



Interrogating Safeguards Under the Mental Health Act in Ontario: Towards a Postmodernist Relational Understanding of Disability

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ABSTRACT *Employing critical discourse analysis (CDA), this paper examines how medicalized concepts of mental illness and paternalistic views are framed and used in the legal case, Thompson and Empowerment Council v. Ontario (2013). The paper argues that the case utilizes a pathologized notion of mental illness to justify and defend the legality of involuntary treatment, specifically, the community treatment orders (CTOs) under Ontario's Mental Health Act (MHA). This paper shows how the Thompson case relies on medical reductionism and binary notions of capacity versus incapacity while failing to consider intersecting factors and contextual and social determinants of psychosocial disability. Following this, I suggest that a postmodernist relational theory of disability could change the legal discourses about the MHA. Challenging the medicalized view of mental illness through the relational approach to psychosocial disability could have strengthened the plaintiffs' case and prompted legal reforms for better safeguards under the MHA. In doing so, this paper offers a basis and future direction for legal reforms that can lead to legal mandates for improved social and healthcare services to enhance the autonomy of individuals subjected to CTOs.*

KEYWORDS Mental Health Act (MHA); CTOs; mental health; psychosocial disability; postmodernist model of disability; human rights; medicalization

Introduction

In April 2011, Karlene Thompson, Amy Ness and the Empowerment Council challenged the constitutionality of community treatment orders (CTOs), section 33.1 of the *Mental Health Act (MHA)* (2000) in Ontario (*Thompson and Empowerment Council v. Ontario*, 2013).¹ The plaintiffs argued that CTOs

¹ Karlene Thompson and Amy Ness were the complainants in the case which involved a challenge to the use of CTOs based on their experiences of the negative effects of forced

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ISSN: 1911-4788



violated individuals' right to self-determination in medical choices under the *Canadian Charter of Rights and Freedom* (1982), as the law allows involuntary treatments based on the assumption that people diagnosed with mental illness are public dangers (*Thompson v. Ontario*, 2016).² However, the challenge was unsuccessful as the judges found that the *MHA* contains safeguards that minimize harm inflicted by the *MHA*'s violation of *Charter* rights. The court argued that since the safeguards minimize the harms, the rights violation is proportional to the purpose of the legislation which is to protect public health and safety (*Thompson and Empowerment Council v. Ontario*, 2013). Such safeguards include a formal process for psychiatric assessment, CTO admissibility criteria, and a rights advisory system that protects people from the law's potential abuses by mandating that people being considered for a CTO be informed of their right to legal advice as well as their right to file a review with the Consent and Capacity Board (CCB).³ After being defeated in the Ontario Court of Justice, the applicants filed an appeal in 2016, which was subsequently dismissed (*Thompson v. Ontario*, 2016).

This paper analyzes legal discourse using critical discourse analysis (CDA), informed by a postmodernist conception of disability, to deconstruct the concepts of mental illness deployed in *Thompson and Empowerment Council v. Ontario* (2013). CDA is a transdisciplinary method devised to investigate constitutive and dialectic relationships between semiosis, cultural values, and institutional norms (Fairclough, 2015). According to Fairclough (2003) and others, unequal social relations and power dynamics are reinstated and transformed through dominant rules, conventions, and established orders of discourse (Fairclough, 2003, 2015; Foucault, 1971). Specific to the analysis of legal discourse, expert knowledge of science, especially psychiatric and psychological expertise, are selectively utilized according to a particular "mode of thinking" (Smith, 2000, p. 285) by courts, and through which dominant principles, normative assumptions, and ideologies are reinforced.

Applying a CDA to legal discourse (Smith, 2000), I argue that a pathologized notion of mental illness taken as expert knowledge is operationalized throughout the *Thompson and Empowerment v. Ontario* (2013) case and justified to protect the public's health. I demonstrate how this reductive and

neuroleptic medication, and maltreatment by nurses (*Thompson and Empowerment Council v. Ontario*, 2013, para. 42-62). The Empowerment Council (EC), founded in 2002, advocates for psychiatric survivors and systemic change in the mental health care system and is funded by the Centre for Addiction and Mental Health (CAMH) but directed by service users separate from CAMH. "The EC has two types of members: service users who are voting members and allies who are non-voting members" (Empowerment Council, n.d., para. 7).

² I use the term "mental illness" in a descriptive manner when referring to legal or medical discourse. I use the term "psychosocial disability" when referring to human rights discourse.

³ The Consent and Capacity Board (CCB) is an independent adjudicative tribunal created under the *Health Care Consent Act*, of 1996. The CCB's mandate is to adjudicate on matters of capacity, consent, civil committal, substitute decision-making, and other issues affecting citizens of Ontario, the healthcare community, and other government agencies (Consent and Capacity Board, 2016).

decontextualized concept of mental illness allows the practice of involuntary treatment through the *MHA*. In this regard, I argue that Thompson's argument could have been made more effective if the plaintiffs challenged the medicalized notion of mental illness in the court. I suggest that a postmodernist relational understanding of psychosocial disability as a counter framework to the medical model would have helped the plaintiffs to seek a court ruling in a direction that requests legal reforms to improve safeguards in the *MHA* (2000). Specifically, these reforms would mandate substantive and holistic social and health care service provisions as a precondition to considering a CTO, and as necessary to protect and increase the autonomy of people put on a CTO.

This paper is comprised of four sections. In the first section, I explain the postmodernist relational theory of disability as distinct from medical models of disability. In the second section, I briefly introduce CTOs inscribed in the Ontario *MHA* (2000), focusing on the critiques of CTOs in the argument in *Thompson and Empowerment Council v. Ontario* (2013). In the third section, through a CDA of the *Thompson and Empowerment Council v. Ontario* (2013) case, I show how medical reductionism, and a binary conception of capacity/incapacity are employed in the rationales of the decision in the case. In the last section, I demonstrate how a postmodernist relational understanding of disability can be used in legal cases, providing a framework for safeguards within the scope of the *MHA*.

The Relational Postmodernist Model of Psychosocial Disability

Critical Disability Studies scholarship is based on the interdisciplinary practices of postmodernist theories, politics, and methodologies of continental feminist and queer studies scholarship, centering on critiques against the medical approach to disability and medicalization that reduces the experience of disability and illness to a naturalized and biomedical matter. Postmodern critiques subsequently call for a non-dualistic approach to disability, impairment, and illness (Goodley, 2013), focusing on the phenomenological accounts of corporeal embodiment (Goodley, 2013) and the normalizing forces of biopower that constitutes the embodied and interconnected nature of bodies, disability, and impairment (Campbell, 2013; Goodley, 2013; Roets & Braidotti, 2012; Shildrick, 2012, 2023; Vandekinderen & Roets, 2016). The concept of normalization, informed by Foucault's (1990) theory of biopower, is central to conceptualizing disability as a non-static, discursive, and materially produced phenomenon (Goodley, 2013; Roets & Braidotti, 2012). Disability is not a static identity but is constituted as an ongoing process through which a sense of self is morphed into a subjectivity via multiple cultural discourses and material practices of biopower (Shildrick, 2012). In Foucauldian terms, modern subjectivity (Foucault, 1990, 2007) emerges under biopower, which operates based on the collective subject's biological claims for health care services (Foucault, 1990, 2007; Rose, 2007). Biopower is reflected in

institutional and legal discourses, and through the discourses of public health, where all bodies are transformed to statistical calculations, and under medical scrutiny (Waldschmidt, 2005). Also, biopower illuminates how subjectivity is formed and constituted in the context of the interrelation between the biochemical explanations of the human brain, body, neoliberal doctrines, and ableist norms and relations that regulate who is desirable and who is not (Campbell, 2013; Goodley, 2004; Rose, 2007). These neoliberal relations, which emphasize limited government intervention, deregulation, and privatization, shape and govern bodily experiences by favouring reduced social service provisions and cutbacks to health care (Morrow et al., 2008). This political doctrine in turn creates new norms for desirable citizens upholding biomedically enhanced capacity as desirable.

In this way, as Diamond (2013) points out, biopower creates biomedical subjectivity by incorporating citizens with disabilities into an array of disciplines that accept and practice biomedical psychiatry, which they refer as the “psy-regime” (Diamond, 2013, p. 65) whereas the population who are not contained in this regime of biopower are criminalized and debilitated (Puar, 2017). This account of biopolitics sheds light on the fact that bodies and their interests can be included in neoliberal society, including those of people with disabilities, if they are aligned with the biomedical industrial complex (Campbell, 2013). However, those diverging from neoliberal ideals and normative relations face institutional disciplines and legal controls (McRuer, 2006; Puar, 2017). The conditional inclusion of biopolitics, which constantly assesses, calculates, marks, and produces bodies in terms of their health, desirability, and productivity, operates through a legal, legislative, and institutional framework. Accordingly, the politics of Mad/psychiatric consumers who benefits from this structure differs from that of those whose capacity or functionality cannot necessarily be improved through the psychiatric regimes.

The postmodernist account of disability points to multiple, intersecting and correlating modes of debilities,⁴ disabilities and impairment and its in-process formation of self, through which what is thought as social and biological (medical), cultural and material, and human and non-human constantly constitute and reconstitute its boundaries (Goodley & Roets, 2008; Roets & Braidotti, 2012; Shildrick, 2023). Borrowing from Deleuze and Guattari’s (1980) ontological shift to vital materiality, and by using the concept of “nomadic subjectivity,” Roets and Braidotti (2012, p. 166) suggest a possibility of thinking of disability subjectivity as a temporal and spatial “becoming.” In other words, disability is thought of as an assemblage of flexible and temporal

⁴ Puar (2017) distinguishes the term “debility” from “disability.” Using “debility,” they conceptualize a neoliberal process of debilitation of racialized bodies that are profited under the global and geopolitical relations. Debilitated bodies are considered disposable in the structure of global economy while individuals with “disability” who are integrated into a society are granted a rights bearing status through exceptional differentiation from debilitated bodies, which is what Puar (2017) terms Crip Nationalism.

experiences, which are in their words “assemblages with multiple others” (Roets & Braidotti, 2012, p. 162). Under a relational approach, experiences of disability and impairment are not separate but open-ended, contextually dependant, and are fundamentally embodied and embedded in accordance with social, institutional, and material renderings of desirable and normative bodies and related material practices (Goodley & Roets, 2008; Roets & Braidotti, 2012; Vandekinderen & Roets, 2016). I argue that the relational approach to disability can be instructive in grasping how corporeal experience is shaped by the intersection of different marginalities and inequality under medico-legal structures (Fennell, 2010). Applying a postmodernist relational approach will also guide us towards the reinterpretation of psychosocial disability by elucidating how multiple forces of normalization unfolding through psychiatry, social inequality and material deprivation constitute and reconstitute the experiences of mental distress and bodily impairment, which can change the direction of legal discourse and cases such as Thompson (Campbell, 2013).

Community Treatment Orders (CTO)

In Ontario, Canada, community treatment orders (CTOs) were enshrined in the Ontario *MHA* in the year 2000 through Bill 68, otherwise known as “Brian’s Law,” which was named after the 1995 murder of Brian Smith (Walker, 2008).⁵ As part of the *MHA*, section 31.1(1), CTOs legally mandate psychiatric treatment for people who are assessed as being mentally ill and a danger to themselves or others unless medically treated.⁶ The target population are those diagnosed as “seriously mentally ill” but repeatedly discontinue taking their psychiatric medications, and thus become subject to repeated hospitalizations (*MHA*, 2000). Under the legislation, a CTO can be issued by a doctor with consent from the person labeled with a psychiatric diagnosis or without consent if a doctor deems the person incapable of making a sound decision. If the person is deemed not capable of making a decision, consent will be made by a substitute decision-maker (SDM) under the *Health Care Consent Act (HCCA)* (1996).⁷ Once a CTO is ordered, a community treatment plan can be negotiated with the client, doctors, a mental health care team, and community service agencies. This contract is effective for six months and can be renewed by the opinion of a physician before its expiration or within a month of the expiry

⁵ The amendment of law was named after Brian Smith in response to the public’s outcry about his murder committed by a person diagnosed with schizophrenia who was understood to have failed to receive psychiatric treatments.

⁶ The *Mental Health Act* (2000) notes that if the person is deemed by a physician, a justice of the peace, or a police officer to constitute a risk of causing bodily harm to themselves or others, the person is subjected to an order for psychiatric assessment which can result in involuntary admission to a psychiatric hospital.

⁷ According to the *Health Care Consent Act* (1996), if a person is found by an evaluator to be incapable of making a decision a substitute decision maker can be engaged.

date. For a second renewal, the Consent and Capacity Board (CCB) is required to extend the order (*MHA*, 2000).

CTOs are controversial, with some considering them a less restrictive way than institutionalization of providing care to people diagnosed as mentally ill (Chaimowitz, 2004; Gibbs et al., 2005; *MHA*, 2000; Mfoafo-M'Carthy & Shera, 2012), and others suggesting that they violate an individual's rights and autonomy especially when they are not accompanied by social supports like housing (Brophy & Ring, 2004; Corring et al., 2019; Fabris, 2011; Francombe et al., 2018; Lawn et al., 2016; Mfoafo-M'Carthy, 2014; Mfoafo-M'Carthy et al., 2018; Schwartz, 2010). A key feature of CTOs is involuntary psychotropic medication for people who fail to take medication as prescribed (Fabris, 2011). A state-sanctioned authority is given to physicians in collaboration with legal enforcement to issue a treatment order, which is enforced at times against their client's will (Mfoafo-M'Carthy & Williams, 2010). The CTOs procedure requires legal consent from a person to whom a CTO is issued for procedural justice in respect to the *MHA* (Klassen, 2017). However, if a person who is eligible for a CTO refuses to consent, then physicians can use legal authority to determine if the person is capable of making such a decision (Mfoafo-M'Carthy & Williams, 2010) and non-adherence to a CTO can result in forced hospitalization under the *MHA* (Francombe, 2018; Klassen, 2017).

Another critique of CTOs indicates that racialized and socioeconomically marginalized people would be more likely to consent to it to access services even though they may not want to receive psychiatric treatments (Mfoafo-M'Carthy, 2010; Mfoafo-M'Carthy & Williams, 2010). Colonization and neoliberal policies have significantly reduced social service provisions for the health and well-being of those who disproportionately experience socioeconomic deprivation and intersecting forms of discrimination (de Leeuw & Greenwood, 2011; Morrow, 2004; Nelson & Wilson, 2017). People who experience intersecting forms of disadvantage are likely to be pushed to a circumstance where consent to a CTO is the only way to receive necessary services that are otherwise not accessible to them (Mfoafo-M'Carthy, 2010, 2014; Mfoafo-M'Carthy & Williams, 2010).

Most unsettling, CTOs are internationally espoused in over 75 jurisdictions in the world (Martinho et al., 2022), yet they are in place without enough evidence for their positive results on the well-being of the population (Barnett et al., 2018; Brophy et al., 2018; Simon et al., 2020). As the critics of CTOs argue, the law is enacted without protective measures, safeguards, and a lack of substantive follow-up care provisions in terms of improving the health and well-being of people (Mfoafo-M'Carthy & Williams, 2010). Informed by the view that mental illness is a pathology, CTOs reinforce and delimit what health care can be provided to those experiencing mental distress, which in turn reinforces structural discrimination. As such, it has been argued that CTOs function predominantly as a mechanism of social control and surveillance to contain people who are deemed to be deviant, unproductive, and "sick" (Jager & Parron, 2020; Klassen, 2017; Veen et al., 2018).

Problematizing the Court Decision in *Thompson and Empowerment Council v Ontario* (2013)

In 2013, in *Thompson and Empowerment Council v. Ontario*, the applicants argued that coerced treatment as outlined in sections 15(1.1), 16(1.1), and 20(1.1) of the *MHA*, and specifically, CTOs, violated sections 7, 9, 10 (a)(b), 12, and 15 (1) of the *Charter* with respect to their rights to self-determination in making medical choices (*Thompson and Empowerment Council v. Ontario*, 2013). The Ontario Court of Justice found that the *MHA*'s deprivation of rights to life, liberty, and security of a person diagnosed with a mental illness was justified under section 1 of the *Charter*. This decision was later upheld by *Thompson v. Ontario* (2016) because the majority found that the rights infringements associated with the *MHA*, and CTOs specifically, did not contradict principles of fundamental justice. They believed the negative impacts of the law were curtailed by the legislation's safeguards that include admission criteria and psychiatrists' ability to "target" the right population through formal psychiatric assessment to screen in those who hypothetically stand to benefit from the law (*Thompson and Empowerment Council v. Ontario*, 2013).

The Judge concluded that coercive means used by a CTO align with the legislative goal of the *MHA*, which is emphasized to improve the health of people diagnosed with mental illness. Judge Edward Belobaba stated that "(b)ox B provisions are not just about public safety but also about providing improved treatment for seriously mentally ill individuals" (*Thompson and Empowerment Council v. Ontario*, 2013, para. 81). Since the *MHA* is recognized as for the good of the public's health, the judge reasoned that the legislation was legitimate because it was enacted to provide medical treatments assumed to be necessary for people defined as mentally ill. Accordingly, although compulsory treatment legislated by the *MHA* has been shown to breach section 7 of the *Charter* rights for people with psychosocial disabilities (*Thompson v. Ontario*, 2016), it is justified to accomplish the end goal of the *MHA*.

Also, the court found that the negative effects of coercive treatment through a CTO will be minimized by the safeguard in section 31.1(4) of the *MHA* implemented to screen out people who do not need medical treatments. Judge Edward Belobaba, came to this conclusion by relying on the medicalized notion of mental illness that focuses solely on whether prescribed psychiatric medication is effective in improving exhibited clinical symptoms. Presently, the logic underlying the *MHA* is premised on the belief that if the medical condition of a person with a psychiatric diagnosis shows clinical improvement through medication, other negative effects of this treatment, such as medication side effects and being stripped of their self-determination are considered as necessary means to achieve the clinical result. In this way, Thompson's claim was denied by the court as they reasoned that people subject to a CTO are individually assessed to determine if they fit the legislative criteria, and thus,

people who are subject to a CTO are, in their terms, patients in need of treatment under the *MHA*, and the provision of such treatment, even if compulsory, is assumed to be necessary for therapeutic reasons (Klassen, 2017).

Importantly, the court argued that the eligibility criteria for the *MHA* were good enough to prevent people from being put on a CTO if they are not in need of it, in part because individual assessments must be conducted by “highly trained medical professionals” (*Thompson v. Ontario*, 2016, para. 38) who would assumedly ensure this. Since the court also endorses the psychiatric system by expressing an absolute trust in medical professionalism, people with psychosocial disabilities are presumed to be patients who need treatment unless proven otherwise. Accordingly, legal authority is granted to medical practitioners to diagnose and screen out people who may be subjected to CTOs based on the legal criteria in the *MHA* s 33.1(4). The criteria, namely the admission of a person only when they have a history of hospitalization and psychiatrists have proved that their condition has improved after psychiatric treatment, are interpreted as safeguard provisions. As such, medical authority is codified in the law. For example, Judge Belobaba stated that:

CTO provisions ... contain strict parameters for their application, stringent procedural protections in terms of review and rights advice, and a requirement of consent. The community treatment plan which underlies the CTO is individualized and tailored to the person’s circumstances. (*Thompson and Empowerment Council v. Ontario*, 2013, para. 95)

Moreover, in *Thompson and Empowerment Council v. Ontario* (2013), when assessing the mental capacity of people subjected to a CTO, professional psychiatric knowledge and judgment are taken for granted as indisputable truths to the exclusion of any counter evidence brought by plaintiffs.⁸ This is quite apparent in the following statement from Justice Edward Belobaba:

I am satisfied on the evidence before me that psychiatrists, as specialists in the treatment of mental disorders, are especially familiar with the phenomenon of mental deterioration. They view the term “substantial mental deterioration” to mean not just a trivial change in symptoms and/or functioning, but rather a significant increase in symptoms and/or a significant decline in functioning (e.g. difficulty in being able to go to work and hold a job, or completing basic activities such as feeding or hygiene). (*Thompson and Empowerment Council v. Ontario*, 2013, para. 115)

While endorsing the ability of psychiatrists to diagnose mental illness by assessing the symptoms and functioning of a person, the judge conflates reduced social functioning with a symptom of mental illness and completely overlooks the day-to-day social and structural realities that shape mental

⁸ Ms. Ness testified a series of negative effects of forced treatment with neuroleptic drugs while attributing her wellbeing to social support and programs she received while being on a CTO (*Thompson and Empowerment Council v. Ontario*, 2013, para. 61).

distress, including the intersections of material inequalities and discrimination that may have contributed to reduced functioning.

Likewise, the psychiatric authority to determine the capacity or incapacity status of a person also relies solely on a medical model of mental illness. The idea of mental illness is grounded upon sane/insane and rational/irrational dichotomies (Clough, 2017) applied to determine this status of legal capacity. As Campbell (2013) notes, the concept of capacity is integral to the construction of legal subjectivity enacted in opposition to “others” who are deemed “incompressible,” and therefore, to be contained in the category of pathology and thus are subject to medico-legal correction (Blanchette, 2019; Campbell, 2013). The legal constitution of the binary between sound subject and those who are mad is at the core of the safeguard provision of the *MHA*.

When a person who is decided to be incapable of making a medical decision disagrees with their Substitute Decision Maker (SDM), this person challenges their status of incapacity by requesting a secondary review via the Consent and Capacity Board (CCB) under the *HCCA* (1996). However, the legal tribunals often holds sanist views and biases about the decision capacity of those who have a diagnosis of mental illnesses (Freckelton, 2010; Kerzner, 2006), and when a binary and medical model of mental illness dominates in a tribunal, a person’s refusal to a diagnosis made by a medical professional is thought to point to their lack of insight, which is used in turn as a basis for determining the person’s incapacity (Kerzner, 2006; Pilling et al., 2018). Moreover, and importantly, this safeguard provision ignores the reality of people whose decision-making agency or capacity is consistently compromised by converging factors such as material destitution, discrimination, racial and economic injustice or previous histories of taking psychiatric medications that may have had de-capacitating effects on their ability to make choices (Fabris, 2011). Even though a person has a right to appeal through the CCB, the Board’s decision-making process remains problematic as it continues to rely on a binary demarcation of capacity/incapacity, which results in the total deprivation of autonomy for those deemed incapable of making informed decisions (Clough, 2017; Flood & Chandler, 2016).

Moreover, the definition of mental disorder, entrenched in the *MHA* and CTOs, ignores the impact of complex multilayered historical harms of colonialism and health inequity, including lack of housing and service provisions for people who experience multiple and intersecting forms of oppression and relevant mental distress (de Leeuw & Greenwood, 2011; Morrow & Weisser, 2012). The official knowledge of mental health, framed as a public’s health and safety, is coupled with other neoliberal policies aimed at reducing public spending on health care and social services (Morrow, 2004; Morrow & Malcoe, 2017). The enactment of CTOs is not detached from this context where psychiatric hegemony emphasizes consumer choice, while community-based resources and services for people experiencing mental distress barely meet the social needs of those under a CTO (Morrow et al., 2008). For example, in Ontario, there is no intrinsic connection between CTOs

and the availability of community resources (Flood & Thomas, 2016). In fact, in Canada, community-based mental health and social service infrastructures are immensely underfunded and inadequate to deal with problems that marginalized people experience, which contributes to massive inequalities in service delivery and access to community supports (Flood & Thomas, 2016; Morrow, 2004). Current mental health law and policy do not adequately account for the social and structural determinants of mental well-being (Veen et al., 2018).

Challenging Rights-based Legalism in Mental Health Law

The paradox in mental health law comes from the inconsistency and discrepancy of rights-based legalism (Flood & Chandler, 2016), which as Weller (2010) explains is a patchwork of existing legal principles and traditions of legal control coated with human rights language (Fennell, 2010; Flood & Chandler, 2016; Weller, 2010). The ideology of entitlement and positive rights in the rights-based approach obligates governments to ensure their citizens receive social and health services; yet positive rights do not effectively protect the rights of those who are socio-economically marginalized under domestic jurisdictions, which delimits the parameters of the human rights courts to discrimination claims (Weller, 2010).

Human rights frameworks include people with psychosocial disabilities as a marginalized group and this is recognized in the *UN Convention on the Rights of Persons with Disabilities (CRPD)* and the Canadian Human Rights Courts (Flood & Chandler, 2016; Lewis, 2010). However, I argue that this framework is not appropriate when engaging with a case that takes on the medicalization of people through legislation such as the *MHA (2000)*. In *Thompson and Empowerment Council v. Ontario (2013)*, Thompson asserted that the legislation infringes on *Charter* rights because the purpose of the legislation was primarily public safety, assuming people labeled with a psychiatric diagnosis are potentially a danger to society. This assertion forwarded by the complainants was made based on an understanding of people labelled with a mental illness as a historically stigmatized group. The applicants used the concept of psychosocial disability as a social category, which provides a basis for the enumerated ground to establish a discrimination case.

In *Thompson and Empowerment Council v. Ontario (2013)*, Judge Belobaba acknowledged that “mental disorder corresponds to an enumerated ground and that persons with mental disorders have historically been subject to stereotyping” (para. 124). This is aligned with the findings by the Supreme Court of Canada in a 1991 case, *R. v. Swain (1991)*, in which the court recognized that “the concept of ‘disability’ ... include[s] perceived disability stemming from others’ subjective and erroneous perceptions,” and that “the mentally ill in our society have suffered from historical disadvantage, have been negatively stereotyped” (para. 933). Similarly, in the landmark decision

in *Eldridge v. British Columbia* (1997), the court noted that paternalistic approaches to disabled people, along with their history of marginalization, must be recognized and considered when assessing discrimination. In this case, people with psychosocial disabilities were recognized as members of an identity group that shares a history of marginalization and subjugation, which led to their unequal treatment and paternalistic attitudes towards them.

However, in *Thompson and Empowerment Council v. Ontario* (2013), the court used an individualized and medicalized definition of mental disorder, which prevented it from seeing mental health as ground for discrimination. Indeed, they positioned CTOs as legislation that provides health care based on the stated purpose in the *MHA*. Judge Belobaba thus distinguishes those cases where people are positioned in the context of being stereotyped as a minority group from those individuals who are considered to be in need of medical intervention. Consequently, the legal debates of rights infringement and its target populations are specified and constructed to be those deemed to have medical concerns, which justified the medico-legal intervention in the name of the interests of those who deemed to need paternalistic state intervention (Klassen, 2017). As Foucault (1990) explains, the juridical mechanism constructs legal subjectivity in relation to sovereign power that grants the legality of individuals, while the disciplinary mechanism produces docile subjects through disciplinary techniques. CTOs are an example of this governing technique that targets and controls people who are not granted legal subjectivity because they are diagnosed with a mental illness, and due to their refusal and inability to be integrated into neoliberal sociality (Puar, 2017).

I argue that the human rights framework and its definition of disability, which was created to prove a discrimination case, was not useful to protect the rights of people with psychosocial disabilities in this case because the purpose of the *MHA* is perceived as protecting the public's health. The appellant's argument that psychosocial disability is constructed as a social danger falls short in protecting the rights of people with psychosocial disabilities from the *MHA* that *pathologizes* mental illness. In other words, the argument made based on disability as a minority group cannot adequately address the crucial interconnection between bodily experience, medicalization, and social and material conditions that enable normalization processes through psychiatry, in which disabled bodies are differentially produced, constituted, and disposed (Goodley & Roets, 2008; Roets & Braidotti, 2012). Campbell states:

Indeed normalization hinges on a belief in disabled people being a discreet, insular minority (henceforth contained) rather than being conceived more as a hybrid, fluid, significant component of the bio-population where recognition of such a cohort can de-throne ableist claims to naturalization. (2013, p. 215)

In this instance, the legal argument based on a human rights framework was not equipped well to address the problems of normalization and how people diagnosed with psychiatric disorders are categorized and treated in and through bio-medical epistemology forwarded by the courts.

Towards an Alternative in *Thompson and Empowerment Council v. Ontario* (2013)

As I argued in the previous section through the analysis of the Thompson case, although the applicants attempted to establish their discrimination case against the *MHA* based on the definition of psychosocial disability as a socially stigmatized group (*Thompson and Empowerment Council v. Ontario*, 2013), the judge accepted the medical definition of mental illness in defence of the *MHA*. In response to this, I will explore the possibilities of postmodernist relational frameworks, arguing that they can change legal discourse in the case of discrimination based on psychosocial disability.

The postmodernist articulation of disability can be useful in formulating a legal argument that emphasizes the socio-material and cultural dimensions of having medical aspects of mental illness (Roets & Braidotti, 2012). While not ignoring the corporeal aspects of having symptoms of mental distress and health crises that require adequate social and medical support, an emphasis is placed on underlying intersecting and overlapping systemic and social contributors to the experience of psychosocial disabilities such as economic precariousness, racial injustice, and colonialism (Morrow & Weisser, 2012). Under the postmodern conceptualization, psychosocial disability is thought of as being embodied and constituted through psychiatry and a normalization process of biopower. Thus, people with psychosocial disabilities who are on CTOs become pathologized while not having their social, material, and medical needs met prior to fitting the criteria of the *MHA*; their capacity is decreased due to lack of social support provisions (Clough, 2017; Fabris, 2011). If this definition of psychosocial disability can be taken up in the interpretation of *Charter* rights and the *UNCRPD*, it can unsettle the biomedical definition of mental disorder entrenched in the *MHA*. For example, mental health can be socially determined by the experiences of intersecting oppressions of psychiatry and material dispossessions as well as imposition of psychiatric medications. Unlike the legal definition of disability that reduces people with disabilities to a minority category who are only discriminated against by social biases and barriers, a postmodern conceptualization of psychosocial disability considers both the social and embodied experiences as they are embedded in processes of medicalization of mental illness and through legal and structural arrangements that contribute to decreased capacity of a person with disability. Using this approach to disability and mental health as socially determined, people who are subject to CTOs could possibly be established under the *Charter* as a specified marginalized subgroup of people who are disadvantaged by the medical reductionism of the *MHA*.

Moreover, if the concept of psychosocial disability is recognized as an unsolidified experience of “becoming” in relation to social, institutional, and psychiatric power dynamics, the courts’ debates on the *MHA*’s safeguards using the *Charter*’s principles, could have led to a possibility of “the progressive realization” (Davidson, 2020, p. 167) of legal reforms to comply

with the *CRPD*. These reforms and an alternative approach to psychosocial disability that encompasses the social elements of people experiencing mental distress could have led the *Thompson and Empowerment Council v. Ontario* (2013) to a possible decision that renders CTOs unconstitutional. A relational approach to determining a person's capacity for decision-making could be substituted for the current binary construction of capacity/incapacity (Clough, 2021; Flood & Chandler, 2016). Unlike a dichotomous view of disability/non-disability and capacity/incapacity, which a rights-based legalism is founded upon, a postmodernist relational approach would not attempt to determine capacity using criteria as narrow as section 4 (1)(2)(3) of the *Health Care Consent Act* (1996). A relational approach would require the law to take into account of the assemblages of care relations and supportive decision-making as a process of social, material, and historical circumstances which constitutes capacity, and requires implementing a variety of measures to assist a person to their autonomy during the course of their decision-making (Clough, 2017, 2021; Kerzner, 2006).

A postmodern relational approach could have led the court in *Thompson and Empowerment Council v. Ontario* (2013) to order an amendment of the legal safeguards. Legal reform to strengthen the *MHA*'s safeguards is essential in complying with the *CRPD* by adding concrete and targeted measures, which are intended to empower people with psychosocial disabilities in the course of being involved in medical decisions before considering imposing any forms of coercion. Davidson (2020) notes, "the use of 'holding' legislation with the intention of improving safeguards and strengthening rights while alternatives to coercion are scaled up is, in essence, 'progressive realization'" (p. 167). For example, an alternative to coercion could be incrementally realized by establishing a social service mechanism that is cross-referenced with other relevant areas of laws that direct housing, income support, and social services, and is inscribed in the safeguards of the *MHA* and *HCCA* (1996). This safeguard codifies provisions of essential services, such as housing, counseling, and community support, to be provided and guaranteed as a pre-condition before any coercive intervention is legal under the *Charter* and *CRPD*. This intra-institutional and inter-legislative approach to the legal case is technically plausible since the *MHA* (1990) is already cross-referenced and inseparable from *HCCA* (1996).

Moreover, if social and structural determinants such as homelessness, social isolation, lack of adequate income, poverty, or a history of institutionalization were legally recognized under the current legislation of the *MHA* (1990) and *HCCA* (1996), psychiatric opinions would carry only secondary importance when assessing needs of people with psychosocial disabilities. Instead, the assessment process for decision-making capacity, and subsequently the right to make decisions about one's treatment, would be focused on contextual questions such as: What has been done to assist the person in reaching their decision of either consenting to or refusing a CTO? What can be done to improve their self-determination in a particular context to maximize their

decision-making capacity? What comprehensive and community-based efforts to support a person were made to minimize the traumatic effects of intrusive psychiatric medication? If medication was used as a last resort, what was done to support the person before and during such coercive measures? These questions are essential in imagining the reconstruction of legal arguments in the direction that includes the lived experiences of people with psychosocial disabilities.

Conclusion

I criticized Judge Belobaba's decision in *Thompson and Empowerment Council v. Ontario* (2013), which renders the *Mental Health Act* (1990) and CTOs constitutional, based on the argument that rights-based legalism and their safeguards are insufficient to protect against the abuse of the law. I argued that biomedical reductionism and a pathologized notion of psychosocial disability undergirds legal reasoning and safeguards, arguing that if a postmodernist relational approach to disability had been taken in *Thompson and Empowerment Council v. Ontario* (2013), a decision may have been reached in a way that required legal safeguard reforms in the *MHA* and *HCCA* (1996). The definition of psychosocial disability should be reframed in legal discourses including the *Charter* in a way that reflects evidence about the social determinants of psychosocial disability, and about decision-making capacities as relational. More detailed and substantive safeguards under the *MHA* could be legally mandated, necessitating that a person with a psychosocial disability has been provided with their chosen supports, adequate housing, community engagement programs, and alternative services before any psychiatric intervention is forced upon them. In this way, instead of providing community services as a condition of consenting to psychiatric medication, new safeguards under the *MHA* would ensure coercive treatments could not be imposed unless it was shown that other approaches and efforts to improving mental distress and capacity, such as housing and adequate income support, had been exhausted to the point of necessitating psychiatric intervention to protect a person's safety. Unlike current CTOs, such legal reforms would contribute to guaranteeing access to much-needed community services and accessible housing for people with psychosocial disabilities.

References

- Barnett, P., Matthews, H., Lloyd-Evans, B., Mackay, E., Pilling, S. & Johnson, S. (2018). Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: A systematic review and meta-analysis. *Lancet Psychiatry*, 5(12), 1013-1022. [https://doi.org/10.1016/s2215-0366\(18\)30382-1](https://doi.org/10.1016/s2215-0366(18)30382-1)

- Blanchette, S. (2019). A feminist bioethical and Mad studies approach to resisting an increase in psychiatric paternalism to competent mental health users/refusers. *Journal of Ethics in Mental Health*, 1-19.
- Brophy, L., & Ring, D. (2004). The efficacy of involuntary treatment in the community: Consumer and service provider perspectives. *Social Work in Mental Health*, 2(2-3) 157-174. https://doi.org/10.1300/J200v02n02_10
- Brophy, L., Ryan, C. J., Weller, P. (2018). Community treatment orders: The evidence and the ethical implications. In C. Spivakovsky (Ed.), *Critical perspectives on coercive interventions: Law, medicine and society* (1st ed.) (pp. 30-43). Routledge.
- Campbell, K. F. (2013). Re-cognising disability: Cross-examining social inclusion through the prism of queer anti-sociality. *Jindal Global Law Review*, 4(2), 209-238.
- Canadian Charter of Rights and Freedoms, Part 1 of The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c. 11.
- Chaimowitz, G. A. (2004) Community treatment orders: An uncertain step. *Canadian Journal of Psychiatry*, 49(9), 577-578. <https://doi.org/10.1177/070674370404900901>
- Clough, B. (2017). Disability and vulnerability: Challenging the capacity/incapacity binary. *Social Policy & Society*, 16(3), 469-481. <https://doi.org/10.1017/S1474746417000069>
- Clough, B. (2021). *The spaces of mental capacity law: Moving beyond binaries* (1st ed.). Routledge.
- Corring, D., O'Reilly, R., Sommerdyk, C., & Russell, E. (2019). The lived experience of community treatment orders (CTOs) from three perspectives: A constant comparative analysis of the results of three systematic reviews of published qualitative research. *International Journal of Law and Psychiatry*, 66, e101453. <https://doi.org/10.1016/j.ijlp.2019.101453>
- Davidson, L. (2020). A key, not a straitjacket: The case for interim mental health legislation pending complete prohibition of psychiatric coercion in accordance with the Convention on the Rights of Persons with Disabilities. *Health and Human Rights*, 22(1), 163-178.
- Deleuze, G., & Guattari, F. (1980). *A thousand plateaus: Capitalism and schizophrenia*. University of Minnesota Press.
- de Leeuw, S., & Greenwood, M. (2011). Beyond borders and boundaries: Addressing Indigenous health inequities in Canada through theories of social determinants of health and intersectionality. In O. Hankivsky (Eds.), *Health inequities in Canada intersectional frameworks and practices* (pp. 53-71). UBC Press.
- Diamond, S. (2013). What makes us a community? Reflection on building solidarity in anti-racist praxis. In B. A. LeFrançois, R. Menzies & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 64-78). Canadian Scholars Press Inc.
- Eldridge v. British Columbia (Attorney General), 1997 SCR 624.
- Empowerment Council. (n.d.). *About us*. <https://empowermentcouncil.ca/about-us/#:~:text=Our%20History,receiving%20end%20of%20CAMH%20services>.
- Fabris, E. (2011). *Tranquil prisons: Chemical incarceration under community treatment orders*. University of Toronto Press.
- Fairclough, N. (2003). *Analysing discourse: Textual analysis for social research* (1st ed.). Routledge.
- Fairclough, N. (2015). A dialectical-relational approach to critical discourse analysis in social research. In R. Wodak & M. Meyer (Eds.), *Methods of critical discourse studies* (3rd ed.) (pp. 86-108). SAGE.
- Fennell, P. W. H. (2010). Institutionalising the community: The codification of clinical authority and the limitations of rights based approaches. In B. McSherry & P. Weller (Eds.), *Rethinking rights-based mental health laws* (pp. 13-50). Hart Publishing.
- Flood, C. M., & Chandler, J. A. (Eds.). (2016). *Law and mind: Mental health law and policy in Canada*. LexisNexis Canada.
- Flood, C. M., & Thomas, B. (2016). Fragmented law & fragmented lives: Canada's mental health care system. In C. M. Flood & J. A. Chandler (Eds.), *Law and mind: Mental health law and policy in Canada*. (pp. 29-50). LexisNexis Canada.
- Foucault, M. (1971). Orders of discourse: Inaugural lecture delivered at the College de France. *Social Science Information*, 10(2), 7-30.

- Foucault, M. (1990). *The history of sexuality: An introduction* (Vol. 1). Vintage Books.
- Foucault, M. (2007). *Security, territory, population: Lectures at the College De France, 1977-78* (A. I. Davidson, Ed.). Palgrave Macmillan.
- Francombe, K. P., Nakhost, A., Tugg, L., Etherington, N., Stergiopoulos, V., & Law, S. (2018). Exploring experiences with compulsory psychiatric community treatment: A qualitative multi-perspective pilot study in an urban Canadian context. *International Journal of Law and Psychiatry*, 57, 122-130. <https://doi.org/10.1016/j.ijlp.2018.02.007>
- Freckelton, I. (2010). Extra-legislative factors in involuntary status decision-making. In B. McSherry & P. Weller (Eds.), *Rethinking rights-based mental health laws* (pp. 203-230). Hart Publishing.
- Goodley, D. (2004). De/constructing "learning difficulties" in educational contexts: The life story of Gerry O'Toole. In C. Barnes (Ed.), *Disability policy and practice: Applying the social model* (pp. 175-190). Disability Press.
- Goodley, D. (2013). Dis/entangling critical disability studies. *Disability & Society*, 28(5), 631-644. <https://doi.org/10.1080/09687599.2012.717884>
- Goodley, D., & Roets, G. (2008). The (be)comings and goings of "developmental disabilities": The cultural politics of "impairment." *Discourse: Studies in the Cultural Politics of Education*, 29(2), 239-255. <https://doi.org/10.1080/01596300801966971>
- Gibbs, A., Dawson, J., Ansley, C., & Mullen, R. (2005). How patients in New Zealand view community treatment orders. *Journal of Mental Health*, 14(4), 357-368. <https://doi.org/10.1080/09638230500229541>
- Health Care Consent Act*, SO 1996, c.2, Schedule A, s.70.1, ss. 1-37.1.
- Jager, F., & Perron, A. (2020). The social utility of community treatment orders: Applying Girard's mimetic theory to community-based mandated mental health care. *Nursing Philosophy*, 21(2), e12280. <https://doi.org/10.1111/nup.12280>
- Kerzner, L. (2006). Mental capacity through a disability law lens. In M. A. McColl & L. Jongbloed (Eds.), *Disability and social policy in Canada* (pp. 336-369). Captus University Publications.
- Klassen, L. A. (2017). Spinning the revolving door: The governance of non-compliant psychiatric subjects on community treatment orders. *Theoretical Criminology*, 21(3), 361-379. <https://doi.org/10.1177/1362480616646623>
- Lawn, S., Delany, T., Pulvirenti, S. M., Smith, A., & McMillan, J. (2016). Examining the use of metaphors to understand the experience of community treatment orders for patients and mental health workers. *BMC Psychiatry*, 16(82). <https://doi.org/10.1186/s12888-016-0791-z>
- Lewis, O. (2010). Educational and proactive roles of human rights: An analysis of the United Nations Convention on the Rights of Persons with Disabilities. *Rethinking rights-based mental health law* (pp. 97-128). Hart Publishing.
- Martinho, S. M., Santa-Rosa, B., & Silvestre, M. (2022). Where the public health principles meet the individual: A framework for the ethics of compulsory outpatient treatment in psychiatry. *BMC Medical Ethics*, 23(77). <https://doi.org/10.1186/s12910-022-00814-8>
- McRuer, R. (2006). *Crip Theory: Cultural Signs of Queerness and Disability*. New York: New York University Press.
- Mental Health Act*, RSO 1990, c. M.7, s. 15 (1); 2000, c. 9, s. 3 (1).
- Mfofo-M'Carthy, M. (2010). "Experience is the best teacher." *Community treatment orders (CTOs) among ethno-racial minority communities in Toronto: A phenomenological study* [Unpublished doctoral dissertation]. University of Toronto.
- Mfofo-M'Carthy, M. (2014). Community treatment orders and the experiences of ethnic minority individuals diagnosed with serious mental illness in the Canadian mental health system. *International Journal for Equity in Health*, 13(69). <https://doi.org/10.1186/s12939-014-0069-3>
- Mfofo-M'Carthy, M., Grosset, C., Stalker, C., Dullaart, I. & McColl, L. (2018). Exploratory study of the use of community treatment orders with clients of an Ontario ACT team. *Social Work in Mental Health*, 16(6), 647-664. <https://doi.org/10.1080/15332985.2018.1476283>

- Mfoafo-M'Carthy, M. & Shera, W. (2012). Beyond community treatment orders: Empowering clients to achieve community integration. *International Journal of Mental Health, 41*(4), 62-81. <https://doi.org/10.2753/IMH0020-7411410405>
- Mfoafo-M'Carthy, M., & Williams, C. C. (2010). Coercion and community treatment orders (CTOs): One step forward, two steps back. *Canadian Journal of Community Mental Health, 29*(1), 69-80. <https://doi.org/10.7870/cjcmh-2010-0006>
- Morrow, M. (2004). Mental health reform, economic globalization and the practice of citizenship. *Canadian Journal of Community Mental Health, 23*(2), 39-50. <https://doi.org/10.7870/cjcmh-2004-0012>
- Morrow, M., Dagg, P. B., & Pederson, A. (2008). Is deinstitutionalization a “failed experiment?” The ethics of re-institutionalization. *Journal of Ethics in Mental Health, 3*(2), 1-7.
- Morrow, M., & Malcoe, L. H. (2017). *Critical inquiries for social justice in mental health*. University of Toronto Press.
- Morrow, M., & Weisser, J. (2012). Towards a social justice framework of mental health recovery. *Studies in Social Justice, 6*(1), 27-43. <https://doi.org/10.26522/ssj.v6i1.1067>
- Nelson, E. S., & Wilson, K. (2017). The mental health of Indigenous peoples in Canada: A critical review of research. *Social Science and Medicine, 176*, 93-112. <https://doi.org/10.1016/j.socscimed.2017.01.021>
- Pilling, M. D., Daley, A., Gibson, M. F., Ross, L. E., & Zaheer, J. (2018). Assessing “insight,” determining agency and autonomy: Implicating social identities. In J. M. Kilty & E. Dej, *Containing madness: Gender and ‘psy’ in institutional contexts* (pp. 191-213). Palgrave Macmillan.
- Puar, J. (2017). *The right to maim: Debility, capacity, disability*. Duke University Press.
- R. v. Swain, 1991 SCR 933.
- Roets, G., & Braidotti, R. (2012). Nomadology and subjectivity: Deleuze, Guattari and critical disability studies. In D. Goodley, B. Hughes & L. Davis (Eds.), *Disability and social theory: New developments and directions* (pp. 161-178). Palgrave Macmillan.
- Rose, N. (2007). *The politics of life itself: Biomedicine, power, and subjectivity in the twenty first century*. Princeton University Press.
- Schwartz, K., O'Brian, A., Morel, V., Armstrong, M., Fleming, C., & Moore, P. (2010). Community treatment orders: The service user speaks exploring the lived experience of community treatment orders. *International Journal of Psychosocial Rehabilitation, 15*(1), 39-50.
- Shildrick, M. (2012). *Dangerous discourses of disability, subjectivity, and sexuality*. Palgrave Macmillan.
- Shildrick, M. (2023). *Visceral prosthesis: Somatechnics and posthuman embodiment*. Bloomsbury Academic.
- Simon, J., Mayer, S., Łaszewska, A., Rugkåsa, J., Yeeles, K., & Burns, T., (2020). Cost and quality-of-life impacts of community treatment orders (CTOs) for patients with psychosis: economic evaluation of the OCTET trial. *Social Psychiatry and Psychiatric Epidemiology, 56*, 85-91. <https://doi.org/10.1007/s00127-020-01919-4>
- Smith, C. (2000). The sovereign state v Foucault: Law and disciplinary power. *The Sociological Review, 48*(2), 283-306. <https://doi.org/10.1111/1467-954X.00216>
- Thompson and Empowerment Council v. Ontario, 2013 ONSC 5392.
- Thompson v. Ontario (Attorney General), 2016 ONCA 676.
- Vandekinderen, C., & Roets, G. (2016). The post(hu)man always rings twice: Theorising the difference of impairment in the lives of people with “mental health problems.” *Disability & Society, 31*(1), 33-46. <https://doi.org/10.1080/09687599.2015.1119037>
- Veen, C. V., Ibrahim, M., Morrow, M. (2018). Containing madness, dangerous discourses: Masculinity, coercion, and psychiatry. In J. M. Kilty & E. Dej, *Containing madness: Gender and ‘psy’ in institutional contexts* (pp. 241-265). Palgrave Macmillan.
- Waldschmidt, A. (2005). Who is normal? Who is deviant? “Normality” and “risk” in genetic diagnostics and counseling. In S. Tremain (Ed.), *Foucault and the government of disability* (pp. 191-207). The University of Michigan Press.

- Walker, J. (2008). The legacy of a story: Commemoration and the double-narrative of Jeffrey Arenburg and Brian Smith. *Disability Studies Quarterly*, 28(1).
<https://doi.org/10.18061/dsq.v28i1.69>
- Weller, P. (2010). Lost in translation: Human rights and mental health law. In B. McSherry & P. Weller (Eds.), *Rethinking rights based mental health laws* (pp. 51-72). Hart Publishing.