 15 (p. 238). Rather, most

case law invokes section 7 of the Charter, which protects the right to life, liberty, and security of the persons (e.g., *Thompson v. Ontario*, 2016).

In addition to its direct infringements on individual rights, institutional confinement has been associated with a wide range of human rights abuses and violations (Capponi, 2003; Minkowitz, 2012; Shimrat, 1997, 2016). Once institutionalized, Canadian mental health legislation empowers medical professionals to use restraints, both physical and chemical, to control patients (e.g., *Mental Health Act*, 1996, art. 32). While any period of involuntary detention infringes a person's basic rights and can cause lasting trauma, longer periods of detention are even more concerning.

Rights of people with psychosocial disabilities are infringed further because some jurisdictions in Canada permit involuntary treatment to capable patients when they are involuntarily detained. British Columbia's deemed consent model is the most egregious example; it automatically empowers the director of the psychiatric unit to make treatment decisions upon admission (*Mental Health Act*, 1996, art. 31). Alberta and New Brunswick have similar "treatment override" provisions for involuntarily detained patients (Dhand & Joffe, 2020). Newfoundland and Saskatchewan also impose higher standards of capacity on involuntarily detained patients which more easily enables substitute consent (Dhand & Joffe, 2020). In *MacLaren v. British Columbia (Attorney General)* (2018) the constitutionality of British Columbia's deemed consent model that is in their *Mental Health Act* is being challenged.<sup>3</sup> Dhand and Joffe (2020) argue there is a strong case for overturning British Columbia's deemed consent model and similar treatment override provisions on the basis of both section 7 and section 15 of the Charter.

### *Access to Justice Issues*

There are problems with mental health legislation implementation and access to justice for detained individuals. Due to the significant consequences of both substitute decision making arrangements and psychiatric detention, these determinations are subject to judicial review either in provincial courts or specialized tribunals (e.g., Ontario Capacity and Consent Review Board). *Operating in Darkness: BC's Mental Health Act Detention System* (Johnston, 2017) highlights the challenges psychiatric patients encounter with the mental health act when trying to exercise their rights. The report highlights the lack of legal criteria governing the use of restraints and seclusion, the lack of access to independent legal advice, and inadequate accountability and oversight mechanisms. Annual reports from specialized tribunals and review boards in British Columbia and Ontario suggest that the use of coercive psychiatric

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<sup>3</sup> The deemed consent model automatically empowers the director of the psychiatric unit to authorize treatments for any individual who is involuntarily detained. Individuals are "deemed to consent" to treatment upon admission.

practices, including involuntary detention, is increasing (Mental Health Review Board 2020; Consent & Capacity Board 2021). The reports demonstrate the number of review hearings have not kept pace with increased detention which suggests people with psychosocial disabilities could be encountering barriers in accessing judicial review mechanisms intended to safeguard their rights (Mental Health Review Board 2020; Consent & Capacity Board 2021).

Susan Hardie elaborates on the current state of mental health systems in Canada and the work that needs to be done for marginalized groups:

If everyone could have access to the same system of “care,” then great!... Unfortunately, the people who are living in poverty, who are marginalized, who are different, diverse, and exposed to violence and substandard or no housing, they are not offered the same services and resources that those with insurance coverage (i.e., more privileged) do. The former will be offered primarily practices grounded in social control while the later are offered emotional health and well-being through social care practices. The “success” of mental health care system transformation needs to be measured by the most marginalized experiences ... hopefully this will scale up increasingly social care practices, policies and legislation in all provinces and territories in Canada. (personal communication, September 30, 2022)

Hardie adds:

The mental health systems are still broken, if not more, since Senator Kirby’s work. We need to ensure the diverse, disability communities know that they will not incur additional harm and trauma if they access the current mental health systems, and together we need to work to co-create community resources grounded in human rights with a vision of emotional health and well-being for all. (personal communication, September 30, 2022)

People with lived experience must be included in the development of laws and policies to ensure compliance with the CRPD.

### **Towards a New Paradigm of Care**

Alberto Vásquez Encalada, an internationally known Peruvian lawyer, disability activist and person with lived psychosocial experience tells us that there is a growing movement to “end all forms of coercion in mental health services, which is consistent with rising evidence showing that community-based crisis services can deliver the desired outcomes in assisting people during crisis situations” (Vásquez Encalada, 2021, p. 138). In this final section we explore other ways to work with people with psychosocial disabilities who are experiencing mental distress. There are many different models, ideologies

and paradigms that could be listed in this section.<sup>4</sup> We have chosen to highlight ones that are mentioned by or connected to the Centre for the Human Rights of Users and Survivors of Psychiatry<sup>5</sup> and the World Network of Users and Survivors of Psychiatry,<sup>6</sup> as well as ideas shared in our roundtable discussion. All of these ideas support creating systems of care and support and upholding human rights. These solutions are advanced by people who have lived experiences of psychosocial disabilities.

### *Moving Towards CRPD Compliant Systems*

As mentioned above, the CRPD calls for supportive decision making to replace substitute decision making. Supportive decision-making supports the rights of people with disabilities by allowing the person with a disability to, through various accommodations and supports, partake in the decision-making process about their life instead of appointing a guardian to make all the decisions on behalf of a person with a disability (Yamin, 2021). This is clearly a departure from the dominant medical model and runs contrary to conceptualizations of psychosocial disability perpetuated by these systems. This is confirmed by the fact that “the CRPD and CRPD Committee’s jurisprudence have been received with incredulity and contempt from part of the [dominant] psychiatric community” (Vásquez Encalada, 2021, p. 137). Even with resistance from psychiatrists, in 2018 Peru changed its Civil Code in a way that, Tina Minkowitz said at the time “has moved [Peru] closer to full compliance with Articles 12 and 14 than any other country in the world” (Minkowitz, 2018). Legislative Decree No 1384 explains that Peru “recognizes the full legal capacity of all persons with disabilities, abolishes guardianship for persons with disabilities, removes restrictions on their legal capacity (e.g., to marry or to make a will), and introduces different regimes for supported decision-making” (SODIS, 2018, n.p.).

SODIS (Sociedad y Discapacidad – Society and Disability) is a disability rights activist group in Peru that initiated this change to the Peruvian Civil Code and provided technical advice on bringing the Civil Code closer to the CRPD (Minkowitz, 2018). In 2019, Colombia tabled similar legislation and in 2022 Mexico amended its legislation to transition away from institutional and guardianship models (Absolute Prohibition, 2022). Peru, Columbia, and Mexico provide a blueprint to bring law closer to CRPD compliance that addresses the gap in implementation criticized by Hardie, O’Hagan and other disability right advocates. It illustrates a legal framework that upholds the

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<sup>4</sup> Some of these practices are also mentioned in a larger guide by the World Health Organization that is designed to provide information and support to people who wish to transform their mental health system to align with the CRPD (World Health Organization, 2022).

<sup>5</sup> Center for the Human Rights of Users and Survivors of Psychiatry (<http://chrusp.org/>)

<sup>6</sup> World Network of Users and Survivors of Psychiatry (<http://wnusp.net/>)

human rights of persons with disabilities that can inform mental health legislation in other countries.

### *Rights-based Models, Ideologies and Paradigms of Care*

Language, particularly the language used in legal and medical environments, often reinforces the medical model and is therefore a contested space. It influences societal understandings of disability and can reinforce harmful stereotypes. Hardie points out:

The language of the DSM [Diagnostic and Statistical Manual of Mental Disorders] is now mainstream language... We [Canadian mental health activists] fought to replace descriptions with the 'Words with Dignity' shift from schizophrenic, manic depressive, to 'people with' a diagnosis of specific mental health issues at a given moment in time. (personal communication, September 30, 2022)

As the manual that informs the basis of modern Western psychiatry, the DSM is based in medical model thinking, and uses medicalized words. The theories and ideas that inform the importance of language use comes from the linguistic relativism of Benjamin Whorf from the first half of the 20<sup>th</sup> century, asserts that language limits our thinking and that if you change language to a desired goal, results will follow the change of language (Halmari, 2011). It is then important that when thinking of changing the dominant paradigm we take a look at the language used and what is saying.

Another interesting model is the Eindhoven model, which uses supportive decision making to respond to mental health crises. Jolijn Santegoeds, founder of Sighting Mind Rights, Co-Chair of the World Network of Users and Survivors of Psychiatry, and an expert with lived experience developed the Eindhoven model:

The Eindhoven Model for supported decision making ... is a potential alternative to avoid forced psychiatric interventions. The Eindhoven Model takes an experience-centered approach in line with human rights principles, and embraces the core view that persons themselves are the experts about their own lives. The Eindhoven Model focuses on identifying desirable support, respecting persons and dealing with diversity in psychosocial crisis situations. (Santegoeds, 2015, p. 20)

Family Group Conferencing, also known as Open Dialogue or Dutch Family Group Conferencing, is a process used in the Eindhoven model that involves a group of individuals important to a person in a psychosocial crisis who engage in a voluntary consultation around a key question of care (Santegoeds, 2015; Shout et al., 2017). The goal is to identify a range of outcomes that the person in psychosocial distress can then choose from (Santegoeds, 2015). The focus is on working with the individual experiencing psychosocial issues and collaboratively finding a solution, instead of thinking of suppressing and controlling distressing behaviours.

Another model worth mentioning is the PO-model. PO stands for “personligt ombud” a Swedish term that loosely translates to “personal ombudsperson” (PO) in English (Council of Europe, 2024). While there seem to be different variations of a PO depending on local contexts, Jespersion outlines the core values, principles and requirements of the PO. A PO has no alliance with psychiatry, any other social service, any other authority, or any family members, (Council of Europe, 2024). A PO is a highly skilled professional who works entirely for the client and does what the client wants and works over the long term with the client to create a trustful relationship, (Council of Europe, 2024). A PO does not fix things but spends a lot of time talking with a client about the things that matter to them and accompanies the clients through their journey with psychosocial disabilities (Council of Europe, 2024). This concrete example of supportive decision-making was developed by people with psychosocial disabilities and gives a blueprint for ways to support individuals with psychosocial disabilities without taking away their rights.

Maths Jespersion in a 2014 presentation recalls the impact his 2006 presentation about POs had as part of a side event for the Ad Hoc Committee that was preparing the CRPD. The side event, which was jointly organized by World Network of Users and Survivors of Psychiatry (WNUSP), MindFreedom International and Inclusion International, and was sponsored by the state of Canada, attracted so much attention that UN ambassadors were unable to find a chair due to the significant interest in the PO-service (Jespersion, 2014). Jespersion credits this side event in generating a hard discussion about the degrading effects of substitute decision making that reinforced the need for a paradigm shift to supportive decision-making (Jespersion, 2014).

### *Reconceptualizing Psychosocial Disabilities*

In addition to creating new models and structures that depart from the dominant medical model, movements of individuals with lived experiences also aim to change societal understandings of psychosocial disabilities. An example is the Hearing Voices movement:

[The Hearing Voices movement] consists of the diverse conversations, initiatives, groups and individuals around the world that share some core values. These include: hearing voices, seeing visions and related phenomena are meaningful experiences that can be understood in many ways; hearing voices is not, in itself, an indication of illness – but difficulties coping with voices can cause great distress; when people are overwhelmed by their experiences, support offered should be based on respect, empathy, informed choice and an understanding of the personal meaning voices have in someone’s life. (Intervoice, n.d.)

The core values align in many ways with the Eindhoven model, including the importance of treating individuals with respect and ensuring they are in control

of their own care. They both challenge dominant models of service provision that require individuals to relinquish autonomy and comply with expert recommendations to access support. However, social movements like Hearing Voices further oppose the stigmatization of psychosocial differences and push for non-judgmental acceptance of diverse ways of experiencing the world and self-expression. It rejects the medical model that conceptualizes psychosocial disability as something “wrong” that must be remedied.

One model of care that has emerged from social movements is Intentional Peer Support, which is non-directional support provided by non-professionals with lived experience (Intentional Peer Support, n.d.). The Red Door project, which is based in India, adopts this approach and centres a psycho-spiritual approach that affirms existential questions and worries can cause psychosocial crises (The Red Door, n.d.). The Red Door focuses on person centric approaches, art and knowledge expansion as ways to address psychosocial crises (The Red Door, n.d.). There is of course room to address something that an individual sees as wrong, but the goal is not to fix people or tell people how to be. Through acceptance of differences, peer support and self-discovery the rights of an individual are respected, upheld and encouraged. Thus, these ideologies help to reframe psychosocial disabilities as human experiences and not some sort of disease. They also help to create other ways of viewing psychosocial disabilities as perhaps not a disability at all, but a difference in feeling and experiencing the world. Psychosocial disability is the language of the CRPD, which is why we use it, but in an ideal world thinking of psychosocial disabilities in other less medicalized terms would be better language and would receive greater uptake in law, medicine, academia, and popular discourse.

The above is not an exhaustive list of new paradigms of care, but a selection of paradigms with the potential to transform Canadian mental health laws, policies, and practices that currently fail to protect the human rights of persons with psychosocial disabilities. These initiatives have all been proposed or led by grassroots groups of psychiatric users, survivors and disability rights activists. They highlight the importance of flexible support strategies and include people with lived experiences to develop and expand supportive decision-making models (Vásquez Encalada et al., 2021). Every individual has a unique set of understandings, which needs to be utilized when thinking about supportive decision making and models of care.

## **Conclusion**

As Irit Shimrat, a Canadian activist and survivor of psychiatry based in BC, says, “the only really bad thing that has ever happened to me is psychiatry. It has damaged my body and mind, destroyed my self-esteem, and forced me to re-invent myself, again and again, every time it tore me apart” (Shimrat, 2016). In permitting the continuation of forced psychiatry, Canada is failing to comply

with its international human rights obligations as outlined in the CRPD. This paper advances the discourse regarding the CRPD and its relationship with Canadian mental health regimes by centering the perspectives of people with lived experiences and disability rights activists. It addresses the current failings of our medical system and its treatment of people with psychosocial disabilities. As O'Hagan reminds us, "the biggest things that enable people to get past their distress or recover is meaningful connection, purpose in life, and the material means to live without stress" (personal communication, September 30, 2022). This contradicts the dominant medical model that is heavily ingrained in public, political and academic consciousness (Beresford & Menzies, 2014). It is not only important for countries to sign the CRPD without reservations, but also to bring their laws in accordance with the ideals of the CRPD to continue to providing care for people with psychosocial disabilities that respects their basic human rights.

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