

Imagining An Equality Promoting Alternative to the Status Quo of Canadian Mental Health Law

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I. Introduction: Seeing the Way Forward in Legislation (and Elsewhere)

Canadian mental health law has been (and remains) predominately coercive, reactive and crisis-oriented. For mental health consumers and their allies, ongoing battles have had to be fought to resist or minimize state authorized intrusions into the lives of vulnerable people. This vigilance will no doubt remain necessary. In a society suffused with paternalism and mental illness prejudice, supposedly benign and efficacious interventions will continue to be forced upon people with mental health problems. Resistance, and an insistence upon the least restrictive, least onerous and least intrusive alternative, will still comprise an essential part of the strategy of mental health consumer advocates. However, this necessary struggle has always carried a burdensome opportunity cost. At the same time as consumers have recognized their multi-faceted real needs, they have had to combat the wave of crude and oppressive legislation. Thereby, they have often been diverted from emphasizing their true requirements for support and services which would assist their integration into the mainstream of society and promote, rather than suppress, their equality interests.

Canadian mental health law *may* have reached a point where the pace of its development will accelerate and where its direction will dramatically shift. Although some aspects of the status quo may need to be preserved, the challenge is to determine whether the essential character of the present legislative framework can be altered to satisfy the largely unmet needs of Canadian mental health consumers.

This paper surveys some contemporary summative proposals from major interest groups and health care analysts in Canada and the United States and a recent study from the World Health Organization (WHO). Using these resources, it proposes an approach to the reform of mental health statutes which avowedly advances the directions which appear in modern policy recommendations. The overall stance of the paper is that new legislation can and should be more ambitious in its objectives.

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Legislative silence or inactivity would indicate an abandonment of institutional responsibility. Legislation should speak with a remedial and reformist voice. Otherwise, there is a real potential for the perpetuation of inequality and discrimination. Health and social service systems may continue to interpret their obligations in diverse ways and promising policy objectives may be diverted, diluted or abandoned. The WHO has advocated legislative change as a primary tool of reform in the mental health law area:

Mental health legislation should codify and consolidate the fundamental principles, values, goals, and objectives of mental health policy. Such legislation is essential to guarantee that the dignity of patients is preserved and that their fundamental human rights are protected.¹

Canadian mental health legislation is largely devoid of broad purposive statements and it has generally not accepted the challenge of actually declaring these “fundamental principles, values, goals and objectives of mental health policy.” Although the major theme herein is the potential of reconfigured statutes, there is a vital part to be played by non-statist measures in the process of addressing the plight of mental health consumers. Government should control policy development through legislation, but either because of its having abdicated its duties or in recognition of the fact that the process of reform may simply be more expedient if government does not have exclusive authority, other ways of achieving the same ends should be pursued. Indeed, the author has previously argued that a reduced reliance on the traditional paradigm of law reform may result in relatively prompt and meaningful changes in practices that vitally affect the interests of patients.² A shift towards reformist goals in areas such as professional standards and practices, hospital accreditation, coroner or other reports, media utilization and advocacy organizations was posited for its comparative speed and efficiency.

Moreover, some non-governmental organizations operating under a legislative mandate but having a large measure of autonomy to enable them to facilitate the achievement of statutory goals may also be propitious loci for the implementation of an equality devoted agenda. For example, the Alberta Mental Health Board (AMHB), a provincial mental health authority, has responsibilities which include the duty to:

- Promote, preserve and restore the mental health of Albertans and work towards the prevention of mental disorders;
- ...
- Promote and act as an advocate for the provision of mental health

¹World Health Organization, *World Health Report 2001: Mental Health: New Understanding, New Hope* (Geneva: World Health Organization, 2001), online: World Health Organization <<http://www.who.int/whr/2001/main/en/pdf/whr2001.en.pdf>> at 84.

²H. Archibald Kaiser, “Restraint and Seclusion in Canadian Mental Health Facilities: Assessing the Prospects for Improved Access to Justice” (2001) 19 Windsor Yearbook of Access to Justice 391 at 403-405, 408.

services in a manner that is responsive to the needs of individuals and communities, and supports the integration of services and facilities.³

In fulfilling their goals, such boards have flexibility to work towards conditions of equality for consumers without explicit legislative direction. Thus, a recent AMHB Annual Report refers to “ideals” which “include having as many people as possible employed, properly housed and receiving the health care and social services they require.”⁴ These types of entities have the attraction of permitting the promotion of equality even in the absence of legislation specifically demanding this direction.

However promising these non-traditional approaches to reform appear to be, they may well fall short. The improvement of legislative standards reduces the risk of discriminatory variations within provinces and territories. Revised legislation carries the corollary of demanding a shift in public spending priorities. Statutory standards indicate authoritative democratic support and legitimacy for equality aspirations. Perhaps most importantly, certainly from the perspective of the balance of this paper, legislative guarantees offer the prospect of enforceability of positive rights, without which the deprived consumer may be left with comparatively hollow promises and illusory entitlements. Therefore, while recognizing the attractions of other strategies, this paper advocates a leadership role for legislation.

Previously, the author has discussed the limits of the equality guarantee under the *Charter*, positing equality-based strategies to invigorate the ability of consumers to assert an expansive right to receive treatment and pointing to broader actions aimed at the social context and preventative aspects of mental health problems.⁵ This paper extends these reflections and develops a statutory vision of equality promotion. Following a discussion of the heritage and omnipresence of discrimination and inequality for Canadian mental health consumers, the paper provides statements of basic legislative principles and standards in language which could form the basis for a new generation of mental health statutes. Each proposed legislative canon is followed by a brief commentary.

II. A Heritage of Inequality

Canadian mental health legislation has either not pursued the goal of equality for consumers or, even if one can charitably identify occasional legislative glimpses of this aspiration, it has failed dismally. In an oft-quoted extract from *R. v. Swain*⁶,

³ Alberta Mental Health Board, *Business Plan 2002-2005*, online: Alberta Mental Health Board <http://www.amhb.ab.ca/about_us/index.html> at 6.

⁴ Alberta Mental Health Board, *Annual Report 2000-2001*, online: Alberta Mental Health Board <http://www.amhb.ab.ca/about_us/archived_bp.html> at 14.

⁵ H. Archibald Kaiser, “Mental Disability Law”, in Jocelyn Downie, Timothy Caulfield & Colleen Flood, *Canadian Health Law and Policy*, 2nd ed. (Toronto: Butterworths, 2002) 251 at 266-271 (equality), 306-312 (right to treatment) and 326-330 (broader strategies).

⁶ [1991] 1 S.C.R. 933, 5 C.R. (4th) 253 [*Swain* cited to S.C.R.].

the Supreme Court of Canada has recognized the lamentable reality which has characterized the lives of Canadians with mental health problems:

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

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

The above description is, in my view, unfortunately accurate and appears to stem from an irrational fear of the mentally ill in our society.⁷

Justice Wilson in *Swain*, concurring in the result, made similar observations concerning "...the mentally disabled, a group in our society which has been negatively stereotyped and historically disadvantaged."⁸

Many consumer organizations have emphasized the centrality of discrimination. For example, a report of the British Columbia Minister of Health's Advisory Council on Mental Health focussed upon the social disadvantage of consumers:

People with mental illnesses are among the most devalued of all people with disabilities ... Beyond just being ostracized, however, people with mental illnesses are routinely excluded from social life and civil rights. They are denied basic rights in the areas of housing, employment, income, insurance, higher education, criminal justice, and parenting, among others.⁹

Indeed, the recently released Romanow Report has provided authoritative recognition of the obligation to face systemic shortcomings for mental health consumers:

Mental health has often been described as one of the 'orphan children' of medicare.¹⁰

⁷ *Ibid.* at 973-74.

⁸ *Ibid.* at 1035.

⁹ Canadian Mental Health Association, BC Division, British Columbia Minister of Health's Advisory Council on Mental Health *Discrimination Against People with Mental Illnesses and their Families: Changing Attitudes, Opening Minds* (April 2002), online: British Columbia Provincial Government <<http://www.healthservices.gov.bc.ca/mhd/advisory/index.html>> at 1.

¹⁰ Canada, Commission on the Future of Health Care in Canada, *Building on Value: The Future of Health Care in Canada – Final Report* (Ottawa: Commission on the Future of Health Care in Canada, 2002) at 178 (Commissioner: Roy J. Romanow) [Romanow Report]. Early reaction by consumer organizations

The Romanow Commission also quoted liberally and approvingly from Canadian Mental Health Association (CMHA) sources on some of the upshots of this pervasive neglect:

As the Canadian Mental Health Association (2001, 8) described it, [the process of de-institutionalization being flawed] ... ‘In addition, fears and prejudices about mental illness, in part responsible for the long history of segregation in conditions, compounded the problems in the community. These attitudes increase the barriers to access to community life in areas such as employment, education and housing.’¹¹

These are not uniquely Canadian problems, to be sure. In the United States, a recent publication from the Bazelon Center highlighted the “results of mental health systems’ failure”, pointing to the over-representation of people with mental health problems in prisons and in the homeless population¹², and unemployment (citing sources suggesting an unemployment rate for people with mental illness of “approximately 90%, exceeding any other group of people with disabilities.”)¹³

The association of mental health problems, discrimination and poverty is a world-wide phenomenon, as determined by the WHO:

The relationship between poverty and mental health is complex and multi-dimensional.¹⁴

...

The poor and the deprived have a higher prevalence of mental and behavioural disorders ... explainable both by higher causation of disorders among the poor and by the drift of the mentally ill into poverty.¹⁵

These representative declarations illustrate the close relationship between mental health problems, discrimination and poverty. Their effect must be to exhort those who discuss policy and who propose legislation to ensure that equality promotion is the litmus test for envisaging any new law. This focus has begun to

has been positive. See e.g. Canadian Mental Health Association, BC Division, News Release, “Implementation of Romanow Report Could Improve Mental Health Care in B.C.” (28 November 2002), online: Canadian Mental Health Association

<<http://www.cmha-bc.org/content/media/releases/2002/28-11-02.pdf>>:

Implementing the recommendations of the Romanow Report may mean that people with mental illness will no longer be the ‘orphan children’ of Canada’s health care system...

¹¹ Romanow Report, *ibid.*

¹² Bazelon Center, “Why a Law is Needed” in *A New Vision of Public Mental Health*, online: Bazelon Center <<http://www.bazelon.org/whylawneeded.pdf>>.

¹³ Bazelon Center, “Commentary”, *ibid.*, online: Bazelon Centre <<http://www.bazelon.org/modellawandcommentary.pdf>> at 3.

¹⁴ *Supra* note 1 at 13.

¹⁵ *Ibid.* at 13-14.

animate many proponents of policy and legal change, as seen, for instance, in a 1993 CMHA study:

By almost any notion of what it means to belong to a community and to fully participate in social life, Canadian society is cold and rejecting to people with mental illness.¹⁶

...

Although serious mental illness will remain traumatic, removing the crippling factors that often accompany it – poverty, social exclusion, stigma and offering real support in a context of social acceptance will create the opportunity for consumers to live as valued citizens.¹⁷

The fight for equality requires broad-based action, ideally stimulated by non-governmental organizations led by consumers, with support from health-care and social service providers, families and other stakeholders. Legislation will not guarantee progress towards equality and, in many spheres where action is required, mental health law will not be able to contribute as much as other tools of social change. However, the balance of this paper will concentrate upon presenting some suggestions for law reform. This is an ambitious undertaking for a short paper and, given the novelty of some of the following proposals, at times it may be too general or inclusive. On the other hand, the contrast with the limited purposes and equality desecration of the status quo of mental health legislation will be obvious and, ideally, instructive.

In thinking about pursuing equality for mental health consumers through legislation, the new statutes would be inspired, but not limited, by pronouncements from the Supreme Court of Canada. In the view of the Court, law can protect and advance human dignity, “the central purpose” of the Charter’s equality guarantee, or law can harm it. Human dignity, as the Court has proclaimed, refers to the individual’s “self-respect and self-worth”, being “concerned with physical and psychological integrity and empowerment.”¹⁸ The proposals which follow seek to enhance these aspirations, using laws “which are sensitive to the needs, capacities, and merits of different individuals, taking into account the context underlying their differences.”¹⁹ The legislation which emerges as a function of priority being given to the equality dimension differs vastly from the present statutory environment.

The reform agenda espoused in this paper keeps recovery and community participation in the foreground, as integral to the notion of equality. Given the enriched concept of health which is advocated, the requirement of consequent

¹⁶ Canadian Mental Health Association (CMHA), *Framework for Support* by John Trainor, Ed Pomeroy & Bonnie Pape, (1993), online: CMHA <http://www.cmha.ca/english/research/framework/framework_full.htm> at 20.

¹⁷ *Ibid.* at 23.

¹⁸ *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 7 at para. 53, Iacobucci J.

¹⁹ *Ibid.*

legislative and policy change outside mental health law will be apparent. Suggestions are made for a new title and preamble, an emphasis on advocacy, a statutory positive right to supports and services, with consumer-driven standards, research and monitoring goals, and a willingness to specify acute needs of particularly vulnerable consumers. It recommends a complementary revision of existing mental health legislation, relegating coercive approaches to last resort status.

Title

An Act to Promote Mental Health and Community Participation

Commentary

The long title of any statute should accurately reflect the purpose of the legislation; it “is supposed to cover everything contained in a bill”²⁰, which this version attempts, admitting its shortcomings given the novelty and compass of the legislation.

Perhaps its short title might be *The Mental Health and Community Participation Act*. These titles link the concepts of mental health promotion and community participation as a way of drawing attention to its proactive role, to assist in maximizing consumers’ opportunities for equitable participation in civil society. A contemporary Ontario study makes the same connections:

Mental health services and supports need to equip consumers to move from limiting roles as service recipients to embrace their primary life roles as citizens. All aspects of the mental health system’s services must inherently support a person’s primary role of citizen, avoid approaches to care that erode the role, and minimize and mitigate life experiences that undermine the role.²¹

In this same vein, “all aspects” of any new legislation, starting with the title (which “may always be considered”),²² should support the achievement of consumers’ “primary life roles as citizens.”

²⁰ Ruth Sullivan, *Driedger on the Construction of Statutes*, 3rd ed. (Toronto: Butterworths, 1994) at 254.

²¹ Canadian Mental Health Association, Ontario Division and Ontario Federation of Community Mental Health and Addiction Programs, *The Whole Picture: A provincial framework for redesigning the Ontario mental health system* by Barbara Everett *et al.*, online: Canadian Mental Health Association: Ontario Division, Policy Documents

<http://www.ontario.cmha.ca/content/policy_and_action/policydocuments.asp?cID=3282> at 3.

²² *Supra* note 20 at 258.

Preamble

WHEREAS mental health problems directly affect one in five people during their lifetime;

AND WHEREAS people with mental health problems have suffered abuse, neglect, stigma, exclusion, poverty, and overall discrimination;

AND WHEREAS the Government of Canada and the Province [or Territory] of [] recognize that health has many determinants, including income and social status, social support networks, education, employment and working conditions, social and physical environments, personal health practices and coping skills, healthy child development and health services;

AND WHEREAS the failure of Canadian society to comprehensively provide these health care determinants has increased the incidence and aggravated the effects of mental health problems;

AND WHEREAS the Canadian Charter of Rights and Freedoms and the [Provincial or Territorial] Human Rights Act guarantee equality without discrimination based upon mental disability;

AND WHEREAS people with mental health problems should be able to insist upon the provision of services and supports which will assist their participating in the community as equals with other citizens,

NOW THEREFORE, this legislation is hereby enacted to respond to these problems and obligations, and specifically with the following goals:

- (1) to promote the equality of Canadians with mental health problems;*
- (2) to enhance the ability of people with mental health problems to fully participate in society;*
- (3) to ensure the accessibility and delivery of a broad range of mental health services and social supports, including treatment, employment, housing, education and income;*
- (4) to provide for the availability and delivery of services and supports in the least restrictive, least onerous and least intrusive manner;*
- (5) to encourage the active participation of people with mental health problems in the advocacy, design and delivery of services and supports in the community;*
- (6) to ensure that services and supports for people with mental health problems will be delivered in a manner which recognizes Canada's cultural diversity and the uniqueness of each citizen;*
- (7) to provide people with mental health problems with the legal ability to advocate for and enforce their individual entitlements to health care and social supports; and*
- (8) to respect the legal and human rights of people with mental health problems.*

Commentary

Providing a preamble for any statute is essential as a way of declaring the purposes of the legislation. It has both educative and interpretive functions. The public should be informed of the social problem to which the statute is responding and of the goals which the legislature is endeavouring to attain.

However, the recitals constituting a preamble may mention not only the facts which the legislature thought were important but also principles or policies which it sought to implement or goals to which it aspired.²³

Those who wield power under the statute or are subject to its provisions must have a guide concerning the interpretation of the legislation, which is necessary both to find a direction and resolve ambiguities.

A preamble in the mental health setting must capture complex themes and aspirations. It has to recognize the inequitable treatment which consumers have uniquely suffered, compared to those with other health problems. It must draw attention to the issues which differentiate mental health policy from other health concerns. The CMHA has specified some of these dimensions, in part reflected in the draft preamble:

- (1) *Mental health is impacted significantly by psychosocial factors which require responses besides medical services.*
...
- (2) *As a result, the parameters of mental health and illness policies tend to be broader than those of typical health policy.*
...
- (3) *Poverty is strongly associated with serious mental illness and must be included in any discussions of approaches to mental illness.*
...
- (4) *Fear, prejudice and discrimination are common public responses to people with mental illness.*²⁴

Finally, the preamble must point to principles which may help to respond to the societal disadvantage of mental health consumers. This draft aims at such broad preambular goals. Discussions which might lead to an acceptable version should be undertaken at the earliest stages of the law reform process, guided by the genuine participation of consumer advocacy associations. Inspiration may also come from broad statements of goals and values of other non-governmental

²³ *Supra* note 20 at 259.

²⁴ Canadian Mental Health Association, *Submission to the Commission on the Future of Health Care in Canada* (October 2001), online: Canadian Mental Health Association <<http://www.cmha.ca/english/advocacy/healthcommission/>> at 1-2 [emphasis in original].

organizations.²⁵ In the final analysis, the new statutory directions advocated in this discussion demand a robust and directive preamble, leaving no doubt about the “mischief” recognized by the legislation and the required responses.

Section 1 – Advocacy

- (1) The importance of independent consumer-focussed advocacy at every level of the system for provision of mental health services and supports will be recognized and promoted as an integral part of the obligations of the Province towards people with mental health problems.
- (2) Systemic advocacy will be fostered by the funding of non-governmental organizations which are led by mental health consumers and their allies.
- (3) Formal and informal individual advocacy, will be supported by the provision of resources for:
 - (1) educational programs promoting self-advocacy and advocacy by family and friends;
 - (2) peer advocates; and
 - (3) legal services, particularly regarding issues involving restrictions on liberty, and access to services and social supports.

Commentary

The prominent placement of a section involving advocacy would foster acceptance of the notion that advocacy services should be an integral part of the systems providing care and support for people with mental health problems. Indeed, advocacy supports are so important that they should be seen as an additional determinant of mental health. Independent and trained advocacy organizations and individuals, including consumers advocating for themselves, are necessary not only for the protection of rights but for the consumer-centred evolution of mental health care services and policy. These needs are increasingly being recognized at the national level and beyond.

The CMHA has drawn attention to the supportive, although often unrecognized, role of family and friends, as well as “consumers themselves”:

Organized in groups, and with adequate resources, consumers can do many things for themselves which were formerly thought to be the sole domain of the formal service system.²⁶

The WHO also encourages “Using Community Resources to Stimulate Change”:

²⁵ See e.g. The Canadian Alliance on Mental Illness and Mental Health (CAMIMH), *A Call for Action*, online: CAMIMH <http://www.cmha.ca/english/research/camimh/call_for_action/contents.htm> at Preface and Appendix A. See also WHO, *supra* note 1 at 80, for a potential checklist of statutory purposes, attached as Appendix A to this paper. The WHO legislative template is intended to be reflected in the Preamble and the balance of the proposed statute.

²⁶ *Supra* note 16 at 7.

The role of the community can range from the provision of self-help and mutual aid to lobbying for changes in mental health care and resources, carrying out educational activities, participating in the monitoring of evaluation of care, and advocacy to change attitudes and reduce stigma.²⁷

There is a burgeoning literature on effective ways of encouraging and funding consumer participation at all levels of the advocacy spectrum, which can assist in according primacy to consumer power, knowledge and control, ensuring the representation of special needs groups and avoiding tokenism.²⁸ A genuine shift towards consumer control is probably the only way of realizing the goal of equality and participation; a broad range of advocacy resources is essential to this new paradigm.

Section 2 – A Positive Right to Services and Supports

- (1) *A person with a mental health problem(s) shall have enforceable rights to:*
 - (1) *information on available services and supports;*
 - (2) *establish his or her own recovery and community participation goals, in partnership with health care and social support providers, family and friends;*
 - (3) *receive sufficient services to support full community participation;*
 - (4) *receive and terminate the provision of services on a purely voluntary basis, except in extreme circumstances, as noted in section (6) herein ; and*
 - (5) *advocacy services, to assist the consumer in asserting his or her entitlement to services and supports.*²⁹

- (2) *Relationship to Involuntary Hospitalization and Treatment*
 - (1) *Where the conditions specified in this legislation for involuntary hospitalization and treatment exist, such portions of the persons' services and support entitlements plan as are shown to be inconsistent with the necessity of involuntary measures shall be suspended until the commitment or treatment order has been fulfilled, varied or vacated, as specified in section (6) herein.*

²⁷ *Supra* note 1 at 99. See also the Bazelon Centre, *supra* note 12 at 22. for their perspective on the necessity for individual advocates to assist the individual in securing mental health services and supports.

²⁸ See e.g. Andrea Sozomenow *et al.*, *Mental Health Consumer Participation in a Culturally Diverse Society*, 2nd ed. (Sydney: Australian Transcultural Mental Health Network, 2000) at 59-77.

²⁹ *Supra* note 12 at 9.

Commentary

The above provisions create enforceable rights to a plan for services and supports, and are inspired by and in large measure drawn from the Bazelon Centre's comprehensive draft of a statute intended to:

Make services and supports available on a voluntary basis and to empower and authorize individuals diagnosed with serious mental illness to obtain needed services and supports through individualized planning.³⁰

The statutory enshrinement of a series of positive rights should be more compatible with the normative tradition of public health care in Canada. The Romanow Report recognized the centrality of several interconnected values which augur well for the creation of such entitlements.

... Canadians have been clear that they still strongly support the core values on which our health care system is premised – equity, fairness and solidarity.

...

Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth.³¹

The Bazelon Center standards should be more achievable in Canada given the prominence Canadians attach to “equity, fairness and solidarity” and the comparative lack of an analogous consensus in the United States. However, it must be conceded that the creation of a positive right to assert a claim for individualized services and supports would be a radical departure from most current Canadian mental health legislation. These statutes tend to emphasize the authority to impose involuntary hospitalization and treatment, and to protect, often on a rather ungenerous basis, the consumer's substantive, procedural and constitutional rights in these processes. The notion of establishing statutory entitlements is not unprecedented in Canadian law, even if this would be innovative in the mental health setting. There are some rough parallels in child protection legislation. Some statutes enact a general mandatory duty to “provide to the child appropriate services or placement”³² with no guidance as to the specific requirements which a vulnerable child could expect. Other statutes are more explicit and directive, particularly where the child is “in care” and the state has assumed parental responsibilities.³³ None-

³⁰ *Ibid.* at 4.

³¹ *Supra* note 10 at xvi.

³² See *Children and Family Services Act*, S.N.S. 1990, c. 5, s. 14(1).

³³ See *Child and Family Services Act*, R.S.O. 1990, c. C. 11, s. 105, which specifies the content standards for “a plan of care” for a “child in care”, referring to matters such as participation in the development of the individual plan, meals, clothing, medical and dental care, education and recreation.

theless, the extent and specificity of the statutory rights of mental health consumers advocated in this paper is unprecedented in current Canadian law.

The Bazelon Center's vision supplements their pivotal positive right to secure services and supports with eligibility standards (defining "eligible person" as "an adult who has or is diagnosed with a serious mental illness" and "presumptively eligible person" as one who is "at imminent risk of hospitalization, incarceration or homelessness"), as well as procedures to petition for, plan and inform about entitlements, to advocate for services, and to appeal against adverse decisions. While beyond the scope of this paper, additional definitions and processes would have to be developed once the basic principle of positive rights has been accepted. To ensure effective access to services and supports, these details would have to satisfy the most stringent drafting standards.

The possibility of involuntary procedures supplanting an individualized consensual plan must be conceded. Canadian society would not likely accept the termination of either *parens patriae* or police power interventions, especially as the creation of positive equality promoting alternatives is still in a nascent stage. The sword of Damocles inherent in the threat of the continuation of a coercive stream might be removed with a recognition that any compatible residuum of a persons's positive entitlements must be permitted to operate concurrently with involuntary measures. Systemic emphasis on consumer planning, entitlements and advocacy should make the utilization of coercive processes rarer and should assist in confining such interventions to last resort use. Further comments on involuntary procedures and their relationship to positive rights will follow.

Section 3 – Standards for Services and Support

Establishment and Communication of Standards

- (1) *The Governor in Council shall appoint a Mental Health Services and Supports Standards Advisory Committee*
- (2) *The Advisory Committee shall comprise:*
 - (1) *a majority of consumer representatives;*
 - (2) *family representatives;*
 - (3) *health care provider representatives; and*
 - (4) *ex officio (non-voting) representatives from the Department of Health, Community Services, Housing, Education and Employment.*
- (3) *The Advisory Committee shall be responsible for:*
 - (1) *the development of effective, recovery-oriented, community-based best practices, based upon national standards wherever possible, including, but not limited to:*
 - (1) *assertive community outreach and treatment programs;*
 - (2) *crisis response programs;*
 - (3) *housing alternatives;*
 - (4) *self-help and consumer-run initiatives;*
 - (5) *assisting families in becoming integrated into services and support plans;*

- (6) *employment, education and recreational opportunities;*
 - (7) *income maintenance programs, which are responsive to the consumer's needs; and*
 - (8) *facilitating diversion or release from in-patient hospitalization to community-based alternative care models, such as home treatment, home assessment and home case management³⁴ and day hospitals.*
- (2) *the development of strategies and methods of informing eligible and potentially eligible members of the community of:*
 - (1) *the range of services and supports inspired by best practices;*
 - (2) *the entitlement of consumers to establish individualized service and support plans;*
 - (3) *the right of consumers to receive services and supports based upon such individualized plans; and*
 - (4) *the methods by which consumers may gain access to advocacy services, as part of their right to receive such services and supports.*
- (4) *The Governor in Council shall, wherever feasible, make regulations implementing:*
 - (1) *the best practices formulated by the Advisory Committee; and*
 - (2) *the outreach and information strategies and methods established by the Advisory Committee.*

Commentary

There seems to be a broad consensus in Canada that standards for the delivery of services and supports should be based upon the best practices model. For example, the CAMIMH incorporates this concept in its "Core Values":

6. We believe that mental health and illness programs and services should be based on effective (best) practices.³⁵

Similarly, the CMHA has emphasized "What Works: Documented Reports of Best Practices" in its submission to the Commission on the Future of Health Care in Canada.³⁶ This shared aspirational base has largely provided the content for the

³⁴Romanow Report, *supra* note 10 at 179. Special attention is paid to this developing modality:

Treating people effectively in the community rather than in institutions or hospitals *requires* home care ... [emphasis in original].

The Report recommends home care services taking the form of case management, "to monitor the individual's health and make sure the appropriate supports are in place" and "home intervention"... "to assist and support clients when they have an occasional acute period ..." (*ibid.*)

³⁵CAMIMH, *supra* note 25 at Appendix A. See also B.C. Ministry of Health Services "Best Practices in Mental Health Reform", online: British Columbia Provincial Government

<<http://www.healthservices.gov.bc.ca/mhd/best.html>>:

Best practices in mental health refers to a growing body of knowledge about services and strategies that have been studied and evaluated and are now accepted to be effective.

³⁶*Supra* note 24 at 6. In its submission to the Romanow Commission, the CMHA noted that its

foregoing proposal. Placing these goals in a statute is untraditional; given the current exaggerated deference to clinical independence, mental health legislation is generally silent on the content of services. Nonetheless, the legislative embrace of the equality mandate compels reference to ways of establishing best practices and to the types of initiatives subsumed under this new umbrella.

The development of standards should be entrusted to advisory committees representing a partnership of consumers, families, and providers of services and supports. Control of such committees should be vested in consumers given their expert knowledge of “what works”, and that they are the chief subjects and beneficiaries of standards and programs.

The commitment to employing national standards is consistent with the perspective of the WHO³⁷ and the CAMIMH. The latter document acknowledges the constitutional responsibility of the provinces and territories to legislate in the area of mental health law, but supports a national strategy³⁸ evolving “out of a consensus among all stakeholders including governments”³⁹ to achieve “national guidelines or benchmarks for key outcome areas.”⁴⁰

The core content of the best practices target alluded to in this recommendation emerges from the recognition that results or recovery-oriented practices will be most acceptable to consumers, and most effective when the focus is on community-based alternatives, embracing a wide concept of health and de-emphasizing traditional medical, in-hospital interventions.

So far, it has been maintained that mental health legislation is the ideal repository for the content and direction of a fundamental policy. However, it has also been acknowledged that there is some potential for effecting change through other public instruments or entities. Recently, Nova Scotia claimed to be “the first province in Canada to introduce formal standards” to support “a strategic direction for mental health.”⁴¹ In a comprehensive statement, the Province established “An overarching set of generic standards” which “may represent maintenance of the

perspectives on these issues were informed by a 1997 project: Federal/Provincial/Territorial Advisory Network in Mental Health: *Best Practices in Mental Health Reform*, by the Health Systems Research Unit of the Clarke Institute of Psychiatry. See also CMHA, Alberta Division, “A Summary of the CMHA’s Top Priorities”, online: Canadian Mental Health Association, Alberta Division <<http://www.alberta.cmha.ca/advocacy/issues.htm>>.

³⁷ *Supra* note 1 at 111, 114.

³⁸ *Supra* note 25 at “Collaborative National Leadership Required”.

³⁹ *Ibid.* at “National Policy Framework”.

⁴⁰ *Ibid.* Eventually, the Uniform Law Conference of Canada could be the locus for attempts at specifying such national standards, having previously advanced a *Uniform Mental Health Act*, online: Uniform Law Conference of Canada <<http://www.ulcc.ca/en/us/index.cfm?sec=1&sub=1m1>>.

⁴¹ Department of Health, News Release, “A Canadian First: Nova Scotia Sets Standards for Mental Health” (20 February 2003), online: Government of Nova Scotia <<http://www.gov.ns.ca/news/printpage.asp?id=20030220001>>.

status quo” or which are more ambitious as they constitute “a challenge for mental health provider organizations” in a five to ten year implementation process.⁴² While a detailed analysis of the content of these standards is beyond the scope of this discussion, the Nova Scotia statement is noteworthy for its prospective usefulness as a quasi-legislative declaration. Even if it falls short of establishing enforceable entitlements for individual consumers, there is still some valuable overlap with some of the standards and processes which have been highlighted in this paper.

The second major aspect of the foregoing proposal (s. 3(3)(b)) is intended to ensure that consumers are informed about their rights under new mental health legislation. This requirement relates to what the Bazelon Center has called:

‘Outreach’, a mandate ‘to encourage both a general education campaign and more intensive efforts to reach individuals who are likely to benefit from the right to recovery-oriented services.’⁴³

In creating what would be, for Canada, the unusual positive entitlement to supports and services, it would be imperative to communicate effectively with the citizenry in general and, more particularly, with individuals at risk who might otherwise have no awareness of an emerging effective matrix of assistance.

Section 4 – Quality Improvement

Research and Evaluation

- (1) The Minister shall develop and implement research and evaluation mechanisms with the following essential features:
 - (1) Where feasible, data shall be collected based upon national research guidelines;
 - (2) In research design and evaluation protocols, emphasis should be placed upon the measurement of outcomes;
 - (3) Outcomes should, among other criteria, address factors such as:
 - (1) quality of life, both as perceived by the consumer and as measured by other objective indices;
 - (2) maximum employment level attainable by the individual;
 - (3) suitability of housing for the consumer and stability of housing arrangements;
 - (4) use of community support programs, such as peer-support or self-help groups, or other social support methods;
 - (5) criminal justice system interactions, if any;
 - (6) in-patient hospitalization or crisis service use;
 - (7) reduction in substance abuse;

⁴²Nova Scotia Department of Health, “Standards for Mental Health Services in Nova Scotia”, (20 February 2003), online: Government of Nova Scotia <www.gov.ns.ca/health> at 1.1.

⁴³*Supra* note 13 at 17.

- (8) educational and career development opportunities and attainments; and
- (9) such other criteria as are advanced by the Mental Health Services and Supports Standards Advisory Committee.
- (4) Research should involve consumers as participants across the spectrum of issues in the collecting, analysis and evaluation of data.
- (5) Research projects should comprise many perspectives on mental health problems, and recovery-and participation-oriented strategies, including:
 - (1) medical/clinical knowledge;
 - (2) social science knowledge;
 - (3) experiential knowledge; and
 - (4) customary and traditional knowledge.

Commentary

The statute should communicate the legislature's emphasis on ongoing service quality improvements, which are best attained through monitoring outcome data in the context of a consumer-driven research process. There is a high level of concurrence at the national and international level about the need for contemporary research philosophies, capacity and participation as vital components in ensuring effective mental health services and supports. The WHO has drawn attention to research as part of the monitoring obligation:

Monitoring is necessary to assess the effectiveness of mental health prevention and treatment programmes, and it also strengthens arguments for the provision of more resources. New indicators for the mental health of communities are necessary.⁴⁴

Canadian studies, such as CAMIMH, strongly support “a national research agenda” that “informs policy development” and increases “the involvement of consumers, other stakeholders and their organizations, and the voluntary sector.”⁴⁵ Consumer-oriented groups, such as the CMHA in its submission to the Romanow Commission, indicate the importance of their increased participation in “development, implementation and dissemination of knowledge.”⁴⁶ They also demand a richer concept of the “Knowledge Resource Base” itself, embracing different types of knowledge, beyond the conventional medical/clinical type.⁴⁷ The value of social science knowledge, consumers’ experiential knowledge, and the customary and traditional knowledge received informally “from family, friends, and their community, but not from organized formal systems like medicine and social science”⁴⁸, is

⁴⁴ *Supra* note 1 at 112.

⁴⁵ *Supra* note 25 at “Research” (Goals C6 and C7).

⁴⁶ *Supra* note 24 at 21.

⁴⁷ *Supra* note 16 at 16.

⁴⁸ *Ibid.* at 17.

recognized by advocacy organizations. The infusion of this more receptive notion of knowledge into the basic framework of research should assist in keeping the agenda on an equality-promoting footing.

Finally, as discussed by the CMHA, Ontario Division (and others), the need to centre evaluation research “on *outcome* data, as too often, evaluations get lost in describing programmatic processes to the neglect of measuring whether or not the system, actually works” is reflected in the proposal.⁴⁹ To further direct the perception of outcomes in a reconfigured mental health system, the input of consumers is sought in establishing what is a “good” outcome, from the point of view of maximizing community participation and hence, equality. The list of indicators above elaborates upon the outcome measures proposed by the Bazelon Center⁵⁰, which track outcomes in a manner which attempts to measure the overall level of community integration of the consumer.

The requirement of conducting research in ways which assure consumer participation and consumer-stipulated indices of effectiveness and satisfaction should assist in more sensitive and respectful equality-oriented policy development and implementation.

Section 5 – Development of Services and Supports for Acute Systemic Problems

- (1) *The Minister shall develop programs to respond to the need for services in areas designated by the Governor in Council as having special priority, using principles similar to those stipulated in the general framework herein. Without restricting the generality of the foregoing, these programs shall address:*
 - (1) *the adequacy of programs for children, ethnocultural minorities and Aboriginal peoples;*
 - (2) *the need to enhance suicide prevention strategies;*
 - (3) *the diversion of people with mental health problems from the criminal justice and penal system; and*
 - (4) *the needs of people with mental health problems who live in rural areas.*

Commentary

Any general strategy for the establishment of positive rights to equality-promoting mental health services and supports could still be read as contemplating the special needs of some groups. On the other hand, to the extent that a particular segment of the population in any province or territory is seen as being acutely

⁴⁹ *Supra* note 21 at 29 [emphasis in original].

⁵⁰ *Supra* note 13 at 31. See also CMHA, Alberta Division, *supra* note 33 at 1, in which it is noted that “the CMHA would like to see: ... A plan of concrete measurable outcomes.”

exposed to harm (or a social problem with mental health effects which has reached crisis dimensions), a reformed mental health statute should explicitly set forth the need for discrete attention. For example, the Alberta Division of the CMHA⁵¹ recently included in their “top priorities” the need to promote children’s mental health services, diversion from the criminal justice system and suicide prevention. The designation of an issue or group as demanding special concentration within a framework of principles and methodologies with broad applicability should be compatible with the orderly development of new overall programs.

6. Relationship with Involuntary Examination, Hospitalization and Treatment Provisions

- (1) *The provisions of this Act establishing the statutory framework for involuntary examination, hospitalization and treatment shall continue in force, subject to the following principles:*
- (1) *the services and supports specified herein, and the right to insist upon them, shall form the primary response to preventing and responding to people with serious mental health problems;*
 - (2) *any involuntary or coercive measure permitted by legislation shall be employed as a last resort, normally when all other ways of responding have been tried and have failed;*
 - (3) *any intervention which is authorized by legislation shall be the least intrusive, least restrictive and least onerous procedure feasible in the circumstances, and shall be resorted to for the shortest time possible;*
 - (4) *even where some coercive procedure is used, as much credence and weight will be given to the consumer’s wishes and preferences as is feasible and prudent in the circumstances; and*
 - (5) *whenever an involuntary procedure has supplanted the normal consensual arrangements, part of any discharge planning shall include strategies and programs to avoid the necessity of using coercive methods again in the future and to restore the consumer’s individualized goals for services, supports and community participation.*

Commentary

The relationship between the redesigned statute and the older conventional mental health law must be approached with caution, to ensure that positive entitlements and state obligations are not thwarted or undermined by the ready availability of coercive procedures. Legislatures will have to accord statutory and

⁵¹ *Supra* note 36. The Alberta CMHA statement also noted a provincial priority relating to the confidentiality of mental health records. See the Romanow Report, *supra* note 10, which, although a document dealing with general principles devoted separate Chapters to “Rural and Remote Communities” (7) and “A New Approach to Aboriginal Health” (10).

fiscal primacy to the community-based and equality-oriented services and supports mandated in reformed legislation. Inconsistency should be eliminated, both by statements of principle as seen above, but also by other careful consequent statutory excisions and revisions. A thorough presentation of reforms necessary to reflect this complementarity is beyond the ambit of this paper. Given the variation among existing provincial and territorial mental health statutes, the exercise would be required in each jurisdiction. The Bazelon Center Model Law perhaps oversimplifies this relationship between the two radically different types of legislation, stating that:

3B. The provisions of this Law shall not be construed to impair the validity of court orders under [State's involuntary treatment statutes]⁵²

Their draft does acknowledge that “some consumers have experienced the mental health system as coercive” and that even the “entitlement to voluntary recovery-oriented services may not overcome this history.”⁵³ However, the connection between the two major prongs of a mental health statute, entitlement to voluntary services and the last resort use of interventions would have to be closely assessed to protect against the perpetuation of habitual, if discarded, intrusive practices. The Mental Health Monitoring Coalition of British Columbia has assessed the effects of a de-emphasis on equality promoting supports and services:

When people with a mental illness are not able to access less intrusive services such as supported living, their conditions can deteriorate and ultimately require more intensive intervention.⁵⁴

The Supreme Court of Canada has recognized this correlation between mental health problems, social neglect, and the resultant likelihood of conflict and consequent coercive responses in its approving reference to Dr. Paul Mullen in *Winko v. British Columbia (Forensic Psychiatric Unit)*⁵⁵:

... the social dislocation and economic decline which accompany the more disabling forms of schizophrenia put sufferers at risk of being forced into the ranks of the dispossessed. Homelessness, poverty and social isolation all too often accompany schizophrenia. These increase the risks of conflict with others and the police.⁵⁶

Constant vigilance on the need to use these primary strategies advocated in a refurbished statute will help to avoid the resort to coercion by default.

⁵² *Supra* note 13, “Article 3: Right to Recovery-Oriented Services and Supports” at 10.

⁵³ *Ibid.* at 9.

⁵⁴ Mental Health Monitoring Coalition of British Columbia, *National Health Reform Priorities – Where Is Mental Health?* (September 2000), online: Canadian Mental Health Association BC Division <<http://www.cmha-bc.org/content/coalition/reports/reports.htm>> at 3.

⁵⁵ [1999] 25 C.R. 625 (S.C.C.).

⁵⁶ *Ibid.* at 655, McLachlin J. (as she then was).

III Conclusion

If the discrimination and inequality which has been imposed upon mental health consumers is to be ameliorated, the many directions and policies suggested in this paper will have to be accepted as part of a new wave of legislation. Although it is difficult to express evolving principles in the precise and directive language of a statute, an alternative direction for Canadian law has been proposed which concretizes modern perspectives on maximizing the societal participation of people with mental health problems. The prospect of truly empowering mental health consumers makes this effort essential. It is time for Canadian mental health legislation to break with its past.

Appendix A

WHO: *The World Health Report 2001*, at 80

Formulating policy: the key questions

The successful formulation of a mental health policy depends on ensuring that it responds affirmatively to the following questions:

- Does the policy promote the development of community-based care?
- Are services comprehensive and integrated into primary health care?
- Does the policy encourage partnerships between individuals, families and health professionals?
- Does the policy promote the empowerment of individuals, families and communities?
- Does the policy create a system that respects, protects and fulfils the human rights of people with mental disorders?
- Are evidence-based practices utilized wherever possible?
- Is there an adequate supply of appropriately trained service providers to ensure that the policy can be implemented?
- Are the special needs of women, children and adolescents recognized?
- Is there parity between mental health services and other health services?
- Does the policy require the continuous monitoring and evaluation of services?
- Does the policy create a system that is responsive to the needs of underserved and vulnerable populations?
- Is adequate attention paid to strategies for prevention and promotion?
- Does the policy foster intersectoral links between the mental health and other sectors?