ACCESS TO JUSTICE FOR ETHNO-RACIAL PSYCHIATRIC
CONSUMER/SURVIVORS IN ONTARIO

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Ethno-racial psychiatric consumer/survivors face complex forms of discrimination as a result of the culture specific stigmatization of mental health disabilities, institutional racism and culturally inappropriate care. In an effort to achieve better access to justice for ethno-racial communities, we must strive to understand their complex needs, perspectives and conceptions of mental health. Thus, I identify and critique the legal barriers, which are perceived to differentially affect ethno-racial psychiatric consumer/survivors in Ontario, through an analysis of the Consent and Capacity Board [CCB]. I propose the hypothesis that factors such as race, ethnicity, culture, poverty and social exclusion are not fully addressed by the CCB. I use data collected from interviews with stakeholders to reveal the procedural, structural/systemic and discretionary barriers faced by ethno-racial psychiatric consumer/survivors within the CCB’s pre-hearing, hearing and post-hearing processes, along with recommendations to address these barriers.

Les consommateurs/survivants de la psychiatrie ethnoraciale doivent surmonter des formes complexes de discrimination en raison de la stigmatisation culturelle des troubles mentaux, du racisme institutionnel et des soins culturellement inappropriés. Pour améliorer l’accès à la justice des collectivités ethnoraciales, nous devons nous efforcer de comprendre leurs besoins complexes, leurs perspectives et leurs conceptions de la santé mentale. Dans le présent travail, je relève et critique les obstacles juridiques, qui sont perçus comme touchant différemment les consommateurs/survivants de la psychiatrie ethnoraciale en Ontario, en effectuant une analyse des travaux de la Commission du consentement et de la capacité (la « CCC »). J’émet l’hypothèse que la CCC ne prend pas pleinement en compte des facteurs comme la race, l’ethnicté, la culture, la pauvreté et l’exclusion sociale. J’utilise des données provenant d’entrevues avec des parties prenantes pour illustrer les obstacles procéduraux, structurels/systémiques et discrétionnaires auxquels font face les consommateurs/survivants de la psychiatrie ethnoraciale lors des audiences préparatoires et des audiences de la CCC et dans le cadre des processus suivis par la CCC après les audiences, et je formule des recommandations visant à surmonter ces obstacles.
I. INTRODUCTION

Ethno-racial communities make up over 13% of Canada’s population. Approximately 57% of Canada’s ethno-racial population will live in Ontario by 2017. In Toronto, 43% of the population belongs to a “visible minority.” Individuals from ethno-racial communities are at a higher risk than majority communities of experiencing mental health issues. The Centre for Addiction and Mental Health [CAMH], for instance, estimates that one quarter of visible minority immigrants experience discrimination, and concludes that those experiences may jeopardize mental health. People from ethnic minorities are also more likely to experience mental health stigma and legal barriers than the majority group. The legal barriers faced by ethno-racial psychiatric consumer/survivors are complex. Factors such as racism, poverty, unemployment, separation from family and community support, socio-cultural mental health stigmas, misdiagnosis, mistrust of the mental health system and culturally inappropriate care often define experiences within the civil mental health system. Consequently,
ethno-racial consumer/survivors have higher rates of involuntary admission and a higher likelihood of misdiagnosis leading to involuntary admission in the civil mental health system. Yet, against this reality, ethno-racial psychiatric consumer/survivors’ voices remain silenced and marginalized and there is a dearth of progressive legal literature analyzing their experiences within the civil mental health system. Their lives remain highly regulated by law but access to justice, understood as procedural fairness and equal protection through the law, is often denied to them. The inherent societal prejudices that mark the lives of ethno-racial psychiatric consumer/survivors silently infiltrate into the legal regime that regulates the lives of consumer/survivors generating not only questionable medical judgments but, more importantly for this paper, unjust legal outcomes.

Focusing on the Consent and Capacity Board [CCB], an administrative body with broad powers that impinge upon liberty and human dignity, this paper identifies and critiques the socio-legal barriers that differentially affect ethno-racial psychiatric consumer/survivors in Ontario and offers a contextual understanding of the experiences of ethno-racial psychiatric consumer/survivors within the province’s civil mental health system. It draws upon critical, theoretical perspectives on discrimination, studies of mental health in Canada and data collected from intensive interviews conducted with twenty ethno-racial psychiatric consumer/survivors, lawyers, psychiatrists, CCB adjudicators and mental health service providers in Ontario. These interviews elicited the respondents’ perceptions of the extent to which intersecting factors such as race, ethnicity, culture, poverty and social exclusion are addressed by the CCB, and what approaches could be used to improve the processes of administering justice. The empirical and legal research revealed the procedural, systemic/institutional and discretionary barriers faced by ethno-racial psychiatric consumer/survivors within the CCB’s pre-hearing, hearing and post-hearing processes.

Part II briefly outlines the CCB’s legal powers vis-à-vis consumer survivors and identifies the theoretical and qualitative methodology adopted in this paper. Part III presents the results of the interviews that ground this paper. As many of the CCB’s decisions are not written and there is a dearth of literature examining the experiences of ethno-racial psychiatric consumer survivors within the civil mental health system, these interviews offer a unique and critical understanding of the experiences of ethno-racial psychiatric consumer/survivors within the CCB’s legal framework.


mental health system, this empirical research represents an important contribution to socio-legal analysis of the regulation of mental health in Canada. I highlight the emergent themes from the qualitative interviews to assess the legal barriers that ethno-racial psychiatric consumer/survivors face, and I analyze the influence that race and culture may have had on the CCB’s outcomes and decision-making, from the pre-hearing procedures to the ultimate determination of whether an individual should be coerced into treatment and/or involuntarily detained. I conclude that there are three main sites at which the lack of cultural competence of actors within the civil mental health regime is unfairly and unjustly impacting the rights of, and ultimately the treatment imposed upon, ethno-racial consumer/survivors. Individuals interviewed pointed to procedural barriers that include inadequate attention to race and culture at various points in the pre-hearing and hearing process, systemic racism within the system itself, and barriers created by the exercise of discretion through the lens of “colour-blindness.” If access to justice is to be realized for ethno-racial psychiatric consumer/survivors and mental health services and supports are to be provided equitably, all players in the civil mental health system must understand the impact of factors such as race, ethnicity, culture, poverty and social exclusion on diagnosis, capacity assessments, involuntary admissions, long-term care options, and treatment incapacity decisions.

Throughout the paper, the term “ethno-racial communities” refers to Canadians of non-European background or heritage including those who are Canadian born and those who have come to Canada as immigrants or refugees. I do not include a discussion of Aboriginal peoples since contextual and historical factors affecting the discrimination faced by Aboriginal peoples are distinct from ethno-racial communities. The term psychiatric consumer/survivors is used to describe those who are recipients or former recipients of psychiatric and/or addiction services. There is no consensus on appropriate terminology and it is a contested issue. Other terms that are used include “mad,” “people with mental illness,” “mental health disability” and “psychiatric disability.” However, I use the term psychiatric consumer/survivor because of its relevance to a critique of the CCB and in an attempt to be as inclusive as possible.

A. Significant Intersections: Mental Health Law, Race, Ethnicity and Culture

Canada’s common law recognizes that all individuals have the right to determine the nature and scope of medical treatment to which they will be subject. The right to consent to treatment is considered an attribute of human

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15 Ibid.
Some individuals, however, are deemed unable to grant consent and the law recognizes that in strict circumstances treatment can be imposed upon those deemed to lack the capacity to consent. Cases of incapacity are adjudicated by the CCB. An administrative tribunal established under the Health Care Consent Act [*HCCA*], the CCB holds hearings and adjudicates legal matters arising from Ontario’s civil mental health legislation. It is an independent body created by Ontario’s provincial government and the Lieutenant Governor in Council appoints its board members. It has the authority to adjudicate issues of “involuntary committal and community treatment orders under the [*MHA*]” and management of property under both the *Substitute Decisions Act* [*SDA*] and the [*MHA*]. The CCB also adjudicates matters that come under the *Long Term Care Act*, the *Mandatory Blood Testing Act*, and the *Personal Health Information Act*.

CCB decisions are generally made by a panel consisting of a lawyer, a psychiatrist, and a member of the public. From 2009 to 2010, the Board had 134 appointed members who heard approximately 2365 cases. In keeping with *R v Conway*, the CCB’s rulings must comply with the *Canadian Charter of Rights and Freedoms*. Clearly, the CCB decisions implicate individual’s civil rights, liberty and autonomy against the interests of the State.

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19 S.O. 1996, c.2 [*HCCA*].
21 R.S.O. 1990, c. M.7 [*MHA*].
22 *Supra* note 19.
23 S.O. 1992, c.30 [*SDA*].
27 S.O. 2004, c.3, Sched. A [*PHIPA*].
29 *R. v Conway* 2010 SCC 22.
30 *Ibid.* Conway affirms that the *Charter* applies to tribunals. However, there are limits on the scope of available remedies under s. 24 (1) to those specifically granted by legislature, or rather, to those expressly removed by statute.
31 Hiltz & Szigeti, *supra* note 24 at ix.
33 *Ibid.* For example, in order to complete a certificate of involuntary admission or a certificate of renewal in Ontario, the attending physician must be of the opinion that after personally examining the patient, the patient is suffering from a mental disorder that will likely result in “serious bodily harm to the person, serious bodily harm to another person or serious physical impairment of the person, unless the patient remains in the custody of a psychiatric facility and the patient is not
legal scholars have paid insufficient attention to the explicit factors that those within the civil mental health regime must bring to bear on their decision-making, the factors that implicitly and sometimes unconsciously influence decision-making have been altogether ignored in the context of mental health law. In other areas of law, we have come to appreciate that implicit bias and factors such as race and culture do impact on the decision-maker in subtle yet profound ways. Yet, these questions remain largely unasked in mental health law. The following section of this paper seeks to fill the gap in legal analysis by asking ethno-racial cultural survivors and other stakeholders within the civil mental health system in Ontario how they regard the influence of race and culture on decision-making. Before presenting the analysis, however, I explain my methodology in large part because the methodology itself helped define the priorities that are addressed in this paper.

B. Methodology

I assume the importance of taking an interdisciplinary approach to this topic and as such the theoretical underpinnings of this research used the grounded theory approach, a research method in qualitative methodology, in combination with tenets of disability theory, critical race theory and intersectionality. This framework was used to inform the interview guide, the interview process and the data analysis procedure for this research. Grounded theory enabled me to explore the CCB’s work through the perceptions of a variety of different stakeholders, with the goal of developing policy recommendations that are “grounded in the data.” The process of generating grounded theory is a “way of arriving at theory suited to its supposed uses.” The hypotheses and concepts arise from the data developed during the course of the research, while the source of certain ideas may come from theories and models outside of the data itself. In law, the use of grounded theory enables the researcher to have an “open methodology” using a variety of theories from other disciplines, which allows the legal researcher to “move forward in addressing the needs of the population.” There is an underlying assumption that legal norms and structures can be changed because reality is suitable for admission or continuation as an informal or voluntary patient.” MHA, supra note 21 at s. 15 (1) (d) (e) and (f), 16 (1), 17 and 20 (5). These are referred to as the “Box A,” risk of serious harm/impairment, criteria. The other criteria used for patients incapable of consenting to treatment, referred to as the “Box B” requirements, include two additional grounds of committal, which are “substantial mental deterioration and substantial physical deterioration.” MHA, supra note 21 at s. 15 (1.1), 16 (1.1) and 20 (1.1). In Starson v Swayze, the Supreme Court affirmed that a person is capable of making a treatment decision if they have the ability to understand the “nature, purpose, risks and benefits of the particular treatment being proposed; the foreseeable benefits and risks of treatment; the alternative courses of action available” and the ability to appreciate the “expected consequences of not having the treatment.” Supra note 17 at paras 80 and 81.

36 Ibid at 45.
socially constructed. While the grounded theory approach is flexible in nature, this approach also consists of explicit guidelines to analyze qualitative data.

Exploring models of disablement, I found the social model was most relevant to analyzing the CCB. The social model relies on the assumption that “disability is not inherent in the individual,” and that there is something in society that needs to be fixed to address the social consequences of impairments. Although contested by the psychiatric consumer/survivor movement, the social model (when applied to mental health) rejects the priority placed upon psychiatric diagnosis within the medical model of disability and emphasizes the “socially constructed nature of impairment.” In short, this model instructs observers to examine how the social context within medical analysis takes place, much as critical race theory and feminism point to the importance of social context in understanding how law is interpreted and applied. Neither medicine nor law is value neutral but always reflects prevailing social discourses, norms and biases.

The social model is thus especially relevant to understand the intersecting role that race, ethnicity, religion, immigrant/refugee status, language, sexual orientation, class, gender and disability plays on the CCB’s jurisprudence. In Part II, I draw upon lessons from the social model to recognize the socially constructed nature of disability, and I discuss the link between the medical model which dominates the CCB’s processes of administering justice and the CCB’s insistence on racial-blindness. Critical race theory also proves essential to the project of deconstructing the impact of race on the legal context. Because disability should not be seen as an isolated factor, critical race theory is relevant in highlighting the

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38 Ibid at 244.
39 Glaser & Strauss, supra note 35 at 105. There are four steps to the constant comparative method: “1) comparing incidents applicable to each category 2) integrating categories and their properties 3) delimiting the theory and 4) writing the theory. Although this method of generating theory is a continuously growing process – each stage after a time is transformed into the next – earlier stages do remain in operation simultaneously throughout the analysis and each provides continuous development to its successive stage until the analysis is terminated.” These guidelines are further described in Glaser and Strauss’ constant comparative method, which enabled me to compare and contrast ideas within a transcribed interview to another.
42 The social model of disability has not been fully embraced by psychiatric consumer/survivors because of the fear that a monolithic theory or set of ideas may subordinate them similar to the illness model of psychiatry. Susan Wendell, “Toward a Feminist Theory of Disability” in Debra Shogan, ed, Reader in Feminist Ethics (Toronto: Canadian Scholars’ Press, 1993) at 213.
44 Geoffrey Reaune, Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940 (Toronto: University of Toronto Press, 2009).
fact that there may be unique and additional barriers ethno-racial psychiatric consumer/survivors face as a result of their linguistic, racial and ethnic background. I also use other tenets of critical race theory such as the counter narrative and a rejection of the colour-blind approach when analyzing the qualitative data in the legal analysis. Intersectionality analysis enabled me to understand the multiple levels of discrimination experienced by ethno-racial psychiatric consumer/survivors. The concept of intersectionality is defined as “intersectional oppression that arises out of the combination of various oppressions which together produce something unique and distinct from any one form of discrimination, standing alone.” In regard to the CCB specifically, intersectionality is used to question whether the experiences of psychiatric consumer/survivors from ethno-racial communities are “qualitatively different” as result of a combination of their intersecting identities.

Applying the theoretical framework described above, I analyzed data obtained from approximately twenty in-depth interviews with five members of each of the following stakeholders: lawyers, psychiatrists, mental health service providers, CCB adjudicators and psychiatric consumer/survivors from various ethno-racial communities. These stakeholders were chosen because of their role in the CCB legal process and/or the wider mental system.

The inclusion criteria used for the lawyers, psychiatrists and mental health service providers was the following: 1) licensed lawyers, psychiatrists and mental health service providers in Ontario and 2) experience working with psychiatric consumer/survivors from ethno-racial communities. The inclusion criteria for psychiatric consumer/survivors from various ethno-racial communities included: 1) psychiatric consumer-survivor from an ethno-racial community in Ontario, 2) who had been through a CCB hearing between 2006-2009, 3) was over the age of 18 years and 4) was willing to participate in the interview process. The potential participants from these stakeholder groups were identified through the advice of my supervisors, informal networking with my colleagues in the area of mental health law and mental health support services and subsequent “snowball sampling,” which involved requesting initial contacts to refer their peers.

45 Deborah Stienstra, “The Intersection of Disability and Race/Ethnicity/Official Language/Religion” (Paper delivered at the Intersections of diversity seminar held at Canadian Centre for Disability Studies, March 8, 2002) [unpublished], online: Canadian Centre on Disability Studies <http://canada.metro-polis.net/events/Diversity/Disability_stienstra_e.pdf> at 1.

46 This refers to the omission of a racial or cultural analysis. Aylward, supra note 12.


49 The CCB adjudicators are included amongst the lawyer, psychiatrist and service provider categories.

50 Although mental health service providers may not be licensed, they should be qualified to work with psychiatric consumer/survivors in Ontario.

51 Exclusion criteria: not considered stable by their treatment team.

Throughout the research process, I also attended a number of CCB hearings which enabled me to fully understand the nuances of the legal proceedings. I went through two ethics protocols and I obtained informed consent from the respondents before the research began.

The interviews were conducted primarily in Toronto because the majority of CCB hearings take place there and there are a higher number of ethno-racial psychiatric consumer/survivors who appear before the CCB in Toronto. As a qualitative study, these findings are not conclusive statements and they are “grounded” in the views of the respondents. However, a strength of the study is the respondents’ level of candour and the quality of information provided vis-à-vis their particular experiences. Such information is not otherwise accessible. Respondents openly expressed their views, beliefs, perceptions and attitudes of and towards the CCB pre-hearing, hearing and post-hearings procedures, along with their experiences with the mental health system. The findings therefore offer a framework for analysis that can serve as the starting point for further discussion and critique.

II. RACE, CULTURE AND ACCESS TO JUSTICE WITHIN THE CCB

A. Perceptions of Mental Health

Since neither the CCB nor CAMH keeps statistics on the ethnic make-up (or breakdown) of its clientele, a preliminary point of inquiry of this research was to ascertain the particular ethnic backgrounds of psychiatric consumer/survivors appearing before the CCB. The majority of respondents indicated that ethno-racial psychiatric consumer/survivors appearing before the CCB were generally from Punjabi, Tamil, Arab, Vietnamese, Caribbean, Cambodian and Chinese communities. Respondents indicated that the types of legal cases involving psychiatric consumer/survivors from ethno-racial communities most often concerned involuntary status, treatment incapacity, and financial incapacity.

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53 I received ethics approval from the University of Toronto Research Ethics Board on October 24, 2009 and I received ethics approval from the Centre for Addiction and Mental Health [CAMH] on March 19, 2009.
54 The findings of this study might have varied if there were interviews done in rural areas of Ontario.
55 Hartley & Muhit, supra note 34.
56 There are no statistics available on the ethnic backgrounds of psychiatric consumer/survivors appearing before the CCB. In this regard, the extent of information available is very limited. The statistics that are available include CAMH’s patient profile, which unfortunately does not document the ethnicity of patients. For instance, the most recent patient profile available indicates that “85% of the CAMH unique patients were Canadian citizens, 5% were landed immigrants and 9% had unknown status.” Those with “refugee statuses comprise less than 2%” of the patients. Centre for Addiction and Mental Health, Patient Profile 2005/2006 (Toronto: CAMH, 2006) at 7. Similarly, data available in 2007-2008 indicates that there were approximately 2000 requests for interpretation services and the patient population represents 150 countries. Dr. Paul Garfinkel, “CEO Program Visits,” (Toronto: CAMH 2009) [unpublished] at 9.
57 Data derived from interviews conducted with lawyers, psychiatrists, service providers, CCB adjudicators and psychiatric consumer/survivors from November 2008 until May 2009 [Interviews].
58 MHA, supra note 21 at s. 20; See explanations at supra note 33.
59 HCCA, supra note 22 at s.10-25; See explanations at supra notes 33.
However, more empirical research should be conducted given the lack of statistics available. As one respondent argued, “It is difficult to try and improve the CCB in regard to diversity issues or hold it accountable when there is no data available on racialized clients, in terms of statistics.”

Despite the lack of statistics, respondents, drawing on their vast personal experiences with the CCB, emphasized the multifaceted ways in which culture frames mental health discourses and defines the interaction of individuals within the mental health system. First, cultural and religious factors often influence attitudes towards mental health amongst ethno-racial communities. Perceptions of mental health could vary tremendously amongst different cultures and even amongst certain families. For instance, a service provider emphasized how Somali communities often viewed mental illness as a “gift from God.” As she explained:

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

Health care providers must therefore inevitably grapple with culture because all persons are deeply cultured to their very core.

Culture also determines how mental health concerns manifest. Some respondents felt that individuals from ethno-racial communities presented symptoms of mental illness in the form of somatic complaints (making no distinction between the body and mind) because it was perceived to be more acceptable. Culture can also influence the severity of the stigma associated with mental illness amongst ethno-racial communities. For instance, a consumer/survivor felt “it is a double stigma.” As a psychiatrist explained:

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

60 SDA, supra note 23 at ss. 4-42.
61 Interview with service provider 4 (20 January 2009).
63 As respondents indicated, culture is not static, and it is amorphous and changing.
64 Interview with service provider 4 (20 January 2009).
65 Ibid.
66 Interviews, supra note 57; Agic, supra note 62.
67 Interview with psychiatric consumer/survivor 3 (13 May 2009).
68 Interview with psychiatrist 1 (5 November 2008).
As a result of varied understandings of the causes and treatments of mental illness, the stigma of mental illness amongst ethno-racial communities can extend to the family and the entire community more than in mainstream society. An entire family or even community can feel stigmatized by the mental health status of some of its members. As a lawyer suggested, “North American cultures are not free from stigma either. But, the individualistic culture promotes more freedom in talking and dealing with it.”

Culture informs the very definition of mental health itself. Although the symptoms of mental illness are similar across cultures, its manifestations and how people interpret the symptoms often vary with race, ethnicity, and culture. The World Health Organization lists twelve frequently culture-bound syndromes in the ICD-10 [International Classification of Diseases]. The classification of culture-bound syndromes challenges the standard psychiatric classifications within the illness model of psychiatry. There is “no such thing as a culture free syndrome – all disease classifications have to exist in a cultural context” and psychiatrists need to make culturally appropriate diagnoses. In keeping with this literature, although not necessarily cognizant of it, respondents interviewed emphasized that the Western definitions of mental illness could not be applied homogenously to ethno-racial communities. For instance, a psychiatrist suggested, “We call certain things mental health which is not mental health in other cultures. We define things differently.”

Western definitions of mental illness cannot be applied homogenously. The meanings, definitions and understandings of mental illness are often unique amongst ethno-racial communities. For instance, the term “dhut” is an Indian folk term that refers to “severe anxiety and hypochondriacal concerns associated with the discharge of semen, discoloration of urine, and feelings of weakness and exhaustion similar to ‘Jiryan’ (India), and ‘Sukra prameha’ (Sri Lanka).” However, Western culture, adopting the DSM, characterizes this state as an anxiety disorder.

Virtually all ethno-racial psychiatric consumer/survivors interviewed felt that it was important for the CCB, lawyers, psychiatrists and service providers to

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69 Ibid. This will be analyzed further in the section on “Systemic and Institutional Barriers.”
70 Interview with lawyer 2 (5 December 2008).
73 Cheryl Ritenbaugh, “Obesity as a Culture Bound Syndrome” (1982) 6:4 Culture, Medicine and Psychiatry 347 at 347. According to Ritenbaugh, a culture bound syndrome cannot be understood apart from its specific cultural or subcultural context.
75 Interviews, supra note 57.
76 Interview with psychiatrist 1(5 November 2008).
77 Perlin & McClain, supra note 7.
understand the different cultural approaches to dealing with mental health crises and to be attuned to the possibility that culture may be at play in a given set of symptoms and concerns. As one consumer/survivor queried, “How can someone say what is normal in my culture is not normal in another? Where does cultural sensitivity begin and psychiatric symptoms start?” In short, consumer/survivors wanted assurances that they would be understood and treated as whole human beings before becoming embroiled in the CCB’s procedures. Without this preliminary understanding and without assurances that culture would be considered where and how it mattered, consumer/survivors and other respondents worried that virtually every step of the CCB’s processes could become tainted. Indeed, their experiences suggest that the process is tainted precisely because culture is ignored altogether or treated as a factor external to their mental health concerns rather than a factor that shaped their experiences with mental health and the system designed to regulate it. Not surprisingly then, respondents pointed to procedural barriers that compromised the equal participation of culturally diverse communities in CCB decision-making. The following section of this paper identifies the procedural barriers to equality in the civil mental health regime based on cultural misunderstandings, biases and assumptions. These barriers impinge on virtually every aspect of the consumer/survivor’s interaction with the CCB system, often even before the hearing process begins. The rights advice system; pre-hearing lawyer meetings; psychiatrists’ capacity assessments; the hearing process itself; and, the post-hearing process are all tainted by lack of cultural competence. Respondents noted that lack of cultural competence throughout the CCB produced cultural misunderstandings that often led to misdiagnosis, complicated familial conflicts and ultimately generated culturally inappropriate care.

B. Culture and Procedural Barriers to Access to Justice

1. Rights Advisers

Section 15 of the MHA seeks to protect the right of the consumer/survivor to make an informed decision regarding their treatment and interaction with the mental health regulatory regime. Specifically, the system provides for a rights adviser who must give “rights advice” to a person who is an involuntary psychiatric patient, a person who is found incapable to make decisions about their psychiatric treatment or management of her property, a person who is an informal patient between the ages of twelve and fifteen and a person who is notified of an “intent to issue or renew a CTO.” In Ontario’s major hospitals, including the CAMH, a rights adviser is supposed to explain to the person the importance of the medical finding of incapacity and the option to make an application to the CCB to

\footnote{Data derived from interviews with psychiatric consumer/survivors 1, 2, 3, 4, and 5 from November 2008 to May 2009.}

\footnote{Interview with psychiatric consumer/survivor 1 (19 January 2009).}

\footnote{S. 15 Reg. 741 to MHA, R.R.O. 1990. CTO refers to a community treatment order which can “provide a person who suffers from a serious mental disorder with a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility” as per s. 33.1 (3) of the MHA, supra note 21; Hiltz & Szigeti, supra note 24 at 6, 9 and 311.}
review the finding. If the person agrees, the rights adviser often assists in making the legal aid application and contacts a lawyer of the person’s choosing.

Respondents generally concluded that the rights advice system under s. 15 of the MHA worked “fairly well” to ensure that those applying for legal aid had assistance. During the rights advice process, interpretation services are also available for those who do not speak English. However, the rights advice process did not always appreciate the subtle but pervasive ways in which consumer/survivors understood and evaluated the rights framework presented to them. In particular, rights advisers too often approached culture as an irrelevant factor. The advice that is granted to members of ethno-racial communities is often not sufficiently tailored to their specific needs and does not acknowledge their culturally-specific concerns about participating in any rights claiming process. Respondents commonly observed that cultural factors inhibited some ethno-racial psychiatric consumer/survivors from taking part in the CCB hearing process. Yet, many of their fears and misconceptions about the system often remain unaddressed by the system. As a result, ethno-racial psychiatric consumer/survivors were more likely to underutilize the CCB process not only because of its adversarial nature but also because of the initial perceptions of inaccessibility, language, and communication issues. In this regard, the fact that the psychiatric consumer/survivors made the decision to participate in the CCB process was a barrier itself because “a lot of people from ethno-racial communities don’t really want to use the system or they don’t really understand it.”

For instance, psychiatric consumer/survivors from ethno-racial communities may have a different understanding of the mental health system and also of their civil rights. Lawyers representing consumer/survivors repeatedly made the point that they had to account for their clients’ general reluctance to contest their doctor’s decision. They found contesting their doctor’s decision an intimidating and unfamiliar exercise because of the “trust” bestowed upon the doctor. This point was reiterated by consumer/survivors who expressed the view that the process “sounded scary” and “difficult” because the hearing was in opposition to their doctor, whom they trusted. The majority of lawyers also reported that the type of legalese and language used to convey the “rights information” actually deterred ethno-racial psychiatric consumer/survivors from participating in the

82 Hiltz & Szigeti, supra note 24 at 6, 9 and 11.
83 Interview with service provider 1 (13 January 2009).
84 S. 15 Reg. 741 to MHA, R.R.O. 1990; Hiltz & Szigeti, supra note 24 at 6, 9 and 311.
85 However, the quality of the interpretation is questionable.
86 Interviews, supra note 57.
87 Ibid.
88 Ibid. and Interview with psychiatrist 5 (11 February 2009).
89 Interview with psychiatrist 1 (5 November 2008).
91 Interview with psychiatric consumer/survivor 5 (8 April 2009).
CCB hearings. In this vein, since rights advisers are mandated to discuss the CCB’s formal processes and procedures, culturally specific barriers to exercising rights may be insufficiently addressed.

The notion of rights themselves remained alien. For example, a consumer/survivor stated: “I didn’t understand…what is the point of a process that just tells me I am crazy anyways?” They remained skeptical of the suggestion that they may have rights to protect them against preconceived results.

Moreover, the notion of “medical treatment” in certain cultures may be fundamentally different. As a psychiatrist suggested:

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

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

2. Access to Counsel
While respondents felt that the system was well set up for ensuring that legal services were available, they expressed concerns about lawyers’ abilities to understand, represent and meet the needs of psychiatric consumer/survivors from ethno-racial communities. For instance, lawyers explained that they could not specify what language they spoke or which ethnic-background they belonged to on the “list of lawyers” used by the rights advisers. This is unfortunate because “clients pick their lawyer randomly.” The language skills of the lawyer is not matched to the language needs of the client/consumer/survivor. It can be

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92 Interviews, supra note 57.
93 Interview with psychiatric consumer/survivor 3 (13 May 2009).
94 Interview with psychiatrist 1 (5 November 5 2008).
95 Interview with CCB psychiatrist adjudicator 2 (11February 2009).
96 Ibid. Interview with psychiatrist 1 (5 November 2008).
97 Interview with CCB psychiatrist adjudicator 2 (11 February 2009). This is in comparison to the majority culture.
98 Interviews, supra note 57.
100 Data derived from interviews conducted with lawyers from November 2008 until May 2009.
101 Interview with service provider (rights advisor) 1 (13 January 2009); Interviews, supra note 57.
especially daunting for those who do not speak English and would prefer a lawyer from their own background who may have a better understanding of their cultural context and can speak the same language as their client.

Lawyers also expressed concerns that they were not sufficiently culturally competent. As a lawyer explained,

> It is not that lawyers are not open. I think the concern is we often don’t recognize there is a cultural issue that is creating an issue before the CCB. We are often not trained to understand what the significance of a particular cultural act might mean if a client is from a diverse community…

Indeed, lawyers representing psychiatric consumer/survivors from various ethno-racial communities often grapple with family conflicts and wondered if these are generated by culturally defined attitudes towards the mental health system. Many families from particular cultures put faith in the advice of the psychiatrist and mental health system, in opposition to the wishes of their consumer/survivor relative.

While there is a dearth of literature documenting their experiences, respondents perceived these conflicts to occur more amongst some ethno-racial communities because of the reverence given to the psychiatrist, and the acceptance of the inherent paternalism within the system.

Family members often also wanted their loved ones to stay in the hospital instead of having to face the stigma associated with mental illness in the community. The depth and degree of the stigma attached to mental illness within a given community and the tightness of a particular community often dictated the approach of family members towards rights claiming within the mental health system. As one lawyer observed, the competing demands of family and client can create conflict and confusion for lawyers who may not be fully aware of the cultural dynamics at play.

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

Consumer/survivors suggested that the family-client dynamic can itself become a barrier to good legal representation. As one individual noted, “I just wanted my lawyer to listen to me and not to my family.”

102 Interview with lawyer 2 (5 December 2008); Interview with lawyer 1 (17 November 2008).
103 Although they may try to pick a lawyer with a familiar last name, there is no guarantee that the lawyer will speak the same language as the consumer/survivor.
104 Interview with lawyer 2 (5 December 2008).
105 Interview with psychiatric consumer/survivor 5 (8 April 2009).
3. Psychiatrists’ Capacity Assessments

For an individual to be involuntarily admitted into a psychiatric facility, the admission process includes an initial psychiatric capacity assessment. In the inquiry about this process, respondents believed that psychiatrists’ capacity assessments prior to the CCB hearing failed to properly acknowledge the importance of culture, ethnicity and other socio-cultural factors. A common perception amongst those I interviewed was that cultural barriers and language discrepancies between the psychiatrist and ethno-racial psychiatric consumer/survivors led to incorrect capacity assessments. Cultural and racial stereotypes cause under-diagnosis or over-diagnosis. For instance, one psychiatrist suggested,

If African patients are uttering to the sky, we may diagnose them as being psychotic, but really they may be chanting. In these cases, we over-diagnose. But, in other cases – we can under-diagnose. With Chinese patients who are very quiet and don’t say much. They are totally psychotic in their head and they don’t tell you. And we think okay- they can go home.

In some cases, respondents felt that religious and spiritual beliefs were inaccurately perceived as indicia of mental illness. In this vein, there may be inherent dangers of inappropriately using cultural factors during capacity assessments. Although cultural context must be recognized, “generalization on the basis of ethnicity can lead to stereotyping.”

As the literature indicates, psychological distress is expressed differently across cultures depending on “culturally pervasive norms, generative themes, and health concerns.”

Respondents indicated that it is imperative that psychiatrists understand not only the psychiatric symptoms of ethno-racial psychiatric consumer/survivors, but also their social history, their culturally embedded idioms of distress and their cultural standards of normality and abnormality. However, in light of the time restraints and lack of resources, the majority of psychiatrists felt that it was difficult to address cultural issues in capacity assessments. As one psychiatrist argued, “When patients talk about cultural issues, some psychiatrists don’t pay attention because they are not symptoms to be treated, and medication cannot take

108 Hiltz & Szigeti, supra note 24 at 290; MHA, supra note 21, s. 15 (1), (5).
109 Interviews, supra note 57.
110 Interview with psychiatrist 1 (5 November 2008).
111 Interviews, supra note 57.
113 Ibid at 29.
115 Interviews, supra note 57.
116 Data derived from interviews conducted with psychiatrists from November 2008 until May 2009.
them away.” Thus, although psychiatrists are trained to be culturally aware, they remain insufficiently attentive to culture despite their training. Respondents expressed strong concern that the cultural explanations for illness are not always factored into the assessments.

C. Language/Communication Barriers

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

In 2007-2008, CAMH indicated that there were 2000 requests for interpretation services in approximately 50 different languages. Although psychiatrists and service providers interviewed believed that CAMH did have the “best interpretation” services available in the Toronto area, a number of barriers were identified in the pre-hearing stage. For instance, respondents felt that ethno-racial psychiatric consumer/survivors often had misunderstandings within the hospital because interpreters were not always available on the unit and generally only staff were able to request interpreters. This can be especially traumatic for ethno-racial psychiatric consumer/survivors who are being prescribed medications that they have concerns about and feel they need to communicate with their treatment provider. As a consumer/survivor expressed, “I have never understood what my medications were…and I have been on medications for almost thirty years.” Another lawyer argued, “If you are unable to communicate with staff, and you are standing outside the nursing station speaking in another language, and they don’t understand you, to me, that is a safety issue.”

In S.A. (Re), the attending physician in the emergency room had fundamentally misunderstood S.A. because of language and communication

117 Interview with psychiatrist 3 (12 January 2009). Also, see generally, Reem Bahdi, “Re-Imagining Haj Khalil v Canada: Cultural Competence and Tort Law” (2009) 27:1 Windsor YB Access Just 53. This article critiques the decision of the Federal Court which purportedly relies on a psychiatric assessment of what caused trauma to the refugee torts claimant.

118 Interviews, supra note 57; These views are consistent with the research presented in Paula Chaplan and Lisa Cosgrove, eds, Bias in Psychiatric Diagnosis (New York: Rowman and Littlefield, 2004).

119 Interviews, supra note 57.

120 Ibid.

121 Data available in 2007-2008 indicates that there were approximately 2000 requests for interpretation services and the patient population represents 150 countries. Garfinkel, supra note 56.

122 However, it is important to note that different hospitals have different resources for interpreters; Interviews, supra note 57.

123 Interviews, supra note 57.

124 Ibid.

125 Interview with psychiatric consumer/survivor 5 (8 April 2009).

126 Interview with lawyer 1 (17 November 2008).

127 S.A. (Re), 2007 CanLII 37457 (ON C.C.B.); TO-07-1551.
problems. In this case, the applicant was Arabic and there was no interpreter available for him in the emergency room. As a result, S.A. was involuntarily detained and he remained in hospital unnecessarily for the week prior to his CCB hearing. Since the applicant had limited English skills, the attending physician and treatment team misconstrued his failure to eat “normal” meals as a sign of mental distress and used this observation to support a finding of involuntary status. However, the CCB rejected the hospital’s findings and was not persuaded that the limited evidence supported a finding of mental disorder-induced serious physical impairment. The CCB reasoned that, “there were almost no objective signs at the time [of the applicant’s incapacity], and which may have emanated from at least a limited capacity on the part of the applicant to describe his history and that nicety which is required in the face of lack of any such signs.”

The case illustrates the unfortunate impact that language and communication barriers within the hospital have upon ethno-racial psychiatric consumer/survivors. Appropriate cultural and interpretation services could have prevented S.A. and others the agony of staying in the hospital and being required to undergo a CCB hearing.

There were also language/communication barriers within the pre-hearing lawyer/client meetings. Legal Aid Ontario [LAO] procedures do not allow for an easy match between the language skills of lawyer and client. Lawyers are frustrated by the process for obtaining an interpreter through LAO, and noted that their own language abilities were not specified on Legal Aid Ontario’s lists. Thus, some lawyers go without interpreters during the meetings relying only on the minimal English the client is able to understand.

Psychiatrists take similar short-cuts. During the pre-hearing capacity assessments, the majority of respondents felt that language discrepancies between the psychiatrist and ethno-racial psychiatric consumer/survivor led to incorrect capacity assessments. Psychiatrists would often not use interpreters for the capacity assessments if ethno-racial psychiatric consumer/survivors appeared to have some knowledge of English, because assessments could take twice as long when an interpreter is involved. As a psychiatrist explained,

> Although we have been trying to train psychiatrists to use interpreters more, we don’t make use of them enough because it makes the process more complicated. So, the reports vary a lot between those that are English speaking and non-speaking.

Obtaining collaborative information from the families and understanding the full cultural context of the ethno-racial psychiatric consumer/survivors’ experience is

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128 Ibid at para 22.
129 Interview with lawyer 1 (17 November 2008).
130 Ibid.
131 Data derived from interviews conducted with lawyers from November 2008 until May 2009.
132 Interviews, supra note 57; In some cases, lawyers may ask the interpreter to come a half an hour before the hearing if the CCB has scheduled them in advance (Interview with lawyer 1 (17 November 2008)).
133 Interviews, ibid.
134 Ibid.
135 Interview with psychiatrist 3 (12 January 2009).
difficult. As cultural psychiatry suggests, recognizing the culturally embedded idioms of distress or explanatory models of distress rest on the ethno-racial psychiatric consumer/survivor’s ability to communicate. In this regard, a psychiatrist argued that “language barriers create a higher potential for misclassification, misdiagnosis or mismanagement in the capacity assessments.”

Language and communication problems also abounded in the hearings themselves. According to the CCB, interpreters were used for 62 hearings from January 2008 to December 2008, and for 29 hearings from January 2009 to July 2009. Respondents felt that the quality of interpretation during the CCB hearing was generally “okay.” However, there were cases where the subjective bias of the interpreter was problematic during the CCB hearing. Specifically, a service provider referred to a case where a South Korean client was given an interpreter who was North Korean and wearing a nationalist symbol. The service provider believed that that the client was obviously uncomfortable and tense during the hearing. She stated, “I really questioned whether the interpreter was putting in his own interpretation or not.” There were also other anecdotal accounts that were provided to me about interpreters who did not have the relevant expertise to properly translate medical evidence.

Overall, respondents felt that “cultural interpretation” was a barrier. As a psychiatrist explained:

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

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

Although CCB adjudicators felt that they tried their best to stay away from medical jargon and legalese throughout the hearing process, a few ethno-racial

136 Interview with psychiatrist 5 (25 January 2009); Mezzich & Caracci, supra note 114.
137 Interview with psychiatrist 5 (25 January 2009).
138 Email from CCB registrar on July 10, 2009. Interpreters were used for 44 hearings from April 2006 to December 2006 and for 51 hearings from January 2007 to December 2007.
140 Interviews, supra note 57.
141 Interview with service provider 1 (13 January 2009).
142 Ibid.
143 Interviews, supra note 57.
144 Ibid.
145 Interview with psychiatrist 5 (25 January 2009).
146 Data derived from interviews conducted with lawyers November 2008 until May 2009.
consumer/survivors interviewed indicated that they had trouble understanding the hearing, even when language was not an issue. The majority of lawyers interviewed suggested ethno-racial psychiatric consumer/survivors’ accent, body language and demeanour might have contributed to communication barriers.

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

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

In regard to the length of the hearing, the CCB was flexible and there were no limits on how long hearings would last. Hearings could last as long as seven hours and some continued on for almost two days or more. However, given that the goal of the legislation includes “a fair and speedy resolution of the matters,” all of the psychiatric consumer/survivors interviewed felt that the hearings were too long. Despite the length of the hearings, the CCB was perceived to be accommodating to the needs of ethno-racial psychiatric consumer/survivors during the hearing in certain respects. For instance, respondents felt that there were enough breaks given throughout the long hearings. Also, as per CCB’s rule 12.1, the hearings were held in the hospital where the psychiatric consumer/survivor was staying to ensure accessibility and convenience. Overall, respondents felt that ethno-racial

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147 Data derived from interviews conducted with CCB adjudicators from November 2008 until May 2009.
148 Data derived from interviews conducted with psychiatric consumer/survivors from November 2008 until May 2009.
149 Data derived from interviews conducted with lawyers from November 2008 until May 2009.
150 Interviews, supra note 57. The Board renders its decisions within one day of the hearing. Most of the reasons for the decision are not written. Parties may request written reasons for the decision. This is supposed to be provided to the party within four days of the request.
151 Ibid.
152 Interview with a CCB adjudicator 3 (17 February 2009).
153 Interview with a CCB adjudicator 1 (30 January 2009).
154 Interviews with psychiatric consumer/survivors from November 2008 until May 2009. The timing of the hearing was problematic for some who felt uncomfortable and tired because the hearing was so early in the morning.
155 Interviews, supra note 57.
156 Hiltz & Szigeti, supra note 24 at 592. As Hiltz and Szigeti explain, “The Board is a traveling tribunal and most of its hearings are held in the hospital, psychiatric facility or nursing home where the applicant is located. However, there are a number of applications which concern individuals residing in the community (for example, CTOs, financial capacity hearings under the SDA)…” The Board does have access to hearing rooms at its Toronto head office and will make
psychiatric consumer/survivors had trouble answering questions put to them as part of a CCB hearing because of their general circumstance, language, cultural misunderstanding and/or lack of education. Respondents gave anecdotal accounts of this occurring in cases where recent immigrants were frightened they would “lose their immigration status” during the CCB hearings. Thus, they were much more apprehensive to willingly give information during the hearings.

The family’s role in the hearing also affected the comfort of ethno-racial psychiatric consumer/survivors. The majority of respondents felt that family support enhanced the comfort levels of those involved. However, a few respondents felt that some cases involving family members created unnecessary discomfort and tension in the hearing. As a consumer/survivor explained: “My sister came as a hostile witness...in that she didn’t represent me and she wanted me to stay in the hospital.” Other cases required intervention by the CCB itself. For instance, a CCB adjudicator recalled a case where a young Pakistani woman could not speak freely in the presence of her father in the room. As the CCB adjudicator, she grappled with whether she should ask the applicant’s lawyer to seek an order excluding witnesses or not. She suggested that the “CCB should have the expertise and confidence to deal with these issues properly – especially because we are not going to get it all laid out and explained to us.”

D. Adversarial/Therapeutic Relationship Compromised

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

Some attempts have been made to mitigate the adversarial effect. For example, the CCB adjudicators indicate that the “CCB summary form” has reduced the disruption in hearings and it has been a positive step for all parties to the CCB. The CCB summary enables the psychiatrist to fill out the evidence that they have

hearing rooms available elsewhere across the province where necessary. Sometimes a neutral setting is itself helpful to facilitate the conduct of the proceedings.”

157 Interviews, supra note 57.
158 Ibid.
159 Ibid.
160 Interview with psychiatric consumer/survivor 5 (8 April 2009).
161 Interview with CCB adjudicator 3 (17 February 2009).
162 Hiltz & Szigeti, Supra note 24 at 593.
163 Starson v Swayze, 1999 CanLII 15052 (Ont. S.C.) at para 17; It is important to note that the CCB has both inquisitorial and adjudicative functions, Hiltz & Szigeti, supra note 24 at 555; In Starson v Swayze, Justice Malloy supports the view that the CCB is adjudicative in nature. In order to make this argument, he compares the CCB to other disciplinary tribunals in paras 15-17.
164 Interviews, supra note 57. As argued by Hiltz and Szigeti, “it is a “party driven process and the parties choose the way in which they present evidence, or whether they choose to present evidence or testimony of witnesses to the Board.” Supra note 24 at 593.
165 Data derived from interviews conducted with CCB adjudicators from November 2008 until May 2009.
in order to meet the legal test. The hearing becomes more “streamlined, focused and shorter,” because traumatic events and the “litany of episodes that led to the mental health crisis” do not have to be repeated by the psychiatrist in front of the ethno-racial psychiatric consumer/survivor. Despite these improvements, the majority of psychiatrists felt strongly that the adversarial model was not ideal for the CCB hearings and should be changed to a mandatory mediation model.

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

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

The debate between psychiatrists and lawyers within the CCB is by no means unique and reflects the tension between the medical and rights-based perspectives. Those who favoured the medical perspective argued that lawyers had made the process too adversarial and legalistic by complicating hearings with procedural objections and other technicalities. These views are consistent with the illness model of psychiatry. For instance, Gray, O’Reilly and Clements argue that psychiatrists find it difficult to “embrace a process that appears to them to ignore the patient’s best interests.”

The majority of respondents felt that the increasingly adversarial hearings had compromised the therapeutic relationship between the psychiatrist and the ethno-

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166 Interview with CCB adjudicator 4 (17 February 2009).
167 Interviews, supra note 57. Under s. 15 of the CCB’s Rules of Practice, the CCB only uses mediation as “part of the proceeding and not part of the hearing.” Supra note 139.
168 Data derived from interviews conducted with lawyers from November 2008 until May 2009.
169 D’arcy Hiltz, “Impact of the Consent and Capacity Board on Psychiatric Patient’s Rights” in Psychiatric Patient Advocate Office, Mental Health and Patient’s Rights in Ontario: Yesterday, Today and Tomorrow (Queen’s Printer for Ontario: 2003) 40 at 40; Aaron Dhir, “The Maelstrom of Civil Commitment in Ontario: Using Examinations Conducted During Periods of Unlawful Detention to Form the Basis of Subsequent Involuntary Detention Under Ontario’s Mental Health Act” (2003) 24:2 Health L Can 9 at 16. As a lawyer explained, “it serves our client to have a more formal process, that we object to evidence that is not admissible… that we enforce a formal process as much as possible and raise procedural issues if we see them.” Interview with a lawyer (17 November 2008).
170 Interview, ibid.
A lawyer recalled a case where the psychiatrist had attempted to cross-examine a young Somali psychiatric consumer/survivor in the hearing. As a result of the psychiatrist’s aggressiveness, along with other cultural and language barriers, the hearing was counter-therapeutic for the woman. Similarly, a consumer/survivor argued: “After the hearing, I really didn’t like my doctor. So, I didn’t stay with him a long time after because of that…” As a CCB adjudicator explained:

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

While the adversarial process may not in and of itself impact upon ethno-racial communities differently, it can aggravate other cultural dynamics evident within the CCB process. In a cultural context, the adversarial system is a set-back for ethno-racial psychiatric consumer/survivors because of their general mistrust of the mental health system and the language barriers they face. For instance, the consumer/survivors interviewed felt the formality of the proceedings, the questions posed and the nature of the evidence presented caused them discomfort and confusion. Also, lawyers felt the ethno-racial individual’s credibility (whether the applicant or family member) was questioned as a result of intangible qualities such as eye contact, mannerisms, body language and accent.

E. Systemic and Institutional Barriers

This section gives an overview of the systemic/institutional barriers experienced by ethno-racial psychiatric consumer/survivors. I examine how factors such as race, poverty and other social constructs of identity tend to impose a burden on those individuals who share those identifying elements, as a result of institutional racism and challenges faced by practitioners involved in trying to understand differences in illness models, psychotherapy and preferred mental health services and treatment for ethno-racial people with mental illness. I argue that these underlying systemic and institutional barriers influence the extent to

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172 Interviews, supra note 57.
173 Interview with lawyer 4 (5 March 2009).
174 Interview with psychiatric consumer/survivor 5 (8 April 2009).
175 Interview with CCB adjudicator 4 on (17 February 2009).
176 Interviews, supra note 57.
177 Data derived from interviews conducted with psychiatric consumer/survivors from November 2008 until May 2009.
178 Data derived from interviews conducted with lawyers from November 2008 until May 2009.
179 McKenzie & Bhui, supra note 7; Perlin & McClain, supra note 7 at 264.
which the CCB can address the needs of ethno-racial communities in its processes and jurisprudence. Studies confirm the impact that intersecting oppressions such as poverty, class, race, gender and sexual orientation have upon the mental health prospects of members from ethno-racial communities. As respondents indicated, the social, historical and political context of discrimination faced by ethno-racial psychiatric consumer/survivors has to be understood by the CCB and the wider mental health system. For instance, a service provider argued:

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

Intersecting with poverty, respondents identified racism as another significant systemic/institutional barrier. Racism, manifested in individual acts and institutional processes, can lead to barriers to care and increased likelihood of developing mental illnesses for individuals from ethno-racial communities. A 2005 Canadian survey indicated that approximately one in six people from racialized communities within Canada had been a victim of racism. Victims of discrimination, whether racial discrimination or some other form, are twice as likely to develop psychosis. Canadian research suggests that perceived racial discrimination has been linked to depression amongst Koreans in Toronto and Southeast Asian refugees in Canada.

The mental health system frequently “mirrors systemic discrimination” by not acknowledging how racism and other oppressions affect ethno-racial psychiatric consumer/survivors. Respondents gave anecdotal evidence of how misdiagnosis

181 Interview with service provider 5 (28 January 2009).
182 Interviews, supra note 57.
185 Ipsos-Reid, supra note 183.
could occur as a result of the institutional racism.\textsuperscript{188} For instance, a psychiatrist believed “ethno-racial patients are more likely to be given the schizophrenia label because of racist stereotypes within the institution.”\textsuperscript{189} As Dr. Jaswant Guzder argues:

\begin{quote}
[Ethno-racial psychiatric consumer/survivors] often have to contend with a collusion of professional blind spots, beginning with our institutional stance that is unwelcoming or that denies cultural axis issues. If an institution doesn’t facilitate the building of a therapeutic alliance that takes into account both a person’s experiential cultural map and previous racism encounters, this clinical setting is taking an approach that reflects overt racism or an implicit racism related to ignorance, lack of acknowledgement or sheer oversight, a situation that constitutes institutional racism.\textsuperscript{190}
\end{quote}

Ethno-racial psychiatric consumer/survivors found it frustrating that the CCB did not want to hear about their experiences of discrimination in the hospital, whether racial or otherwise.\textsuperscript{191} This refusal to hear alienates the ethno-racial psychiatric consumer/survivor and complicates their case, exacerbating the feeling that they have not been understood and that justice has not been done. As a lawyer explained:

\begin{quote}
If someone has applied to the Consent and Capacity Board, the doctor isn’t supposed to go ahead with the treatment unless the Board has confirmed the decision of incapacity. In some cases, especially where there are cultural and language barriers, doctors go ahead with treatment. If you raise this at a hearing, the Board will say: “I am not here to hear this type of information, maybe you have a civil action, maybe you want to complain to the College of Physicians and Surgeons, our only mandate is to say whether you are capable or not. The fact that your rights related to your capacity were violated and you faced racial discrimination in the hospital is not relevant to what we are here to decide and so I am not going to hear any evidence about that.”\textsuperscript{192}
\end{quote}

\textsuperscript{188} Interviews, \textit{supra} note 57.
\textsuperscript{189} Interview with psychiatrist 3 (12 January 2009).
\textsuperscript{190} Roberts, \textit{supra} note 187.
\textsuperscript{191} Data derived from interviews conducted with psychiatric consumer/survivors from November 2008 until May 2009.
\textsuperscript{192} Interview with lawyer 1 (17 November 2008); Hiltz & Szegeti, \textit{supra} note 24 at 182. Under s. 18, 33 (1), (2) and (3) of the \textit{HCCA}, “Once a person has indicated an intent to the Board, however, treatment may only commence in the following circumstances: 1) once 48 hours have elapsed since the health practitioner was informed of the intended application but no application has been made; 2) if the application to the Board has been withdrawn; 3) when the Board has rendered a decision in the matter and no party has indicated an intention to appeal the Board’s decision; 4) where a party has indicated an intention to appeal but the time for filing the appeal (seven days)
Evidence such as this highlights the reality that the CCB does not fully address and indeed does not fully appreciate the significance of rights violations and systemic discrimination experienced by ethno-racial psychiatric consumer/survivors. To minimize or ignore these experiences may lead to further marginalization for ethno-racial psychiatric consumer/survivors because the discrimination may have contributed to their mental health crisis.

1. Alternative and Culturally Appropriate Treatment Options

The inability to access culturally appropriate treatment and service options represents another form of systemic and institutional discrimination. In cases involving treatment incapacity, applicants wish to “retain the right to refuse the recommended treatment.”193 The CCB has a limited jurisdiction to address the type of medications being proposed because “the refusal of treatment is often equated with the lack of capacity to consent to treatment.”194 As a result, the CCB’s role in these cases is to determine whether the person is capable of consenting to the treatment.195 This was confirmed in Starson v Swayze, where the Supreme Court found that “the legislative mandate of the Board is to adjudicate solely upon a patient’s capacity. The Board’s conception of the patient’s best interests is irrelevant to that determination…”196

Within this context, I asked respondents whether the proposed treatment options for ethno-racial psychiatric consumer/survivors were culturally appropriate. Given the lack of jurisdiction, the CCB itself cannot consider whether treatment plans are culturally appropriate.197 In this regard, respondents believed the lack of culturally appropriate treatment options within the mental health system fundamentally affected how ethno-racial psychiatric consumer/survivors’ cases were determined before the CCB. Respondents argued that there were “no alternatives within the mental health system” because the predominant medical view was that mental illnesses such as schizophrenia, bipolar disorder and depression should be treated with pharmacological drugs.198 The emphasis on drug therapy can itself prove problematic. For instance, a lawyer observed:

I guess what bothers me is that there is a degree of forcing coercion within the system that the CCB has come to accept. If you are incapable and the board confirms this, then you will receive medication by injection, you will be held down by security guards and receive that medication because that is determined to be in your “best interests.” And there is an acceptance that that is what will happen. And that seems to me

\[\text{[References]}\]

193 Hiltz & Szigeti, supra note 24 at 182.
194 This presumption is confirmed in cases such as Khan v St. Thomas Psychiatric Hospital (1992) 7 O.R. (3d) 303, par. 312 c.; Boimier v Saminath, [2003] O.T.C. 644 (ON S.C.).
195 Under s. 2 of the HCCA, “treatment includes a course of treatment, plan of treatment or community treatment plan.” Under s. 33.7 of the MHA, supra note 21, the Community Treatment Order is based on the Community Treatment Plan in s. 33.1 (4) (b) of the MHA. Supra note 19.
196 Starson, supra note 17 at para 76.
197 Interviews, supra note 57.
198 Ibid.
something that we should naturally be repulsed by... because it is such a violent intervention. Not only the act of holding someone down, injecting them and restraining them, but the actual act of injecting them with neuroleptic medication that will put them in a chemical prison. I use these words because over time I have learned from people that this is their experience.

Drug therapy impinges on the dignity and integrity of the person forced to accept treatment regardless of identity. However, the lack of alternatives to drug therapy within the mental health system can have racialized dimensions as well. The resort to coerced drug therapy is complicated by ethnic physopharmacology research which indicates that the side effects and responses to psychiatric medication can vary amongst ethnic-racial groups. For instance, data indicate that African groups have a higher likelihood of experiencing episodes of neuroleptic toxicity from taking neuroleptic drugs, and may have more severe side effects than Caucasians when being treated with the regular dosages of lithium. Data also suggest people of East Asian origin have a higher likelihood of developing side effects from anti-depressants. In treatment incapacity cases, the CCB may not be sufficiently aware of these varied cultural and racial responses to medications and may not understand a racialized person’s reluctance to accept the medication because of its racially-linked adverse effects. The CCB may thereby assume ethno-racial psychiatric consumer/survivors are refusing or unable to consent to certain medications for other unjustifiable reasons.

Overall, respondents felt that alternative and complementary medicines, such as megavitamin therapy, acupuncture, homeopathy, light therapy and naturopathy, should be considered viable options for treating mental illness. Many of these alternatives or complementary approaches are predominantly used amongst certain cultures and respondents suggested that ethno-racial psychiatric consumer/survivors would be more willing to consent/comply with recommended treatment if they had such options.

The lack of ethno-specific mental health services in Ontario was identified as another significant systemic and institutional barrier for ethno-racial psychiatric consumer/survivors. As one psychiatrist argued, “the lack of ethno-specific services within the hospital results in no accountability for mental health amongst diverse groups.” Although respondents felt that the CAMH’s psychiatrists and

199 Interview with lawyer 2 (5 December 2008).
201 Ibid.
203 Ibid.
204 Interviews, supra note 57.
205 Ibid.
206 Ibid.
207 Interview with psychiatrist 1 (5 November 2008).
treatment teams were becoming more racially diverse, anti-oppression policies and accountability mechanisms for ethno-specific mental health services had not been fully developed within the hospital setting.

Within the community, respondents indicated that the resources for ethno-specific mental health services were insufficient. For instance, ethno-specific mental health agencies in Toronto such as Hong Fook Mental Health Association and Across Boundaries: An Ethno-Racial Mental Health Centre are well known and rapidly growing. As a consumer/survivor recalled from his experience at Across Boundaries, “it was great to see someone like me who had made it, trying to help me too.” More resources for these and other ethno-specific mental health agencies are needed, especially in the Greater Toronto Area.

F. Discretionary Barriers

This section analyzes the extent to which factors such as race, culture, and ethnicity are considered at particular points within the CCB’s jurisprudence, legislation and policies indicative of discretionary decision-making. As a result of the aforementioned procedural and systemic barriers, the CCB has not been sufficiently attentive to justice, fairness and human rights for ethno-racial communities in involuntary status, treatment incapacity, and financial incapacity cases. The empirical evidence suggests that the CCB is not using its discretionary powers to mitigate the systemic and institutional discrimination faced by ethno-racial survivors. On the contrary, discretion often works to heighten the burden imposed upon consumer/survivors as a result of factors such as race, culture and ethnicity.

I highlight cases where a “colour-blind approach” was adopted and as a consequence the CCB did not further explore discrimination faced by the ethno-racial psychiatric consumer/survivor. This theme arose from questions posed to respondents about how the CCB exercises discretion where factors such as race, ethnicity, and culture became an issue. Overall, respondents felt that the CCB gave little recognition to these complex issues.

Board members generally have an uneasiness dealing with cultural issues. I think a lot of it goes back to the question of confidence of our members. We need to keep working on members feeling comfortable with these racial and cultural issues and feeling confident to deal with them...feeling empowered that we are qualified members to address these issues as opposed to shying away from them and thinking that

208 Interviews, supra note 57.
209 Interview with psychiatric consumer/survivor 5 (8 April 2009).
210 This refers to the omission of a racial or cultural analysis. Aylward, supra note 12.
211 Interviews, supra note 57.
212 Ibid.
we are going to offend someone. I think there is a general
shyness about these issues which need to be gotten rid of.

This “uneasiness” results in the CCB adopting a “colour-blind” approach (the
omission of a racial or cultural analysis). More, specifically, respondents
identified problems with the CCB’s limited jurisdiction and the gap in the
legislation. The legislation does not specify how the CCB should account for
racial or cultural factors. In this lacuna, the CCB adjudicators have taken a
relatively narrow interpretation of their mandate, which is focused on analyzing
whether the medical evidence fulfills the criteria of the legislation. In my inquiry
on this issue, the majority of respondents felt that CCB adjudicators should go
beyond this narrow interpretation and use their discretionary powers to address
racial and cultural factors.

In this regard, respondents believed that the CCB did not sufficiently explore
contextual cultural factors, which might have impacted the individual’s
understanding of their mental illness and treatment. This was the perception in
cases such as L; File TO-06-1167 (Re), B.; File TO-05-6467 (Re), because race
is merely mentioned in the evidence and its impact is not analyzed. In L, the
psychiatrist notes that L, the ethno-racial psychiatric consumer/survivor, has
“bizarre thoughts about her race.” However, these “thoughts” are not explained.
Similarly, in B., it states that “Mr. B believes he is in hospital because of his race,”
but the role of race is omitted altogether within the CCB’s analysis.

213 Interview with CCB adjudicator 3 (17 February 2009).
214 Interviews, supra note 57; Aylward, supra note 12.
215 Interviews, supra note 57. As a lawyer explained, “there are significant complaints about the
discretionary powers of the CCB and its mandate. It often can’t do the things that people want it
to do. You can’t talk about treatment that you are receiving in the hospital. It only talks about
whether you stay in or stay out. The CCB actually doesn’t litigate or adjudicate on the issues that
are often most important to the client which is what they are entitled to and respect for rights in
the hospital.” Interview with lawyer 2 (5 December 2008).
216 Interviews, supra note 57. For instance, the CCB reviews the medical evidence for involuntary
detention. Section 20 (5) of the MHA states: “The attending physician shall complete a certifi-
cate of involuntary admission or a certificate of renewal if, after examining the patient, he or she is of
the opinion both, (a) that the patient is suffering from mental disorder of a nature or quality that
likely will result in, (i) serious bodily harm to the patient, (ii) serious bodily harm to another
person, or (iii) serious physical impairment of the patient, unless the patient remains in the
custody of a psychiatric facility; and (b) that the patient is not suitable for admission or
continuation as an informal or voluntary patient.” Supra note 21.
217 Interviews, supra note 57.
220 It is important to note that CCB decisions, (where reasons are given) do not generally state the
ethnicity of the applicant.
221 Supra note 218. Race is mentioned in the evidence as follows: “Dr. Kluckach, staff psychiatrist,
noted that her presentation was somewhat consistent with a mood disorder, with a past history of
depression He noted that her [effect] was such that she might have some hypomanic presentation
in addition to her somewhat bizarre thoughts about her race and her bizarre behaviour.”
222 Supra note 219. In this case, the CCB states: “Dr. Wong said Mr. B believes he is in hospital
because of his race. Dr. Wong said Mr. B believes Dr. Wong is racist. He said he does not need to
rebut this type of belief.”
The CCB’s colour-blind approach is also problematic in cases where the discrimination, whether racial or otherwise, was the precursor to the deterioration of mental health for ethno-racial psychiatric consumer/survivors. For instance, a lawyer referred to a case where the client’s experience of racial discrimination in the hospital caused him to go on a hunger strike, which led to his deterioration of mental health. As the lawyer explained,

The board traditionally has been disinterested in the precursor to the behavior. And if you talk about racial discrimination and you suffer from paranoid schizophrenia, then they think you are being paranoid. So, if you already have the label of suffering from a mental disorder, then your complaints about your treatment in your hospital are discounted as are most of your complaints because you have a mental health problem. It is not to say that the board is racist, it is the evidence that is gathered is only analyzed from a medical perspective.223

The irony of course is that those with mental illness are more, not less, likely to experience discrimination but the mental illness itself blinds those who treat the illness to the discrimination and thus undermines the very treatment itself.

Race and culture also factor into decision-making at CCB hearings in negative ways. During the hearing, the majority of lawyers felt that the CCB rarely posed questions about an individual’s ethnic background and the cultural factors at play. Intangible qualities such as a racialized person’s demeanour, eye contact and mannerisms influenced the CCB’s perception of that particular individual’s credibility.224 A lawyer referred to a case where she argued that the Board perceived the applicant’s mother, the substitute decision maker, to be less credible because she had a heavy accent. The lawyer argued:

What I do see of more regularly at the Board is a discounting…because it is a quality that you cannot really ascribe to…it is difficult to describe, but when you have a mom who is truly emotional about their child and they are crying and they speak with an accent. I get the impression often when I am before the Board that they are discounted as an emotional parent who is caught in emotions of their child being unwell and can’t reason the decision.225

Race and culture therefore influences the way in which family members are assessed and the weight that is attached to their concerns and wishes. Cases became even more complicated when explicit conflicts arose between the ethno-racial family member or ethno-racial psychiatric consumer/survivor and the psychiatrist. The perspective of the family and/or the consumer/survivor is generally trumped by that of the doctor. As one lawyer pointed out, “I am never

223 Interview with a lawyer 2 on (5 December 2008).
224 Data derived from interviews conducted with lawyers from November 2008 until May 2009.
225 Interview with a lawyer 2 (5 December 2008).
successful at a capacity hearing unless the ethno-racial client acknowledges that they have the diagnosis that the doctor is saying that they have. 226 Indeed, a number of respondents referred to cases where conflicts arose because of cultural expectations related to the care of aging parents. 227 In these cases, the alternative care arrangements or treatments proposed by ethno-racial family members and their cultural norms are often not considered. A lawyer felt:

If the family members don’t go along with what the doctor says, they are often marginalized. And when the substitute decision maker is from a racialized community, I think that marginalization is greater. Cultural evidence such that... “You never put your parent in a nursing home in Chinese culture” will generally not be considered by the Board. 228

Respondents also believed that the CCB’s colour-blind approach might lead to cultural misunderstandings. This was most apparent in cases where the ethno-racial psychiatric consumer/survivor was involuntarily detained for risk of harm to another person. 229 Words and phrases, for example, are often not assessed in cultural context though consumer/survivors and their lawyers propose that a cultured understanding of communication patterns would be desirable. One lawyer provided the following example as illustration:

There are some cultures where people will say “I will kill you,” and the client may say – yeah but in my culture I don’t mean that as a threat – it is a phrase, I say that all the time. I have one client where his son came to the hearing and said “yeah – I say that in our culture all the time… I say it to my kids, you know we just say that I will kill you.” That family was Phillipino and amongst Phillipino males there is kind of macho culture. It is something that you have to understand. But, the board didn’t really seem to buy that. They seemed to assess it from the point of view of the “average, reasonable person in Canada.” They didn’t really seem to buy that type of cultural argument. 230

Proponents of critical race theory argue against using a colour-blind approach in legal cases. As Lopez suggests, 

In order to get beyond racism, we need to take race into account. There is no other way...This is the basic flaw of color-blindness as a method of racial remediation. Race will not be eliminated

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226 Interview with lawyer 1 (17 November 2008).
227 Data derived from interviews conducted with lawyers from November 2008 until May 2009.
228 Interview with lawyer 2 (5 December 2008).
229 Interviews, supra note 57.
230 Interview with lawyer 1 (17 November 2008).
through the simple expedient of refusing to talk about it. Race permeates our society on both ideological and material levels. But, the CCB does not embrace the value of making race explicit. Indeed, a few CCB adjudicators felt that having race, culture and ethnicity as factors in decision making could create varying standards for ethno-racial psychiatric consumer/survivors and other psychiatric consumer/survivors. As an adjudicator explained,

We are afraid of opening up the floodgates and having all kinds of varying standards. Are we going to hear evidence from every family member about what their particular values and customs are? And could that suffer the overwhelming reasonableness of the law?

Clearly CCB adjudicators encounter a difficult task when considering how to address racial and cultural factors in their adjudication. There are a multitude of customs and factors to consider and no one can be an expert in all areas. Evidence would have to be called and proper standards established. However, the colour-blind approach, adopted by the CCB is problematic. Ultimately, how reasonable is the law if its purported neutrality ends up being little more than a mask for the values of the cultural majority? Race and culture are always present. The key question before the CCB is not whether race and culture are relevant but whose race and whose culture frames the process through which the rights of ethno-racial individuals are adjudicated.

1. Membership of the Board

Ultimately, the extent to which the CCB addresses issues specific to ethno-racial psychiatric consumer/survivors flows from the composition of the CCB and the cultural competence of its members. In this regard, I inquired about how “diversity” amongst the CCB’s membership was perceived to influence decision-making, particularly discretionary decisions. As a starting point, the majority of respondents observed that the CCB’s membership was not culturally diverse. Although the CCB composition has improved, there is no policy within the CCB’s mandate to ensure diversity amongst its adjudicators. As a CCB adjudicator explained,

It is not terrible, but it is not great. There has been a real effort made in the last few years to recruit and appoint people who reflect the province of Ontario better than just white people. When I joined it was mostly white men, now there are quite a few white men, quite a few white women and a few members of racialized groups, but not as many as we should have. It is something that we need to continue to work on. First of all,


\(^{232}\) Interview with CCB adjudicator 3 (17 February 2009).

when you get people who come from a culture that is not the majority culture, they inherently have an expertise in this area. And those of us that don’t, we are lacking in confidence, we feel that we are lacking in skills and knowledge, we don’t really know how to approach ethno-racial applicants. So, to have colleagues that can show us and teach us is one important thing that we need to work on.

In general, respondents argued that CCB adjudicators’ ethnicity, socio-economic background, gender, values and experiences impacted their discretionary decisions. Although difficult to pin down, respondents referred to cases where ethno-racial psychiatric consumer/survivors felt at ease with adjudicators with diverse backgrounds and perspectives. For instance, in *E.R.; File TO-04-1115 (Re)*, Mr. R, an African-Canadian man appearing before the board asked that “some members of the panel constituted to hear his application be of African Canadian descent.” The CCB denied this request in order to ensure the proceeding was cost-effective, efficient and timely. Moreover, the CCB argued the following:

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

Despite the CCB’s denial of the request for an ethno-racial adjudicator in this case, respondents gave anecdotal evidence of the positive impact that a diverse composition of the CCB has upon ethno-racial psychiatric consumer/survivors in proceedings. These views were consistent with literature suggesting “the more perspectives and backgrounds included in public decision making, the more qualitatively enhanced that the decision making in the aggregate will become and the more legitimate it will be viewed by those affected.”

The perception of “diversity” went beyond race and ethnicity. Respondents emphasize that it is not necessary that CCB adjudicators be from ethno-racial

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234 Interview with CCB adjudicator 3 (17 February 2009).
235 Interviews, supra note 57.
237 Ibid at para 4.
238 Ibid.
239 Interviews, supra note 57.
communities if they are competent and sensitive when approaching cultural issues. They should have an understanding of how their own assumptions, underlying prejudices, privilege and social context impact their perspectives and decision-making abilities.

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

> Although one or two take their own point of view, I have the sense that community members are kind of intimidated by the other members of the panel and they defer to them for whatever decisions they are making. If there is a three member panel on an involuntary issue, it is kind of sad because you don’t have someone there who is predisposed to think about the patient’s point of view.

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

IV. CONCLUSION

Ethno-racial psychiatric consumer/survivors face complex forms of discrimination as a result of the culture specific stigmatization of mental health disabilities, institutional racism and culturally inappropriate care. Ultimately, eradicating this discrimination will require legislative reform, sustained research and evaluation, education of all stakeholders within the system including cultural competency training, increased diversity within the CCB, and, inevitably more funding for legal aid and culturally appropriate mental health interventions. But, eradicating discrimination and adopting appropriate legislation, policy and practices in response to the discrimination derived from exclusion must start with an understanding of their diverse needs, perspectives and conceptions of mental health.

To date, the CCB has failed to adequately address how diverse social realities affect ethno-racial psychiatric consumer/survivors. Using the theoretical framework described, I identified and critiqued the procedural, systemic/institutional and discretionary barriers faced by ethno-racial psychiatric

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241 Interviews, supra note 57.
242 Ibid.
243 Interview with lawyer 1 (17 November 2008).
244 Interview with CCB adjudicator 3 (17 February 2009).
245 Interview with a CCB adjudicator 3 (17 February 2009).
246 Kwame McKenzie & Kamaldeep Bhui, supra note 7.
The procedural barriers that were identified recognize how cultural conceptions, misunderstandings and stigma associated with mental illness amongst various ethno-racial communities inhibited some ethno-racial psychiatric consumer/survivors from taking part in the CCB process. Ethno-racial psychiatric consumer/survivors faced barriers accessing lawyers who were able to understand how to incorporate cultural issues within the CCB challenge, and psychiatrists who acknowledged the importance of race, culture, ethnicity and other factors within the pre-hearing capacity assessments. Significant language and communication barriers were identified throughout the pre-hearing (within hospital, pre-counsel meetings and psychiatrists’ capacity assessments) and the post-hearing CCB process.

An analysis of the systemic/institutional barriers was critical to understand how intersecting oppressions such as institutional racism, discrimination and poverty affect the mental health prospects of ethno-racial psychiatric consumer/survivors. The lack of consideration given to alternative and culturally appropriate treatment plans within the mental health system and the lack of ethno-specific mental health services creates further disparities for ethno-racial communities. Lastly, the section on discretionary barriers identified tensions arising from the CCB’s adoption of a colour-blind approach in treatment incapacity, involuntary detention and long-term care cases complicated by racial, cultural and other social issues. Given the complexity of these cases, the lack of diversity amongst the CCB’s membership revealed challenges for all parties involved.

In our increasingly multi-racial society, the exclusion faced by ethno-racial psychiatric consumer/survivors can no longer be ignored. I hope that the findings and recommendations from this study can contribute to successful advocacy for ethno-racial psychiatric consumer/survivors. However, I recognize that there are no easy answers or simple solutions, and this research is only the beginning. The above analysis suggests the need for reform in the areas of legislation, education and training, research and evaluation, communication and language policies, membership, and funding. At the completion of this research, I was able to present the qualitative findings and suggestions for reform recommended by the stakeholders interviewed to the Chair of the CCB and a dialogue was created. Additionally, through the advocacy and support of the Mental Health Legal Committee, letters have been written by their dedicated Chair, Marshall Swadron, to the key stakeholders including the Chair of the CCB, the Minister of Health and Long-Term Care, the Vice President Policy of Legal Aid Ontario, the Director of the Psychiatric Patient Advocate Office, and the CEO of the Centre for Addiction and Mental Health.

Given the dearth of research on these significant issues, it is imperative that this dialogue continues in order to better understand and contextualize the

247 Due to the limitations of this study, it is not possible to make conclusive statements from the empirical evidence.
248 Interview with CCB psychiatrist adjudicator 2 (11 February 2009); Interviews, supra note 57.
249 Interviews, supra note 57.
250 Ibid.
251 Ibid.
experiences of ethno-racial psychiatric consumer/survivors within the civil mental health system. The future challenge for the CCB will be to collaborate with all the committed and hard-working stakeholders, and to build upon the existing training and mentoring programs used for adjudicators. On the systemic level, decision-makers must recognize the importance of funding ethno-specific mental health research and services, and we must all continue to question the institutional racism and stereotypical assumptions within society. As Rani Srivastava argues, “It is only when we embrace the difference, and deal with forces that impose conformity that we will discover cultures and the true value of diversity.”