Canadian Mental Health Legislation and the CRPD

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What is the CRPD?

The United Nations Convention on the Rights of Persons with Disabilities (CRPD)* is an international agreement designed to eliminate discrimination on the grounds of disability. It states that disabled people have the same human rights as everyone else, and instructs governments on how to ensure that disabled people are able to enjoy those rights in practice.

The CRPD was adopted by the UN on December 13, 2006, and Canada ratified (became bound by) it on March 12, 2010. Canada also acceded to the Optional Protocol (OP) to the CRPD on December 3, 2018. The OP allows Canadians whose rights have been violated on the grounds of disability to make their complaints directly to the UN Committee on the Rights of Persons with Disabilities (the international committee of experts that monitors CRPD implementation).

How does the CRPD define disability?

The CRPD supports a social and human rights-based view of disability: that the challenges faced by people with disabilities are caused not by their own individual limitations but rather by barriers such as physical obstacles, discriminatory behaviour, practices, policies, or legislation. Under the CRPD, persons with disabilities must be recognized as holders of human rights, rather than as objects of pity, charity, or the decisions of others with respect to their lives.

Why do people with psychosocial disabilities specifically need protection under the CRPD?

Canadians with psychosocial disabilities face discrimination based on stereotypes associated with their differences (often labelled "mental disorders").

Canadian society's standard responses to emotional, social or individual differences or difficulties are often experienced as instances of discrimination and as rights violations. Many people with psychiatric diagnoses would prefer social or peer-based support systems, which generally receive little or no funding, to biomedical and institutional interventions.

Psychiatry is the only branch of medicine that routinely treats patients against their will. Diagnoses and treatments are based on the theory that emotional distress and behavioural differences are caused by abnormalities in the brain, which can be corrected with drugs and/or electroshock. The medicalization of extreme emotional states ignores not only the spiritual and emotional dimensions of human life but also the sociopolitical conditions that are often at the root of problems faced by marginalized individuals. It can result in a flagrant disregard for human rights, especially when a person is drugged or electroshocked against their will, or without their free and informed consent.

The human cost of rights violations

Consider the plight of many "mental health care consumers" who end up in hospital not because they have chosen to seek help but because they have been taken to the emergency department by police – often in handcuffs – after a third party complained about their behaviour. Once in hospital, if they struggle against this abrogation of their freedom, they are likely to be stripped naked and forced into a hospital gown (sometimes by people of the opposite sex); tackled and held down by orderlies; tranquillized with a painful intramuscular injection; forced into physical restraints (immobilized on a gurney or bed by means of shackles); and/or confined in a "seclusion room" (solitary confinement cell).

Using drugs and/or electroshock to alter a person's behaviour constitutes an act of violence. Patients are not only unable to defend their bodies against these intrusions, but are coerced into accepting and participating in

this violence against them, on pain of more restraints, injections, and solitary confinement if they refuse. What would you, or anyone, feel like under such pressures? Now imagine what those pressures must feel like to someone in an emotional crisis.

People in distress often languish in restraints or isolation for days or weeks, deprived of fresh air, freedom of movement, and human contact (other than the few minutes a day required for the provision of food and the administration of drugs), before a psychiatrist decides they're ready to be released into the general population of the ward for further treatment. Imagine what this does to a person's sense of self, and to any expectation that they will be treated with care, respect and responsibility when they need help.

And the violation of one's rights may not end even after release from hospital. "Community treatment" legislation permits treatment teams to monitor and enforce medication compliance. Many outpatients go through a humiliating ritual of "witnessed meds" at their pharmacy, being made to take tranquillizers while a pharmacist watches them swallow. And "treatment team" members regularly invade patients' privacy to medicate them against their will in their own homes, under threat of being returned to hospital if they fail to comply.

The degree of a patient's willingness to acquiesce to a treatment regimen may determine eligibility for housing or other basic human rights. What does this do to a person's perception of human relations and civic society? How can they hope to complete their education, or find employment, when forced to take often incapacitating drugs?

Such egregious human rights abuses are standard procedure in Canada (as elsewhere), despite the fact that they violate the obligations of our country as a state party to the CRPD.

What protections must be enshrined in all provincial and territorial mental health legislation?

The CRPD obliges Canada to prohibit forced psychiatric interventions. Article 14 guarantees the right to liberty and security of the person, and is directly relevant to prohibition of involuntary commitment. According to the Committee on the Rights of Persons with Disabilities' Guidelines on article 14, "[extant mental health laws] still provide for instances in which persons may be detained on the grounds of their actual or perceived impairment [defined as conditions that may limit body, mind or senses], provided there are other putative reasons for their detention, including that they are deemed dangerous to themselves or others. That practice is incompatible with article 14; it is discriminatory in nature and amounts to arbitrary deprivation of liberty [paragraph C.9]."✷ Services can be provided only if informed consent is given.

Article 15 ensures the right to be free from torture and other cruel, inhuman or degrading treatment. Article 16 guarantees freedom from exploitation, violence and abuse, and article 17 protects the integrity of the person. Article 19 defends the right to live independently and to be included in the community. It stipulates, for example, that governments should be "implementing support services and effective deinstitutionalization strategies in consultation with organizations of persons with disabilities."✷ Together with articles 25 (which guarantees free and informed consent in health care), and 12 (which guarantees the right to legal capacity on an equal basis with others in all aspects of life), these provisions are interpreted decisively by the Committee as mandating *the abolition of involuntary commitment and involuntary treatment in all mental health settings*. This obviously includes the use of physical and chemical restraints and isolation rooms.

Article 14, in its defence of security of the person, meaning the physical and mental integrity of the person, is inextricably entwined with all of the Convention's other articles. It protects the person's autonomy, just as article 12 protects the right to legal capacity and thus the right to choose. Article 12 is significant in guaranteeing the right to freedom from forced psychiatric interventions, especially when criteria such as "mental deterioration" are used to deny the right to informed consent. This is the provision that enshrines the right of all persons, regardless of disability, to make decisions about every aspect of their own lives – including what kinds of medical treatment, if any, they are willing to accept – based on their free and informed consent.

The CRPD acknowledges that people may at times need help to make decisions, which can include decisions related to treatment, and are legally entitled to whatever kinds of personal supports they might need for that purpose. The Convention upholds the right to supported decision-making – as opposed to substitute decision-making, where someone else decides on their behalf. Supported decision-making means that, whatever the process, each person ultimately decides for themselves. Anyone helping them decide must do so according to the person's wishes and preferences – even when the person is in a state that is out of tune with or upsetting to others, including the person helping.

How Canada fails its citizens by ignoring the Convention

It is a major problem that our government has made a "conditional reservation" to its acceptance of article 12. This reservation supports provincial and territorial mental health legislation in its continuation of both the denial of legal capacity and the practice of substitute decision-making. As such, it *violates the purpose and intent of the CRPD*. It succumbs to outmoded thinking that those who refuse treatment "lack insight into their illness" and should therefore be forcibly treated "in their best interests."

Adults have the right to say no to medical treatment. Article 12 recognizes that the right to make decisions that affect one's own life, and especially those that affect one's physical and mental integrity, is fundamental to being legally recognized as a person. Yet Canadian law does not provide for international human rights treaty provisions to be directly enforceable in domestic legislation. Therefore, Canada's laws still allow clinicians to overrule the refusal of any person whom they have deemed legally "incapable" of making treatment decisions.

It is appalling that the rights protections of the CPRD have not prevented Canadian mental health practitioners from depriving citizens with psychosocial disabilities of their liberty and security; subjecting them to treatments they experience as torturous, degrading, violent and abusive; and violating their personal and physical integrity.

Canada's obligations under the CRPD

Canada is obliged, specifically under article 4, to eliminate all legislation and all practices that discriminate on the basis of disability. Mental health legislation authorizing involuntary commitment and involuntary treatment is discriminatory because it targets people with psychosocial disabilities for deprivation of liberty and for denial of control over their own bodies, minds and health, based on psychiatric opinion.

The practice of substitute decision-making is also discriminatory. Its denial of the right to legal capacity contravenes the Convention. In its 2017 Concluding Observations on Canada§, the Committee on the Rights of Persons with Disabilities states: "The committee is concerned about the State party's reservation, which it continues to uphold, to article 12 of the Convention, preserving substitute decision-making practices. The reservation contradicts the object and purpose of the Convention as enshrined in article 1 and prevents the State party from fully implementing and addressing all human rights of persons with disabilities... [paragraph 7]."

The Committee recommends in paragraph 8 that Canada "carry out a process to bring into line with the Convention federal, provincial and territorial legislation that [currently] allows for the deprivation of legal capacity of persons with disabilities."§

The Committee further expresses concern that "provisions of the Convention have yet to be appropriately incorporated into legislation and policies across sectors and levels of government [9(a)]," and notes that these concerns should be addressed "in consultation with persons with disabilities through their representative organizations… [10(a)]."§ Furthermore, the "Committee is concerned about the absence of formal, recorded consultations on comprehensive plans for the implementation of the Convention...[11]."§

Paragraph 27 of the Concluding Observations adds, "In many provinces and territories, a substitute decision-maker is permitted to make health-care decisions for a person who is found to be 'incapable' of making his or her own decision. The Committee is also concerned that a number of federal statutes reinforce exclusionary tests of legal capacity and do not provide recognition of supported decision-making."§

In paragraph 38, "the Committee recommends that the State party: (a) [provide through the provinces and territories] the right to live independently and be included in the community as a subjective and enforceable right for persons with disabilities, reaffirming the principle of respect for the individual autonomy of persons with disabilities and their freedom to make choices about where and with whom to live; (b) Adopt a human rights-based approach to disability in all housing plans and policies at all levels [and] increase the availability of affordable and accessible housing units for persons with psychosocial and intellectual disabilities, as well as support services; (c) [...] set up strategies with time frames to close institutions and replace them with a comprehensive system of support for independent living; [and] (d) [e]nsure that accessibility legislation, plans and programmes [facilitate] the inclusion of persons with disabilities in the community and [prevent] their isolation and institutionalization."§ However, despite specific instructions for Canada, in paragraph 60, to "provide information, within 12 months of the adoption of the present concluding observations [issued in 2017] and in accordance with article 35 (2) of the Convention, on the measures taken to implement the

Committee's recommendations contained in paragraphs 8 (declaration and reservation) and 14 (c) (equality and non-discrimination),"§ no action has been taken.

As an international instrument that is binding on Canada, the CRPD should be a powerful tool for establishing and enforcing the human rights of people with psychosocial disabilities within Canadian legislation, policy, and practice. However, even though Canada ratified it more than a decade ago, it appears that legislators and officials are not even discussing, much less implementing, the Convention as it applies to the abolition of psychiatric coercion. Canada's mental health laws continue to allow people to be locked up, and to be forcibly treated both in hospital and in the community.

When will Canada act?

Canada's government submitted reports to the Committee on the Rights of Persons with Disabilities in 2014 and in 2017. Their next report is due this year, and the Committee will surely question the government on its implementation of previous Concluding Observations. In 2017, the Mad Canada Shadow Report Group was one of several non-governmental organizations that submitted parallel, or "shadow," reports. Our report highlighted numerous human rights abuses throughout Canadian mental health practice.‡ We recently conducted a nation-wide survey attempting to elicit the views of various relevant bodies, such as health and human-rights authorities. The lack of response was gravely disappointing.

Catalina Devandas-Aguilar, the United Nations Special Rapporteur on the Rights of Persons with Disabilities, visited Canada in 2019 to meet with representatives of disabled persons' organizations, including our group. In her End of Mission Statement, she stipulated: "Provincial and territorial legislation across Canada provides for the involuntary hospitalization and treatment of persons with psychosocial disabilities, in contradiction to article[s] 14 and 25 of the CRPD […]. I urge the provincial and territorial governments to transform their mental health systems to ensure a rights-based approach and well-funded community-based responses, ensuring that all health care interventions are provided on the basis of free and informed consent." ¶ Regardless of Canada's objections to article 12, the practices of psychiatric detention and forced treatments still violate articles 14 and 25 of the Convention.

We have no evidence that any of the Rapporteur's recommendations have even been discussed, much less followed. Mental health legislators, policy-makers and practitioners are obliged to adhere to the most up-to-date human rights standards that advance the rights of people with psychosocial disabilities by following the Rapporteur's recommendations, as well as those of the Committee on the Rights of Persons with Disabilities. These standards require state parties to abandon, both in legislation and in practice, the incarceration and forced treatment of persons with psychosocial disabilities. It is our hope that the present document will serve to help initiate action on these matters.

* The United Nations Convention on the Rights of Persons with Disabilities (CRPD)
https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx

✷ Guidelines on the right to liberty and security of persons with disabilities (in the Appendix)
http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=dtYoAzPhJ4NMy4Lu1TOebOyWznln3F6u2vVkqo%2fomXtSn4CLtA238Fdsx9hOv5ZF626c2zYyRNX0SwvVArEwf4XUnu3wzBuwoY3uXOileJQ%3d

§ Concluding Observations on the Initial Report of Canada (May 8, 2017)
https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD/C/CAN/CO/1&Lang=En

¶ End of Mission Statement by Catalina Devandas-Aguilar, United Nations Special Rapporteur on the Rights of Persons with Disabilities (April, 2019)
https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24481&LangID=E

‡ Mad Canada Shadow Report (with additional research)
https://madcanada.wixsite.com/shadowreport