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## A "Patient-Centred" Path towards Ignoring Patient Rights

A Critical Analysis of the Federal Senate Committee's Dismissal of Concerns about Involuntary Treatment Laws and Civil Rights Abuses in the Canadian Mental Health System

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### Preface

The Canadian Standing Senate Committee on Social Affairs, Science and Technology released a report on the mental health system in [2006](#), "Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada". The Committee's central recommendation was that Canada create a more patient-centred mental health system. Yet, the Committee utterly failed to address the fundamental lack of patients' legal rights which drives the current, non-patient-centred system. Despite extensive discussions and witness testimonials that were extremely critical of routine involuntary psychiatric treatment and civil rights abuses in the Canadian mental health system, the Committee's final report included no recommendations in this area. Through analysis of the language, arguments and rhetoric in the Committee's writings, this paper demonstrates that the Senate Committee 1) accepted uncritically numerous erroneous or unproven claims from particular mental health professionals about the accuracy and efficacy of psychological and psychiatric science, and 2) deliberately misrepresented and ignored important civil rights issues surrounding involuntary treatment due to their uncritical faith in psychiatric science and deeply embedded prejudices against people diagnosed with mental illnesses. As a result, Canada lost an ideal opportunity to develop a more balanced national discussion of current involuntary treatment laws and point towards more progressive options.

### Introduction

Reports about Canada's health care system published in 2002 by the Canadian Standing Senate Committee on Social Affairs, Science and Technology raised serious concerns about Canada's mental health care system ([Standing Senate Committee, 2002](#)). As a result, in [2003](#), the Senate began an investigation specifically into mental health care. Senator Michael Kirby was appointed to chair the investigation, leading research and consultations over the next three years. Three "interim" mental health reports were released in November of 2004. In May of 2006, the Standing Senate Committee on Social Affairs, Science and Technology released its concluding report, referred to here as the "Final Report", "Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada" ([Standing Senate Committee, 2006](#)). This Final Report lacked any specific legal authority, and acknowledged that health care was primarily under the jurisdiction of provincial and territorial governments rather than the federal government. Nevertheless, its approximately six hundred pages represented the most extensive overview of mental health services ever done in Canada, and were intended to provide a guiding

roadmap for reform. One of the principle recommendations, the creation of a Mental Health Commission of Canada to help further the Final Report's other recommendations, was enacted by the federal government in March of 2007 and Michael Kirby was named Chair of the new Commission. Since then, over \$200 million in federal funding has strengthened the Mental Health Commission's growing role in helping set agendas and conduct and guide policies and programs across the country ([Mental Health Commission of Canada, 2008](#)).

### **Overview: The Final Report's Central Recommendation and the Key Missing Element**

The main thrust of the Senate Committee's arguments and conclusions in the Final Report revolves around making Canada's mental health services more patient-centred and focused on recovery. The section on "Vision and Principles" concludes, "In the Committee's view, what is needed is a genuine system that puts people living with mental illness at its centre, with a clear focus on their ability to recover." ([Standing Senate Committee, 2006](#), p.37) Repeated critical emphasis is given throughout the Final Report to the "severely limited" range of choices currently available to mental health patients, and frequent endorsements are given to the idea of offering people living with mental illness "the opportunity to choose" from a wide range of services and supports those which will "benefit them most" ([Standing Senate Committee, 2006](#), p.46). The "Summary of Principles" section argues that mental health patients "must be accorded equal respect and consideration" as patients suffering physical illnesses. In addition, the Committee writes, mental health patients must have full responsibility for their own recovery while utilizing to their own benefit "collaboration" from friends, family, the community, and mental health professionals. The Committee declares, "It is people living with mental illness themselves who should be, to the maximum extent possible, the final arbiters of the services that are made available within the overall mental health system and of the ways in which they are delivered." ([Standing Senate Committee, 2006](#), p. 57-8).

In this context, well-established tenets of patient empowerment, such as different therapeutic options, housing, employment, community supports, peer support networks, and patient involvement in policy and program design, are repeatedly described as central to reforming the mental health system, and are given strong endorsements in the Committee's recommendations.

There is, however, a major block standing in the way of literally every type of patient-centred or patient-empowered reform which the Committee proposes. In every jurisdiction in Canada, people who have been diagnosed with mental illnesses are potentially subject to involuntary committal laws that can remove from them most of the civil rights and powers which ordinary citizens take for granted. Mental health patients can be certified under mental health legislation and stripped of many powers to make decisions for themselves both inside and outside of hospitals, and even when these powers are not stripped from them, they must nevertheless live with the constant threat that such an event could occur at any time relatively quickly and easily. A person may be involuntarily committed and incarcerated in a psychiatric hospital and/or made subject to involuntary outpatient treatment orders while living in the community if he or she is threatening bodily harm to others. However, in most jurisdictions in Canada today, a person may also be certified "in the interests of the person's own safety or the safety of others" ([Province of New Brunswick, 1973](#), s.7.1) or, quite simply, if the person is deemed to be in danger of mental or physical "deterioration" or "impairment" if left untreated ([Province of British Columbia, 1996](#),

s.22; [Province of Ontario, 2004](#), s.19; [Province of Manitoba, 1998](#), s.8.1). Meanwhile, no jurisdiction in Canada provides any legal or scientific criteria for what exactly in this context constitutes "safety", "deterioration", or "impairment", or even provides a legal definition or scientific reference for what constitutes a mental health examination or a mental illness. So in practical terms, the treating psychiatrist renders final judgments about any particular patient's status under involuntary committal laws with wide-ranging personal and professional discretion. A second psychiatrist's signature is typically required for longer term certifications, but according to legislation this can usually be a routine sign-off by the director of the treating hospital.

The rights of people who are involuntarily committed vary somewhat amongst jurisdictions. Generally, individuals may be restrained, incarcerated and, in most Canadian jurisdictions, forcibly treated with chemical, electro-convulsive, or other interventions for periods of weeks or months, while certification renewals can extend committal orders essentially indefinitely. Certified mental patients typically have limited access, or in some cases no access at all except by extraordinary measures, to legal advocates, appeal procedures, or the court system.

Involuntary committals and involuntary treatment are not rare; indeed, involuntary committal and coercion into treatment under the threat of involuntary committal are a principal component of the daily routine of psychiatric hospitals and the mental health system in Canada. ([Sklar, 2004](#); [Wipond, 1998a](#); [Wipond, 1998b](#)). Clearly, then, no serious discussion of empowering mental health patients to choose their own strategies for recovery can take place without addressing the fact that these same people can be and regularly are stripped of many rights and powers of decision-making over their own treatment or recovery by their treating psychiatrists. However, "Out of the Shadows at Last" leaves this entire, absolutely central conundrum largely unaddressed.

Careful review of the discussions about the legal and civil rights of patients in the mental health system in the Senate Committee's interim reports, in the testimonials from witnesses, and in the Final Report, demonstrate that this omission was deliberate. While the Committee apparently wanted to give a public show of support towards empowering patients in their own recoveries, in fact, the Committee chose to distort, ignore and ultimately purge extensive testimony about widespread and routine abuses of the civil rights of mental patients in Canada, and instead gave much weightier support to particular mental health professionals who strongly advocated for forced treatment and reduced patient powers. Ultimately, this undermines the central stated intent of "Out of the Shadows at Last" and, rather than helping mental health patients actively guide their own recoveries, provides a template for an even broader assault on civil rights in Canada.

## **Overview of the Interim Reports**

The Committee released three interim reports in November of 2004. Interim Report 2 is an overview of mental health programs in selected other countries and is not pertinent to this discussion. However, Interim Report 1, "Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada" ([Standing Senate Committee, 2004a](#)), and Interim Report 3, "Mental Health, Mental Illness and Addiction: Issues and Options for Canada" ([Standing Senate Committee, 2004b](#)), are key to understanding the arc of the Committee's attitudes about

involuntary treatment that ultimately led to the Final Report.

### **Analysis of Interim Report 3**

The purpose of Interim Report 3, writes the Committee, is "to outline the major issues facing the provision of mental health services and addiction treatment in Canada, to present potential policy options to address some of these issues, and to launch a public debate to enable Canadians to provide input on how the issues should be addressed." ([Standing Senate Committee, 2004b](#), p.1) In this report, the template is outlined for the primary topics which will be explored at greater length in Interim Report 1 and then brought towards recommendations for reform in the Final Report. There are chapters dedicated to financing of mental health, jurisdictional authorities of the various levels of government, the needs of specific population groups, workplace issues, the state of scientific research etc. Issues surrounding mental health law and involuntary treatment are only hinted at briefly in Interim Report 3. In chapter one, "A Patient/Client-Centered System Oriented Toward Recovery and With Personalized Care Plans", the Committee notes that "Providing services and supports that are tailored to meet individual needs is fundamental to recovery." ([Standing Senate Committee, 2004b](#), p.6) Later in that same section, the Committee writes, "Accordingly, how can a patient/client oriented system ensure an appropriate balance between the rights of individuals with severe mental disorders and the role of society in caring compassionately for them while also protecting itself?" ([Standing Senate Committee, 2004b](#), p.6) This crucial topic of involuntary treatment and the balancing of rights is developed more in Interim Report 1.

### **Analysis of Interim Report 1**

In Interim Report 1, the Committee discusses involuntary treatment within a number of distinct sections dealing with a variety of legal and ethical issues. Along with these sections, it is also vital to examine how the Committee handled the issues of psychological and psychiatric science and the biomedical theory of mental illness, because these subjects are tightly interwoven with the ethical issues surrounding involuntary treatment. Clearly, as long as one believes fully that psychological disturbances are biological diseases of the brain, then treatment of those disturbances, even if it is against people's wills, seems to be fundamentally and finally a health care issue; the operational analogy becomes not that of a protester being dragged to prison to be tortured, but that of an unconscious car accident victim being rushed to hospital for life-saving surgery. The choice of analogy then dramatically affects the ensuing discussion of the ethical issues surrounding treatment without consent.

At no point in any of the reports does the Committee grapple with any scientific details. Specific diagnostic categories are never critically examined, particular drugs or other extant treatments like electroconvulsive therapy or lobotomy are never discussed, and the deeply radical differences and conflicts between different schools of psychiatry and psychology are never mentioned. When the Committee briefly reviews various types of mental illness, it does so by uncritically utilizing currently popular psychiatric diagnostic manuals, and without reviewing either what the most common treatments are in Canada today or the often-poor outcomes associated with them ([Standing Senate Committee, 2004a](#), p.67-72). In Chapter 10 ([Standing Senate Committee, 2004a](#), p.215-230), the Committee summarizes that science "has advanced

our understanding" of mental illnesses, and that we are now "closer to understanding" them. In that growing understanding, the Committee argues, "research . . . plays an important role" and we "should devote additional funding" and develop improved "best practices".

The lack of detail in all of these sections is inscrutable. While acknowledging a dearth of "best practices" guides in mental health, the Committee provides no discussion or commentary on which experts or areas of expertise should lead development of these documents. When advocating for more funding for scientific research, the Committee recognizes the prominent role that pharmaceutical companies are currently playing, yet does not even acknowledge the deep, widespread controversy about this role that has arisen in public, government and scientific debates in medical journals in recent years ([Milloy, 2001](#)). The Committee also chooses its language carefully; for example, it is not that we *do not understand* mental illness, but we are "closer to understanding" it. All together, this repeated lack of any truly *critical* approach to the arguably anemic state of the science of mental illness provides tacit support to the current dominant paradigm and most powerful (through mental health legislation) leaders in the Canadian mental health system: psychiatrists and the biomedical model of mental illness. This tacit, implicit bias is further evidenced when the Committee does step a little closer towards specifics. Then, the Committee's statements frequently lapse into pure hubristic support for common, unscientific, unproven claims of average mental health professionals. For example: "The benefits of early intervention extend to numerous mental illnesses and to individuals of all age groups. Without early intervention and treatment, child and adolescent disorders frequently continue into adulthood. If the system does not appropriately screen and treat them early, these childhood disorders are likely to persist and lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. No other set of illnesses damage so many children so seriously." ([Standing Senate Committee, 2004a](#), p.166)

It is unclear where this series of extraordinary claims came from -- in this and in the Final Report where the claims are repeated, no scientific citations are provided. The remarks do strongly resemble claims made commonly in position statements by prominent Canadian mental health organizations with whom the Committee consulted, like the Schizophrenia Society's position paper on early intervention in schizophrenia ([Schizophrenia Society, 2008](#)). However, according to the Cochrane Review on early intervention for psychosis, for example, there were "insufficient trials to draw any definitive conclusions" ([Marshall and Rathbone, 2006](#)). In the few trials there were, the researchers found "no difference between intervention and control groups". Significantly, the British Columbia Branch of the Canadian Mental Health Association (CMHA-BC) found in their own early intervention study in 1998 that "nearly half of participants received an incorrect diagnosis" ([Macnaughton, 1998](#), p.7), and consequent unhelpful treatment programs. No objective rationale is provided to presume the psychiatrists making the second diagnoses were any less prone to error than the initial psychiatrists, so from a patient perspective this study suggested an error rate in early intervention closer to 75%, essentially dramatically undermining altogether the scientific validity of psychiatric diagnoses in early intervention. Nevertheless, in testimony to the Senate Committee, CMHA-BC indicated they found "challenges" with early intervention in their study, but did not elaborate, and they still endorsed more early intervention ([Canadian Mental Health Association-BC Division, 2005](#), p.5). All of these scientific uncertainties were brought to the Committee's attention prior to the reiteration of the erroneous claims in the Final Report ([Wipond, 2005](#)).

The Committee's unjustified, uncritical faith in the efficacy of psychiatric and psychological science emerges even more in discussions about the ethics of involuntary treatment, where their logical arguments are heavily steeped in the language and conceptual frameworks of the biomedical model of mental illness and its rationalizing ontology for psychiatric intervention by force.

In Section 8.3, "Mental Health Legislation", discussion of involuntary treatment occupies the entire six pages of this section of the 250-page report. The Committee writes that, "Mental health legislation is also meant to reflect a balance between the rights and dignity of the individual, the protection of society, and society's concern to help those not able to help themselves." (Standing Senate Committee, 2004a, p.167) This apparent sensitivity to achieving a "balance" of rights, is followed immediately by a highly debatable assertion presented as unequivocal fact, thereby setting the tone for much of what is to come:

"In fact, all provincial and territorial legislation must comply with the *Canadian Charter of Rights and Freedoms*." ([Standing Senate Committee, 2004a](#), p. 167).

In fact, whether or not Canada's mental health laws comply with the Charter is a matter of widespread, ongoing debate. Even as the Committee's consultations were going on, for example, a widely publicized case concerning circumstances under which an Ontario patient with extraordinary scientific and mathematical talent could legally refuse psychiatric treatments was before Canada's Supreme Court. The case was concluded in 2003, in favour of Scott Starson's right to refuse drug treatments ([Supreme Court of Canada, 2003](#)). Shortly thereafter, however, circumstances changed slightly and psychiatrists felt within their right to again treat Starson with drugs against his will -- highlighting even further the contentious, complex nature of the topic ([O'Neill and Fischer, 2005](#)) and the contentious civil rights debates that have long been common within the psychiatric profession ([Sklar, 2004](#)). In other examples, a separate case challenging British Columbia's *Mental Health Act* was in progress in BC during the Committee's tenure ([Supreme Court of British Columbia, 2006](#)) and legal and civil liberties groups have issued statements in the past expressing doubt that involuntary treatment laws comply with Canadian civil rights laws (British Columbia Civil Liberties Association, [1965](#), [1976](#), [1983](#)). It is nearly impossible to imagine that all the Committee members were entirely oblivious to all such debates throughout their tenure, and in any case both earlier and later presenters brought some of them to their attention ([Hall, 2003](#); [Allan, 2005](#); [Wipond, 2005](#)). Evidently, then, the Committee *chose* to assert that there is no controversy at all on this key issue, when there is actually enormous controversy, and the effect is to downplay the importance of well-articulated *Charter* rights concerns surrounding involuntary treatment legislation. Also in this section, the Committee's uncritical faith in psychiatric science is again evident in the presumptions underlying this assertion: "Without compulsory hospital admission and psychiatric treatment, individuals who will not accept voluntary treatment are abandoned to the consequences of their untreated illness." ([Standing Senate Committee, 2004a](#), p.167) In the Committee's view, apparently, psychiatrists never make errors, and there are inevitable negative repercussions for disobeying their advice.

Such deeply biased, loaded language is brought even more to the fore when disparities between involuntary treatment legislation in different jurisdictions are discussed. The Committee cites

Gray and O'Reilly:

"The criterion which limits involuntary admission and treatment to physical harm raises ethical issues for psychiatrists, who may see a patient who is extremely distressed because of a psychotic illness but who is not likely to be dangerous (physically) to himself/herself or others. In such cases, while psychiatrists know that treatment would be quickly effective and would relieve suffering, they can neither hospitalize nor treat the affected person. As a result, some individuals with severe mental illness and in need of psychiatric treatment will not receive timely care." ([Standing Senate Committee, 2004a](#), p.168).

The strong presumptions underlying the choice of words are evident: Psychiatrists "know" that their diagnoses are always accurate. Their treatments are always "quickly effective" and inevitably "relieve suffering". Conversely, being able in some circumstances to refuse their recommended psychiatric treatments means nothing other than a loss of "timely care" which is a "need". Are there never any possible errors in this process? No misdiagnosed individuals? No ineffective drugs? Never any uncomfortable or debilitating drug side effects to undermine the relief of suffering? In fact, the potentially negative side effects of most psychiatric treatments is standard knowledge. In addition, the fundamentally tenuous and experimental nature of all psychiatric and psychological diagnoses and treatments are well known. The American Psychiatric Association team spearheading the research agenda for the next edition of the definitive *Diagnostic and Statistical Manual of Mental Disorders* has concisely summarized this: ". . . the goal of validating these syndromes and discovering common etiologies has remained elusive. Despite many proposed candidates, not one laboratory marker has been found to be specific in identifying any of the DSM-defined syndromes . . . With regard to treatment, lack of treatment specificity is the rule rather than the exception." ([Kupfer, First and Regier, 2002](#), p.xviii) So once again, the Committee uncritically presents self-evidently non-factual, unscientific contentions as fact. Meanwhile, the contrasting argument is implicitly self-evident: If psychiatric treatments were even *most often* quickly effective and relieved suffering, involuntary treatment would arguably have a minimal, temporary role to play in Canada's mental health system, rather than the ongoing, central role that it currently has. Involuntary treatment is a major issue because treatments are not effective for many people and make many people feel worse rather than better. Additionally, many patients loathe the common treatments and their damaging side effects. The fact that the Committee ultimately ignored all of this, even though it had been iterated frequently in witness testimonies (see below), hints at an unshakable, underlying bias that becomes yet more evident as the discussion continues.

For example, this particular section occurs within the context of a lengthy attack on those jurisdictions which allow patients to refuse treatment under certain circumstances. The Committee cites Gray, Shone and Liddle: "The rise in the number of people with mental illness in prisons and homeless on the streets is blamed in part on laws restricting involuntary admission to the physically dangerous." ([Standing Senate Committee, 2004a](#), p.168) This highly hypothetical claim has an obvious contrary argument: Could the ineffectiveness and damages of psychiatric treatments themselves be partly to blame? This question is not discussed. Instead, the twisting of the discussion away from anything even remotely resembling a logical or balanced treatment of the issues is highlighted in yet another citation from Gray, Shone and Liddle: "While compulsory treatment will usually restore someone's freedom of thought from a mind-

controlling illness and restore their liberty by releasing them from detention, their feelings of autonomy and legal and civil rights may be impacted." ([Standing Senate Committee, 2004a](#), p.167) Far from reaching toward a "balance", this attitude completely denudes any value from people's own perspectives once they have been labelled as mentally ill. Whether they have psychiatric disorders or not, most people seldom regard being incarcerated without charge and drugged against their wills as a "liberating" experience which restores their "freedom of thought". The Committee is engaged here in concept-twisting at an Orwellian level. At least in this quote there is the slightly mitigating inclusion of "usually", but again, the Committee fails to discuss the tremendous significance of this qualification: What about those "unusual" people who aren't being thus "liberated" by compulsory treatment? Are their perspectives and experiences simply unimportant to this discussion?

Many of the quotes and references throughout this section, as noted, come from John Gray, who was previously the Manager of Clinical Psychiatry for the British Columbia provincial government, and was President of the Schizophrenia Society of Canada when he presented to the Committee ([World Fellowship for Schizophrenia and Allied Disorders, 2008](#)). It is clear, then, that rather than seek out middle ground, the Committee actually chose *to take the side* of two prominent public symbols of the polarization of this entire debate, a person and an agency which had been actively involved in the expansion of involuntary treatment powers (Wipond, 1998b) and in the defence of those powers in court cases. ([Schizophrenia Society, 2008](#); [Supreme Court of BC, 2006](#); [Supreme Court of Canada, 2003](#)). Curiously, all of the previous discussion is somewhat contrasted by Chapter 11, "The Question of Ethics Consent and Capacity Issues". Here, the Committee notes, "While decision-making capacity is essential for valid consent, applicable clinical tests to assess competence are controversial, especially for those with mental illness and addiction. Determinations of decision-making capacity raise special issues regarding the vulnerability of those suffering from mental disorders. Adapting the delivery of services, as the patient fluctuates in, or gradually loses, his/her capacity, is a challenge for the mental health and addiction treatment system. Respect for the person requires that the changing or diminishing capacity is identified and diagnosed, and that the system adapt accordingly, in order not to infringe unduly on the autonomy of the person affected." ([Standing Senate Committee, 2004a](#), p.235) Of course, this very question of competence and capacity for decision-making is usually key to the practical justification for treating a person against his or her will. So the fact that the Committee here *acknowledges* the tremendous controversy surrounding determinations of capacity is perplexing, in light of the Committee's complete *lack of acknowledgement* of such underlying controversies in the preceding discussions about involuntary treatment. After all, if we cannot be sure when people are or are not truly incapable of making their own decisions, how can we be sure when it is best to treat them against their wills? All together, then, Interim Report 1 makes it abundantly clear that the Committee understands that involuntary treatment is in any case a vital, central issue in the mental health system worthy of serious consideration. This is what makes it all the more surprising that the entire discussion is simply totally absent from the Final Report.

### **Analysis of the Final Report**

There are three sections of the Final Report, "Out of the Shadows at Last", which are directly pertinent to the discussion of involuntary treatment. These are:

## Chapter 4: Legal Issues

## Chapter 11: Research, Ethics and Privacy

## Appendix A: Recommendations

In addition, it is important to review some of the witness testimonies the Committee heard on the topics of involuntary treatment, civil rights, and the legal rights of mental health patients which were critical of the Canadian mental health system.

In Chapter 11, "Research, Ethics and Privacy", the only ethics discussion which takes place revolves around privacy issues related to electronically tracking psychiatric patients and ex-patients and sharing their health information with others (see below).

In the section on research, once again there is no critical discussion of the uncertainties underlying psychiatric science. In sub-section 11.2.3, "Other Sources of Funding for Mental Health Research", the Committee discusses various government, non-profit, and charitable agencies which support mental health research, and then discusses the role of the pharmaceutical industry:

"Pharmaceutical discoveries are an important product of research into mental illness, because drugs are an essential component of the treatment options for people living with mental illness. In fact, the pharmaceutical industry is the largest single source of funding for health research in Canada. In 2004, it invested \$1.6 billion in health research and development, approximately 27% of the total spent on health research in the country. Just how much of that funding of research by the pharmaceutical industry in Canada goes into mental health and addiction is not known, but it is thought to be substantial."

Then, far from expressing concerns about the immense influence of these private drug companies and the biases they bring to scientific research, the Committee concludes this subsection with a recommendation they be even more involved: "That the Canadian Institutes of Health Research actively seek out more opportunities for research partnerships on mental health and addiction with the private and not-for-profit sector." ([Standing Senate Committee, 2006](#), p.257).

In the witness testimonials, many people expressed enormous concern about involuntary treatment. For example, Jennifer Chambers of the Centre for Addiction and Mental Health's Empowerment Council provided submissions showing a "consistent abuse of rights of people in the mental health system" ([Chambers, 2005](#)). *Our Voice* editor Eugene LeBlanc provided a quote from the World Health Organization discussions of the rights of the mentally ill, stating that "a human rights violation . . . often consists in treatment itself" ([LeBlanc, 2005](#)). Ron Carten of the Vancouver-Richmond Mental Health Network argued the "inordinate power" of psychiatrists requires "stricter oversight" ([Carten, 2005](#)). The British Columbia Ombudsman's report on Riverview Hospital, which was cited to the Committee by this author ([Wipond, 2005](#)), found routine, "systemic" abuses of patients' legal and human rights at BC's major psychiatric hospital, and argued for the adoption of the Ombudsman's own Charter of Patient Rights ([Ombudsman,](#)

1994). Former BC government-appointed Mental Health Advocate Nancy Hall noted most provinces do not even provide legal advocates for people being committed. "Not only are people badly treated, but due process is not often followed," she stated (Hall, 2003). Survivor-activist Francesca Allan provided the Committee with suggested changes to involuntary treatment laws which she had worked out with a branch of the British Columbia Civil Liberties Association, and noted many lawyers argue current laws violate Canadians' *Charter* rights (Allan, 2005).

Yet very little of these perspectives ended up in the Final Report. In Chapter 4, "Legal Issues", there are three section topics: access to personal health information; charter of patients rights; mental disorder provisions of the Criminal Code.

In the first section of Chapter 4, the Committee recommends that more extensive electronic tracking of mentally ill individuals be done, and that governments should make it easier for service providers to share the medical and other personal information of mental patients with family, other health practitioners, police etc, even without patient consent (Standing Senate Committee, 2006, pp.65-72). In a brief subsection, the Committee also recommends, "That provisions in any provincial legislation that have the effect of barring persons from giving advance directives regarding mental health treatment decisions be repealed." (Standing Senate Committee, 2006, p.70) This latter recommendation is, notably, a significant move towards defending the rights of mental patients to determine their own treatment strategies. By supporting advance directives, the Committee implicitly concedes that a person should always retain the right to choose, guide or refuse psychiatric treatments. However, even in an ideal scenario where such directives were recognized under mental health legislation, advance directives would still only empower people who had not yet been declared mentally ill or incompetent. This is because, once one has been declared mentally ill, writing an advance directive falls into extremely weak and tenuous legal territory. The Committee never addresses this. So ultimately, this position further highlights the fact that the Committee implicitly regards a person, once diagnosed as mentally ill, as not deserving of the same rights as others.

In the next section, the idea of a charter of patient rights is discussed. Clearly, any charter of rights which is earnestly developed by users and service providers together provides an opportunity for reinforcing and extending the rights of patients to choose their preferred treatment strategies and participate in their own recoveries, in concert with the Committee's stated main objective. However, when discussing the right of patients to be empowered in their treatment or refusal of treatment, the Committee notes that "There was support for adopting a legislated patients' charter [of rights], although it was somewhat less popular with family members and service providers than with those living with mental illness." (Standing Senate Committee, 2006, p.73) The Committee does not elaborate on the significance of this difference of opinion between these three groups, even though it arguably strikes to the very heart of the reason such charters are needed—a person diagnosed with a mental illness often cannot even rely on the support of service providers or family members to defend his or her civil rights. The Committee then proceeds to argue against any charter of patient rights with a series of peculiar arguments. The Committee argues that such a charter will sometimes simply "duplicate" existing legislation. Even though the Centre for Addiction and Mental Health (CAMH), Canada's leading mental healthy facility and research centre, has developed and endorsed a charter that includes some such reiterations of existing legislation, "[t]he unnecessary duplication puzzles the

Committee." ([Standing Senate Committee, 2006](#), p.75) Yet the Committee makes no reference to asking anyone, from CAMH or elsewhere, to address their confusions. But why would it puzzle them at all? The vast majority of declarations of the rights of specific citizen groups which emerge anywhere from local immigration centres to the United Nations are based in part on reiterations of existing legislation. The intent is for the declaration to serve as reminder and reinforcement of those rights to all involved.

The Committee also laments that a charter could create "further stigmatization" ([Standing Senate Committee, 2006](#), p.74). As has been shown already, being labelled with a mental illness diagnosis automatically puts one into a different subclass of society legally, so why would the Committee object in this way to a charter which would work to remove some of that powerful and very tangible stigmatization? The Committee simultaneously worries that a charter could, rather than boosting patient rights, instead foist "responsibilities" onto patients. In support of this position, the Committee cites a "*Charter of Adult and Family Rights and Responsibilities*" created by "The Adult and Family Rights and Responsibilities Charter Committee of Cranbrook, British Columbia". This document requires mental patients to do things like, "Pay particular attention to your own hygiene. Poor hygiene is offensive to others. Bathe, brush you [sic] teeth, and wash your hair regularly." It is unclear why the Committee would even cite such a blatantly insulting and prejudiced document not explicitly linked to any major Cranbrook mental health organization or described to have ever been adopted anywhere. Overall, then, the Committee uses extremely peculiar, under-researched and flimsy arguments to dismiss a powerful method of defending patients' rights which the BC Ombudsman, the leading mental health facility in Ontario, and many other reputable sources had strongly advocated after extensive research and consultations.

In the third section of this chapter, while discussing the mental disorder provisions of the Criminal Code, the Committee finally revisits the question of forced treatment directly. "The committee heard from many people living with mental illness who strongly oppose forced psychiatric intervention. Their message was unequivocal – imposed treatment is highly damaging to the autonomy and dignity of affected persons[.]" ([Standing Senate Committee, 2006](#), p.83) This is followed by extensive quotes reinforcing and elaborating on these issues from Jennifer Chambers, Rob Wipond, Francesca Allan and Eugene LeBlanc from witness testimonies already cited above ([Standing Senate Committee, 2006](#), pp.83-84). The Committee then writes, "In light of these and other submissions, the Committee has reservations about involuntary treatment although it may be required in very rare circumstances . . . doing so may violate their Charter rights." While this statement sounds like, finally, a very heartfelt support in defence of the rights of mental patients to refuse treatments or choose their own treatments, it is quickly revealed to be merely part of a ruse to rationalize actually expanding forced treatment. The previous statement is followed immediately with this one: "Having said that, the powers granted to courts by the Criminal Code permit involuntary treatment in very limited circumstances. Treatment decisions may be made on application by the prosecutor for the sole purpose of making a mentally disordered accused fit to stand trial. Medical evidence must be presented, the disposition is limited to 60 days, and neither psychosurgery nor electroconvulsive therapy may be administered . . . We acknowledge the objections to forced psychiatric intervention . . . We also recognized, however, the need to shorten the period of time that individuals found unfit to stand trial stay in the system is pressing and substantial . . ." ([Standing Senate Committee, 2006](#),

pp. 84-85) The Committee then concludes by recommending increasing powers under the Criminal Code to forcibly treat the criminally accused.

So what has happened here? First, it is important to understand that none of the above-quoted witnesses were discussing these rarely-used mental disorder provisions of the Criminal Code. These witnesses were discussing the involuntary committals and forced treatment which take place every day inside and outside ordinary Canadian psychiatric hospitals under standard mental health legislation, and their testimonials make that abundantly clear. The overwhelming majority of mental patients in Canada are never charged with any crimes under the Criminal Code and indeed are rarely involved with the mental health system due to any types of criminal activity, but are diagnosed, certified and forcibly treated under jurisdictional mental health legislation. Yet the Committee never even clarifies this fact, let alone addresses it. Instead, these witnesses and their very real and legitimate concerns are utterly dismissed by way of a sleight of hand that makes it appear as if their concerns have indeed been addressed. The Committee is able to express "grave reservations" about involuntary treatment, while reassuringly noting that involuntary treatment is very rarely done under the Criminal Code and that there are many mitigating protections of individual rights under the Criminal Code. Ironically, none of these listed protections -- the requirement for medical evidence to be presented, the 60-day time limit, the disallowance of electroconvulsive therapy or psychosurgery like lobotomies -- exists for ordinary, non-criminally-accused people under any Canadian provincial or territorial mental health laws. Yet despite supposed "grave reservations" about forced treatment, the Committee does not discuss this.

### **Analysis of the Conclusions and Recommendations in the Final Report**

The Committee made just eight recommendations in the Final Report under the topic of "Legal Issues". Four of these recommendations pertain to increasing public access to the personal medical information of mental health patients. Three pertain to increasing powers under the Criminal Code to give mental health treatment to accused criminals against their wills. One recommendation pertains to allowing people to write advance directives and appoint substitute decision makers for mental health care (Standing Senate Committee, 2006, Appendix A, p.I-II). No recommendations pertain to limiting the circumstances under which people can be involuntarily committed, or to protecting or extending the rights of ordinary citizens who have been committed to refuse treatment or choose treatment options. So repeatedly, the Committee exhibits an acute awareness of the abuse of civil rights going on in the mental health system and of the general lack of self-determination over treatment options that most mental patients have. Yet, despite their oft-stated intent of helping empower patients in their own recoveries, the Committee repeatedly avoids actually tackling this problem directly or recommending any kind of reforms with regard to involuntary treatment laws. Senator Michael Kirby later admitted in a news article that the issue of the rights of ordinary mental patients to refuse treatment was not dealt with in the Final Report because the Committee considered it "wildly controversial" (Wipond, 2006). Unfortunately, even this vitally important point was not publicly admitted in the Final Report, let alone discussed anywhere in it. It is a truly stunning abdication of responsibility for dealing with what is, arguably, the single most important and influential issue in how Canada's mental health care system serves and disserves patients. How can we speak meaningfully of "empowering patients" and of creating a "patient-centred" mental health system,

so long as these patients' disempowerment is inscribed into law?

The Committee's choice to ignore this crucial issue is all the more concerning in light of what they do recommend. The Final Report strongly endorses a wide-ranging expansion of mental health services, recommending that mental health professionals be involved in more workplace interventions, more daycare and school interventions, more outreach to the elderly, "telemental health" initiatives etc. And this is done with absolutely no discussion about the prominent role forced treatment plays in Canada's current mental health system and the resulting potential dangers of such an expansion for the civil rights of average Canadians. In the final analysis, then, *Out of the Shadows at Last* is nothing more than an utterly unscientific, propagandistic template for indefinite increases of funding to mental health professionals, and for an unprecedented assault on civil rights in Canada. Unfortunately, the Committee thereby missed an extraordinary opportunity to foster more balanced and sophisticated discussions and point the direction towards better solutions. For example, in 2002 Canada's Yukon Territory overhauled its *Mental Health Act*, and tightened rather than broadened the criteria allowing involuntary treatment, focusing more limitedly on only those people with a mental disorder who were in clearly imminent danger of causing or experiencing "serious bodily harm" ([Yukon Territory, 2002](#), s.5(1)). At the same time, in the *Care Consent Act* ([Yukon Territory, 2003](#)), a plethora of tools were created to encourage and facilitate the process of individuals developing their own advance directives for mental health care in conjunction with care providers, choosing substitute decision makers, and employing new guardianship provisions to help maintain control over certain aspects of their lives even if having to temporarily forfeit control over other aspects. While this still leaves the question as to whether forced psychiatric treatment is necessary where incarceration alone would achieve the same stated goals of physical protection, at least in this model the protection of individual civil rights is going in the direction of a more reasonable balance against the augmentation of state interventions.

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