SANISM AND THE LEGAL PROFESSION: WHY MAD PEOPLE SHOULD BE ANGRY

Suzan E. Fraser[1]

> I do feel very much that there is, based on my own studies and knowing many people, that there are – the prejudices that existed 100 years ago are very much with us in terms of popular attitudes. That is something that hasn't gone away. There's still a large disregard for the rights of people with mental health problems in psychiatric facilities. The fact that people died and don't have their deaths automatically investigated is I think a troubling example of that. Also the fact that to this day a lot of people continue to use the very outmoded stereotypes just as were written about in the late 19th century and the 20th century about people with a psychiatric history as being violent or someone who is a threat.[2]

Fear. It is a powerful emotion. Fear from the unknown drives our need for security. Fear of oppression drives our need for liberty. The fear that drives our need for security leads us to oppress others. We understand this well in the post-911 era. We stave off unknown dangers at the expense of liberty – usually others' – until we come face to face with the impact of our decisions. We take off our shoes at the airport, open our bags without question and dump out our pumped breast milk because Transport Canada says we have to. We chalk these up as minor inconveniences for the price of our own security.

Fear of the unknown is what drives us to oppress mad people. We apprehend them without warrant because they engage in disorderly conduct. We detain them because they may be a danger to others even though they have committed no crime. We inject

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[1] Suzan Fraser is a sole practitioner. She may be reached at fraser@fraseradvocacy.com or 416.703.9555.
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[2] Evidence of Dr. Geoffrey Reaume, Author, Scholar and Survivor at the Human Rights Tribunal, January 11, 2006, page 459, line 9 to page 460, line 17

them with psychotropic medication to quell the thoughts which we find disturbing. We shackle them to beds across the Province for non-compliance and say that is for their good. Deep down, it is for our good. It is fear that drives "us" to oppress "them": those who are different and strange but have committed no crime. They disturb us.

There is a name for this fear, it is sanism. Sanism is "an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry," that "infects both our jurisprudence and our lawyering practices," is "largely invisible and largely socially acceptable", and is "based predominantly upon stereotype, myth, superstition, and deindividualization, and is sustained and perpetuated by our use of alleged "ordinary common sense" (OCS) and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process". [3] It is as pervasive in our legal profession as it is in our community. This paper will examine where and how sanism appears in our profession. First, I will examine my own experiences in representing persons with disabilities, particularly consumers and survivors of mental health services[4], in order to describe the dehumanizing effects of sanism. Second, by

[3] Michael L. Perlin, "'Things Have Changed': Looking at Non-Institutional Disability Law Through the Sanism Filter" 22 N.Y.L. Sch. J. Int'l & Comp. L. 165 at 166

[4] The title of this talk was representing people with disabilities and I have used that term here. Throughout the balance of the paper, this paper uses consumers and survivors of mental health services and mad people because they are terms preferred by the community over "the mentally ill" and "psychiatric patients":

> One of the most fundamental objectives of user groups is to claim the right to self definition for people whose identity and "problems" have been defined by professionals. Reclaiming the right to define themselves and their problems is a prerequisite for attaining other objectives. Participation within such movements can demonstrate that those formerly viewed as passive and dependent recipients of welfare can be actors capable not only of controlling their own lives, but also of contributing to shaping the nature of welfare services and of achieving broader social objectives. Participation can itself contribute to a surer sense of identity.

examining key decisions of our courts, I will examine the justice system's failure to deliver the promise of equality of the *Canadian Charter of Rights and Freedoms* (the *Charter*) to consumers and survivors of mental health services. Briefly, this paper will examine the Courts Ontario's report on *Making Ontario's Courts Fully Accessible to Persons with Disabilities*[5] and its failure to remedy the practical concerns of mad people in the justice system. Finally, I will make recommendations for the profession that will allow lawyers to represent mad people professionally (so please, if you do nothing, go to the end, and read my principles and recommended practices for lawyers who represent mad people).

I have been working in the area of mental health law for almost 14 years and as advocate one of the few who have maintained it as their practice area. When I tell people that I represent mad people, I am often asked, how do you get instructions. The answer is simple – from my clients. Survivors of the mental health system have been analyzed, institutionalized and psychiatrized. On the days they meet with me, they get to be in control. There are some exceptions to this and it depends on the proceeding.[6] In the civil commitment system, the very essence of the legal question demands that the person be able to instruct counsel. And I want to tell you what I have learned in those days, weeks and years of meeting with clients in crisis situations.

P. Barham & M. Barnes, "The Citizen Mental Patient" in N. Eastman & J. Peay, eds., *Law Without Enforcement: Integrating Mental Health and Justice* (Oxford: Hart Publishing, 1999) at 138

[5] http://www.ontariocourts.on.ca/en/accessiblecourts.htm

[6] In proceedings under the *Substitute Decisions Act, 1992*, the court may make an order for the appointment of counsel. In those circumstances, the individual is deemed capable of instructing counsel. The role of counsel under such an appointment is discussed in *Banton v. Banton*, 1998 CanLii 14926 (On. S.C.).

Most of what we read in the paper about mental health is about the family plight and quest to get help for a loved one, we hear about stigma (rather than speak of our own prejudice and discrimination). We hear about the promised technological fixes for madness such as a new medication. Yet, so-called normal people overwhelmingly fail to capture the essence of the challenges faced by people in crisis.

My own experiences tell me that we are a long way from achieving justice and human rights for mad people. As we did with forensic pathology, we put tremendous trust in psychiatry such that there is the unquestioning acceptance of medical opinion at the expense of the voices of our citizens. Given our reliance and acceptance on medicine's response to madness, it will take a complete mind shift for people to understand the degree to which we discriminate.

In my practice, I have noticed that we continue to call upon the professionals to speak to the experiences of mad people so that the stories of mad people are often heard from their health care professionals or their family members and not from themselves. We would not ask white professionals to speak to the experiences of the African-Canadian community simply because they have represented them. We would not ask a visual-impaired person's physician to speak to the experiences of visually-impaired people, so why do we look to the health care professionals to speak for mad people? The danger with the intersection of law and health is that a rights analysis tends to get corrupted by a paternalistic, "for their good", approach. As advocates, we must elevate the voices of

mad people and tell their stories to the courts and tribunals, not just what we think they should hear.

Lawyers are not alone in succumbing to the "for their good" approach. It is interesting to note that:

> Amnesty [International], I must say, once had a horrendous record with regard to people with mental disabilities. We heard earlier in this conference about the use of so-called "unmodified ECT." That is ECT without muscle relaxants or anesthesia. There is actually an Amnesty International report from just over ten years ago that looked at that practice in Romania, and said that it was not a human rights violation because the intent of the medical practitioner was to help the patient, even though the practice of unmodified ECT causes tremendous pain and possibly life-threatening dangers. According to Amnesty's way of thinking, this was not a human rights violation appropriate for international recrimination. It was merely a question of "medical ethics." Somehow, when it is a question of medical ethics, you can leave it to the doctors and police to fight it out amongst each other about how best to treat their patients.[7]

Credible scientific research tells us that medication is ineffective or intolerable for many people. In a study published in the New England Journal of Medicine, 75% of participants discontinued medication because of inefficacy or intolerable side effects[8]. I have examined findings from the World Health Organization cross-cultural studies that demonstrate that patients from developing countries have a significantly better outcome

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[7] Eric Rosenthal, Executive Director of Mental Disability Rights International "The Application of International Human Rights Law to Institutional Mental Disability Law" (2002) 21 N.Y.L. Sch. J. Int'l & Comp. L. 387 at 392 as quoted in Aaron A. Dhir, "Relationships of Force: Reflections on Law, Psychiatry and Human Rights" (2008) 25 Windsor Review of Legal and Social Issues 103 at 104 (n. 9)

[8] Lieberman, J.A., Stroup, T.S. McEvoy, J.P., Swartz, M.S., Rosenheck, R.A., Perkins, D.O., Keefe, R.S., Davis, S.M., Davis, C.E., Lebowitz, B.D., Severe, B.D., Hsiao, J.K., Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) Investigators. (2005) "Effectiveness of antipsychotic drugs in patients with chronic schizophrenia" New England Journal of Medicine, 353(12) at 1209-1223.

than patients in "developed" countries.[9] Those cultures tend to use less medication and have fewer hospitalizations. Another theory is that those cultures embrace their mad people for the gifts they possess. Consider the following:

> I have had various treatments for depression, including drugs, but I am ambivalent about medication. Once or twice they have saved my life, but they also numb me and make it harder for me to connect with my spirit. So in the long run, they make it harder to heal. I haven't worked this out yet.
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> I also experience times of intense joy and creativity. They are a kind of kaleidoscopic switch-back where ideas travel at the speed of light. This is when I know that everything is connected to everything else in the universe. I look at a tree and see how every leaf on that tree is connected with every other leaf on every other tree. I have amazing dreams, sometimes waking dreams, maybe mystical moments.
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> These are also often my source of inspiration as a poet. Creativity is the greatest spiritual experience I have. Creativity is the act of giving breath to life, expressing the spiritual world in the physical world.
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> Sometimes my highs are frightening - when I get close to the edge of what I call a spin. If I cannot "manage them", hold the clay in shape, if you like, as it spins on the potter's wheel, then I am in trouble. I can become so exhausted by the speed and intensity that I get physically ill.
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> So far in my life, I have never allowed the joy to be viewed and treated as a mental illness and no external force has insisted that it should be. I know that I have been fortunate and often reflect that it might have been otherwise.
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> Sometimes, I am not so sure that I would have chosen this life, my life, if I'd been there on the edge of time and had a say about it. I think I'd have asked for something a bit easier from the man upstairs. "'Scuse me Guv. Do you think you could take out a bit of the mood swing stuff and give me a bit more tranquillity." But I think Guv would have turned round and said, "Look Jules, this is all that's on offer today. Take life while you can and accept it for what it is and sometimes you'll know the meaning of miracles."[10]

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[9] G. De Girlamo, 1996 WHO Studies on schizophrenia: An overview of the results and their implications for the understanding of the disorder. *The Psychotherapy Patient*, 9, 213-231; A. Jablensky, *Multi-Cultural Studies and the Nature of Schizophrenia: A Review* 1987 80 162-167

[10] Julie Leibriech, "Making Space: Spirituality and Mental Health" Mental Health, Religion and Culture, Vol. 5, Number 2, 2002

Many of my clients believe that medication helps them manage their illness. Many confess privately that if they hear voices, the voices often do not go away with the medication. They keep that to themselves for fear of the hospital. Unfortunately, second generation, atypical neuroleptic medications have not met their promise as we are seeing too many of our clients develop diabetes and cardiovascular problems. After years of telling a client that the only way he would get out of the forensic mental health system was to take medication, he was hospitalized from complications of it and we almost lost him. As Erick Fabris noted, "survivors experience forced medication as an assault and experience mandatory medication for indefinite or long term periods as a form of imprisonment."[11] Others have commented that forced medication at home is like "house arrest in home-based institutions".[12] We do not fully understand recovery without medication. John Nash, the famed mathematician of *A Beautiful Mind*, recovered, but not with medication as the Hollywood ending would suggest. Rather, he learned to control his symptoms. As advocates, we have a duty to understand and articulate the limitations of science and advocate on behalf of our clients.

Some of my clients are committed to medication as a way of managing the symptoms. They should have that choice just as the right to refuse should exist. That choice should be informed and given in compliance with the law. Often, it is not. In addition, there is no mainstream alternative treatment available to people with schizophrenia (and other major mental disorders). When there is only one choice, there is no choice. There are

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[11] Fabris, E. *Identity, Inmates, Insight, Capacity, Consent, Coercion: Chemical Incarceration in Psychiatric Survivor Experiences of Community Treatment Orders*. Unpublished masters thesis. Ontario Institute for Studies in Education, (2006: University of Toronto, Toronto, Ontario)

[12] Stephen Kisely and Leslie Anne Campbell, "Clearing away the Smoke and Mirrors: Response to Dr. O'Reilly" Can J Psychiatry, Vol 51, No 11, October 2006 689 at 690

other theories about treating psychosis and schizophrenia but they are not welcome in our public health care system and therefore remain out of reach for most people. As advocates, we have to do better and argue for choice and compliance with the law.

Medicine is not infallible. The lessons of medical history tell us that medicine will make mistakes and that it suffers from the same kind of tunnel vision that we see in the justice system. In my opinion, there will come a time when we regard the use of neuroleptic medication as barbaric such that it will join insulin coma, the lobotomy and the water chamber as ill-conceived treatments of the past.[13] With this in mind, as advocates we need to listen to our clients when they speak to us about their experiences with medication.

My experiences with institutionalized mental health care tell me that often it is far from humane. The deprivation of liberty is so grave, the use of chemical and physical restraint is so physically punishing and the social isolation so bleak that we should hang our heads in shame that we permit such treatment in our society. We turn our backs on the brutality of the care because it happens in hospitals rather than in jails and doctors, nurses and orderlies are the agents of the state rather than jail guards. In spite of this, I know that most health care professionals believe that they are caring individuals who feel vulnerable working with people in crisis without adequate supports. We have not demanded that they find other ways of delivering care. If we did and if they could, their

[13] For an examination of the history of psychiatry, see Robert Whitaker, *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*, (Da Capo Press, 2002)

fear and anxiety which often lead to my clients' oppression would be alleviated.[14] As lawyers, we are uniquely situated to bear witness to the dehumanization of mad people and to speak out about it. My experience, however, is that the lack of alternatives, our faith in the medical system and our sanist attitudes dull what might otherwise be fearless advocacy on behalf of our clients.

Some of the most significant victories in mental health law took place almost twenty years ago.[15] *Fleming v. Reid* is one of Ontario's most significant cases of the last century. It is important to note that a survivor was co-counsel to Mr. Reid. The case had in it the voice, brains and heart of the survivor community and that participation, in my view, was an essential component of the successful result. Law reform followed that case and, with the exception of the laws regarding Community Treatment Orders, many of our statutes and legal principles which guide decisions affecting mad people are progressive. Yet those laws make no meaningful difference because they do not represent what happens in practice and the means of enforcement are limited.[16] While there are laws affecting when a person can be detained in hospital, there are few laws which prescribe an individual's entitlements regarding service while detained, in contrast to the rights afforded to prisoners under Provincial regulations.[17]

Mad people have no right to access the *Canadian Charter of Rights and Freedoms* (the *Charter*) when they appear before the tribunals that review their detentions whether they

[14] Lori Ashcraft and William Anthony "Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services," in Psychiatric Services (October 2008; 59[10]: 1198-1202)
[15] *Fleming v. Reid* (1991) 4 O.R. 74 (C.A.), *R. v. Swain* [1991] 1 S.C.R. 933
[16] The enforcement issues are related to the lack of access to the *Charter* at the tribunal level and the access to justice issues regarding applications to the Superior Court of Justice.
[17] Regulation 778, *Ministry of Correctional Services Act*, R.R.O. 1990, amended to O. Reg. 2195/05 sections 13 to 17.2, 22 to 34

be by civil commitment in hospital or outpatient commitment (aka community treatment orders) under the *Mental Health Act* or by virtue of a finding of not criminally responsible pursuant to the *Criminal Code.* Courts have held in *J.C. v. Cameron*[18] and *Jane Patient v. Ontario (Attorney General)*[19] that the Consent and Capacity Board does not have the jurisdiction to grant a remedy pursuant to section 24(1) or to consider the constitutionality of its own legislation (and a subsequent amendment codified this finding). The Court of Appeal recently held that the Ontario Review Board does not have the jurisdiction to grant a remedy pursuant to section 24(1) of the *Charter*.[20]

Consider the words of the Chief Justice of Canada in dissent in *Cooper v. Canada (Human Rights Commission)*[21] which became the majority position in *Nova Scotia (Workers' Compensation Board) v. Martin*[22] on the importance of access to the *Charter* at the tribunal level:

> In my view, every tribunal charged with the duty of deciding issues of law has the concomitant power to do so. The fact that the question of law concerns the effect of the *Charter* does not change the matter. The *Charter* is not some holy grail which only judicial initiates of the superior courts may touch. The *Charter* belongs to the people. All law and law-makers that touch the people must conform to it. Tribunals and commissions charged with deciding legal issues are no exception. Many more citizens have their rights determined by these tribunals than by the courts. If the *Charter* is to be meaningful to ordinary people, then it must find its expression in the decisions of these tribunals. If Parliament makes it clear that a particular tribunal can decide facts and facts alone, so be it. But if Parliament confers on the tribunal the power to decide questions of law, that power must, in the absence of counter-indications, be taken to extend to the

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[18] (1992), 3 Admin. L.R. 223,
[19] (2005), 250 D.L.R. (4th) 697 • (2005), 131 C.R.R. (2d) 65 • (2005), 31 Admin. L.R. (4th) 227 • (2005), 194 O.A.C. 331
[20] *R. v. Conway*, 2008 ONCA 326
[21] (1996) 140 D.L.R. (4th) 193
[22] [2003] S.C.J. No. 54

> *Charter*, and to the question of whether the *Charter* renders portions of its enabling statute unconstitutional.[23]

Since survivors cannot access the *Charter* at the tribunals reviewing their detentions, this leaves clients with the common law remedy of *habeas corpus* but when survivors attempt this route, they are faced with access to justice issues including legal aid funding issues. A progressive law is meaningless without the will to give it effect and without a way of pursuing a legal remedy. Most of my clients are stopped in their tracks because they are impoverished. Legal aid is most often non-existent for anything other than the most basic of challenges such as challenging the legality of a detention, and even in that forum, access to the *Charter* is denied.

It is with these observations, made over the last 14 years that I now approach my legal work and relationships with my clients. There have been some successes in this area of the law in those years. Their impact, however, is diminished by the practice concerns discussed above.[24] There have been many failures, not just of my own, but by leading mental health advocates in the Province of Ontario[25]. These were talented lawyers representing clients with important and meaningful issues which were supported in the survivor community. They were rejected by the courts sometimes on technical grounds

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[23] *Cooper, supra*

[24] *Pinet v. St. Thomas Psychiatric Hospital*, [2004] 1 S.C.R. 528 • (2004), 237 D.L.R. (4th) 23 • (2004), 182 C.C.C. (3d) 214 • (2004), 19 C.R. (6th) 21 • (2004), 185 O.A.C. 8; *Starson v. Swayze* [2003] 1 S.C.R. 722 • (2003), 225 D.L.R. (4th) 385 • (2003), 1 Admin. L.R. (4th) 1 • (2003), 173 O.A.C. 210; *Daugherty v. Stall, 2002] O.J. No. 4715* (QL), 48 E.T.R. (2d) 8 (S.C.J.).

[25] *Edmunds v. McMaster*, Unreported endorsement of Lang J., Somers J. and Epstein J. (Ont. Div. Ct.) released June 17, 2003, Court File No.: 59/03; *Harris v. Ontario Review Board*, Endorsement dated March 23, 2007 Court File No. 06-CV-319871 PD3 (Ont. S.J.); *Braithwaite v. Ontario*, Unreported decision, Court File No. 304/06 (Ont. Div. Ct.); *Re S.H* CCB File Nos: TO-00/1279 and TO-01/04; *Patient v. Ontario(Attorney General), supra*; *J.C. v. Cameron, supra* are examples

or sometimes because of the sanist or "for their good" approach. Perlin argues that, in this area of the law, sanism and pretextuality combine to corrupt the process:

> "Pretextuality" means that courts accept (either implicitly or explicitly) testimonial dishonesty and engage in similarly dishonest (frequently meretricious) decision-making, specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends". This pretextuality is poisonous. It infects all participants in the judicial system, breeds cynicism and disrespect of the law, demeans participants, and reinforces shoddy lawyering, blasé judging, and, at times, perjurious and/or corrupt testifying.[26]

I believe that pretextuality exists in our legal system. Pretextuality, sanism on the part of lawyers and jurists, access to justice issues and common law principles which are discriminatory towards mad people combine to shut mad people out of the justice system.

As noted above, attempts to facilitate access to the *Charter* at the tribunals where survivors most often appear have failed. Legal challenges to the draconian but now almost decade-old community treatment order legislation have also stalled after being stymied by issues around standing, mootness, lack of an institutional client and the ability of the tribunal's to consider constitutional questions. Not a single appeal has proceeded to be heard on the substance of the amended committal criteria (enacted with the community treatment order provisions) for similar reasons. One factor regarding why involuntary committal appeals are seldom heard is that a client's right to a review of the detention before the Consent and Capacity Board is frozen when an appeal is taken.[27] Another is that individuals often are discharged before an appeal is heard making the

[26] Perlin, *supra* at 166

[27] *Mental Health Act*, R.S.O. 1990, c. M.7, as amended, ss. 48(11) – these do not actually freeze the right to apply to the Board but the effect is so.

issue moot.[28] Mootness is an issue faced by litigants in all aspects of *Charter* litigation. It is especially acute for survivors who have trouble reaching the first level of appeal. Consider for a moment that the Consent and Capacity Board hears approximately 3,000 applications a year (it receives that are not heard) and that there are only a handful of appeals each year.

Last year around this time, I was touting the shining success amidst the darkness. The Honourable Mr. Justice Peter Cory[29] sitting as the Ontario Human Rights Tribunal held that Ontario's *Coroners Act* discriminated against mad people by failing to make mandatory inquests into the deaths of psychiatric in-patients in contrast to mandatory inquests for other in-custody deaths. In response, a wise and critical woman (also a survivor) wryly noted that she found it ironic that one of the major legal victories of the psychiatric community is about death. On appeal, the Divisional Court reversed the decision of the tribunal. On October 3, 2008, the Court of Appeal for Ontario denied leave to appeal. It was a shocking disappointment. The case provides a useful example of what could have been and what should have been, had the courts heard the voices of mad people and had sanist attitudes not prevailed.

The late Melba Braithwaite, beloved mother to Renata Braithwaite, died on April 9, 2001 at the age of 53 after collapsing in the shower while involuntarily detained at the Centre for Addiction and Mental Health. Her cause of death is noted to be hypertensive cardiovascular disease but questions remain about her death. At the hearing before the

[28] *Edmunds, supra*, *Harris*, *supra*
[29] Yes, that Peter Cory, retired Supreme Court of Canada Justice sitting as the Human Rights Tribunal

Tribunal, Renata gave evidence that shortly after her mother's death, Renata received an anonymous telephone call and the Psychiatric Patient Advocate Office received information from an unidentified staff member calling into question the emergency response by staff and staff ability to respond in a medical emergency. Renata, who was her mother's substitute decision-maker, learned that while in hospital, her mother received medication to which Renata had not consented. Despite the fact that the coroner's office was statutorily mandated to investigate Melba's death and despite the fact that Melba had been prescribed psychotropic medication, it appeared that no toxicology screen was ever completed. Renata fought unsuccessfully to have an inquest into her mother's death. On January 14, 2003, after the Regional Coroner and the Chief Coroner had refused her request for an inquest, she complained to the Ontario Human Rights Commission.

The late Thomas Illingworth was a letter-carrier who died on June 8, 1995 in the Humber River Regional Hospital at the age of 50. His cause of death is classified as undetermined. What is known is that he suffered from a bi-polar disorder and without his knowledge became involuntarily detained at the Humber River Regional Hospital. He was not seen by a rights advisor. He died in physical restraints 10 hours after a physical confrontation with staff when he attempted to leave the hospital. He was also injected with "chemical restraints". His younger brother, Robert Illingworth, survived him and fought to get answers about the circumstances in which his brother died through the calling of an inquest. One answer he received from the Coroner's office was that "some psychiatric patients just die". On August 7, 2003, after exhausting all efforts to have a

coroner's inquest called, he commenced a human rights complaint. This complaint, together with Renata's complaint, was referred to the Human Rights Tribunal of Ontario (the Tribunal) on December 7, 2004.

Had Melba or Thomas died in a police holding cell, in the custody of police in a police car, in a halfway house or in a correctional facility, an inquest would have been mandatory. Dying behind the locked doors of a psychiatric facility doesn't get you an inquest, only an investigation. An inquest is a public proceeding and creates a full public record. Witnesses are called, placed under oath, examined and cross-examined. People connected to the death can apply for standing. If granted, those people or their lawyers can cross-examine witnesses, call their own witnesses and make submissions. The evidence is heard by a jury of five people who must determine who the person was, where, when and how they died. They may also make recommendations to prevent similar deaths in the future. Inquests, therefore, are about public safety.

The importance of an inquest was noted by the Law Reform Commission of Ontario in 1971:

> one of the primary assumptions underlying the common law, as well as the moral and social rules and values upon which our civilization is based, is the clear policy relating to the need to preserve and protect human life … The death of a member of society is a public fact, and the circumstances that surrounded the death, and whether it could have been avoided or prevented through the actions of person or agencies under human control, are matters that are within the legitimate scope of all members of the community…The role of the office of coroner must keep pace with societal changes and, where necessary, must move away from the confines of doctrines that are inconsistent with community needs and expectations in twentieth century Ontario.[30]

[30] Ontario Law Reform Commission, Report on the Coroner System in Ontario (1971) (hereinafter "Report on Coroners, 1971") at 25

While the Report noted that the coroner's inquest serves an important investigative function in determining who the deceased was, where, when, how and by what means she died, it also stated that a coroner's inquest should serve a second major purpose:

> Beyond this bare determination of facts, a coroner's inquest should serve a second major purpose. This is a vehicle through which the public can formally learn of deaths that have occurred or are rumoured to have occurred under circumstances which indicate malfeasance, insufficient safeguards, failure to take precautions, neglect of human life or homicide. …In addition to providing a means through which the community can initiate corrective measures in some cases, the inquest can also allay suspicions in others by bringing out the truth in lieu of groundless supposition and potentially corrosive conjecture. A modern coroner system should be premised upon an awareness of these aspects of human nature, and should allow the conduct of inquests in response thereto.

The Ontario courts have also recognized the value of public scrutiny in deaths occurring in institutions normally shielded from public view in *Stanford v. Harris*, a case about standing at coroners' inquests:

> One of the functions of an inquest into a death in a prison or other institution not ordinarily open to public view is to provide the degree of public scrutiny necessary to ensure that it cannot be said, once the inquest is over, that there has been a whitewash or a coverup. There is no better antidote to ill-founded or mischievous allegations and suspicions than full and open scrutiny.[31]

Where the deaths of mad people in custody are treated differently, it is, as Jennifer Chambers noted in her evidence before the tribunal, that:

> the only justification for discriminating between being held in the state's custody in a prison versus a psychiatric facility is the devaluation of the feelings of our

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[31] [1989] O.J. No. 1068 (Div. Ct.) at 19 [Q.L. Version]

> community in the sense that we somehow are different than other people, that putting us in custody is somehow less serious.[32]

Justice Cory heard her voice and he heard the voices of others who had lived and worked within the mental health system and psychiatric facilities. Government lawyers critiqued the evidence of these witnesses, stating that they were not "experts" in contrast with the nurses and correctional officers (the people with the keys) called by the Crown[33]. But what if, rather than valuing the experience of those obtained in a meritocracy, we recognized the value of the experiences of those people behind the double-locked door? What if they were permitted to offer an opinion? One only needs to spend five minutes on the back ward of Oak Ridge (and I've spent some time there on more than one occasion when I saw secluded clients), and speak to a client through a small window in a steel door, to understand that the court needs to listen to those voices.

Justice Cory heard from family members about how the differential treatment made them feel. He heard about how inquests provide accountability by providing a public accounting following a death.

The Divisional Court found that the distinction in the Act is not discriminatory.[34] It noted that conditions in jails are more dangerous. It also justified the differential treatment based on the purpose of the detention in that it was "therapeutic" rather than punitive. The Divisional Court's justification for the differential treatment unfortunately promotes

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[32] Evidence of Jennifer Chambers, January 12, 2006, Human Rights Tribunal of Ontario, Transcript, page 61, lines 8 to 13

[33] The Government took the position that a person who is a Professor in Critical Disability Studies and whose Ph.D. was in the study of the experience of mad people was not an expert but argued that a nurse and a correctional officer were.

[34] It is important to note that the Divisional Court heard the case before the release of *R. v. Kapp,* 2008 SCC 41 applied the *Law* test. The Court of Appeal had the case of *R. v. Kapp* before it when it denied leave.

the view that consumers and survivors of psychiatric services are less worthy of recognition through a public examination of their deaths because the deprivation of their liberty is for their own good. This approach fails to appreciate the real experiences of the person held down by security, behind a locked or double-locked door, injected with "chemical restraint", placed in physical restraints and left in restraints at the discretion of nurses.[35]

When you look at the conditions at Oak Ridge and when you think of the death of Jeffrey James at CAMH, the fact that the purpose of the detention is "therapeutic" is cold comfort. It is also wrong in law. It is often the potential threat that mad people pose to society that keeps them detained. Whether they get treatment is actually a different issue. It is fear and it is prejudice that devalues a community under the guise of it being "for their good". If we were to strip away that fear, and hear the voices of the community as Justice Cory did, we would learn to trust those voices and validate them. When the community says, we feel less worthy – our response won't be, well, you shouldn't – it will be – well, let's change that. We won't measure the loss of dignity from the perspective of the so-called "normal", we will look to the reasonable person from the disadvantaged community. If Justice Cory's decision stood, we would have come to learn in a public and systematic way about how mad people die in our psychiatric facilities. More importantly, we might have learned how to save lives. Without opening the doors to the madhouse through public scrutiny, we are left with more of the same,

[35] Take the case of Jeffrey James who died in the summer of 2005 at the Centre for Addiction and Mental Health (Queen Street Site) after being restrained in four-point restraints for FIVE days. The discretion of the Coroner cannot be relied upon to call inquests, there had been a death in restraint before Mr. James died and no inquest had been called, despite the community's request. There has since been another death.

more continuation of the historical prejudice that mad people's lives aren't worth as much as other people's lives and more perpetuation of fear towards mad people alive today.

I have recently seen some light. The Office of the Chief Coroner (OCCO) did call an inquest into the death of Jeffrey James. The jury recommended that OCCO hold an inquest each time a person dies in physical restraint. It is significant to note that survivors had a voice at that inquest through the Empowerment Council and that the jury appears to have heard that voice.

The second beacon of hope is the dissenting judgment of Madam Justice Lang in *R. v. Conway* in which she argued that the Ontario Review Board does have the jurisdiction to grant a remedy under section 24(1) of the *Charter:*

> After decades of cultural shift, Parliament decided that *those of us with mental illness* who are declared not criminally responsible for otherwise criminal conduct should be detained in hospitals rather than incarcerated in prisons. Those detained are patients, not criminals. They do not stand accused of any crime. They are to be treated for their illness, not punished for their conduct. Many such people have illnesses or conditions that may be difficult, or impossible, to treat. As a consequence, the hospital will be their only home. Their liberty interests are severely constrained. These are some of the most vulnerable members of society. *How society treats them is a measure of our civilization*. [emphasis added]

The words "those of us with mental illness" represent a dramatic shift. They move beyond "tolerance". They represent inclusiveness, understanding and equality rather than fear, prejudice and discrimination. Madam Justice Lang saw and heard Paul Conway as he appeared on his own behalf in the Court of Appeal, assisted by *amicus curiae*.

Most recently, in response to an argument made by counsel for a person suffering from sexsomnia that he should not "be branded" as not criminally responsible by virtue of a mental disorder (NCR-MD), Justice Doherty stated (for a panel that included Justice Lang):

> The second part of Mr. Addario's submission would have the court accept the negative stereotyping of those found NCR-MD and decline to impose that verdict on the respondent because he does not fit that stereotype. No one should deny the existence of this negative stereotype and the harm it can do to those found NCR-MD. To give effect to Mr. Addario's submission would, however, promote this negative stereotype. Were the court to decline to find the respondent NCR-MD because he does not fit the negative stereotype of persons so found, the court could be taken as accepting that those who are found NCR-MD do fit that stereotype.
>
> The new mental disorder regime introduced into the *Criminal Code* in 1991 is intended to overcome the improper stereotyping of persons found NCR-MD and to provide for individualized assessment and treatment of those individuals: see *Winko*, at paras. 35-40. The courts can best play a role in the important task of overcoming the negative stereotypes associated with mental illness, not by shaping their verdicts to conform to those stereotypes, but by emphasizing both the basis for a finding of NCR-MD and by explaining what the verdict means. An NCR-MD verdict signals that an accused cannot be held responsible for what would otherwise be his or her criminal act. At the same time, it rejects any suggestion that the accused represents an automatic danger to the public. Instead, the NCR-MD verdict triggers an individualized, careful, current assessment of the accused's condition leading to a disposition tailored to the individual accused.[36]

The words are starting to come. The actions need to follow. In order for the actions to come, lawyers need to be raising the voices of the community and urging accommodation for mad people in the legal system.

We haven't conceptualized how to make mad people equal participants in the justice system. For example, the Report of Ontario's Courts Disabilities Committee, "Making Ontario's Courts Fully Accessible to Persons with Disabilities" articulates in three full

[36] *R. v. Luedecke*, 2008 ONCA 716 at paras. 118 to 119

paragraphs practical means to accommodate the Deaf community by recommending interpreters, funding, PA systems, installation of technology and more. Here is what the report says about vulnerable people including people with mental disabilities:

> a. Victim/witness programmes of the Ministry of the Attorney General across Ontario should develop specialized expertise in providing support to court participants with disabilities who require specialized supports, including court participants with mental health disabilities, developmental disabilities, and acquired brain injuries.
>
> b. Counsel should identify needs and seek appropriate accommodations from the court services official responsible for responding to accommodation and accessibility needs, relating to mental health disabilities of their clients, whether accused persons or litigants in a civil or family matter.

We have to do better. The way to do better is to engage survivors about what they need to navigate and be full participants in the justice system.

I am grateful for the opportunity to participate in this Colloquium and offer the following advice for lawyers seeking to represent and advance the rights and citizenship of mad people. Please remember that this is client instructed advocacy. You need to continue to take instructions from your client, not make decisions that you think are in your client's best interests. If you are taking money from a family member to represent a person with a mental health problem, you need to be careful. Your client is the person that you are representing. This means that you need to take instructions from them. Be critical of the experts as you would with any opposing expert. Be careful of the icon or the expert who is revered. The Emperor may have no clothes. If you are representing a mentally disordered defendant in the criminal justice system, do what you can to divert the matter out of the criminal justice system. Avoid findings of not-criminally responsible except in

the most serious cases (like murder). Do not forget about the things that you normally pursue when you have a mentally disordered client and remember to continue to ask yourself whether the case can be proven. In every tribunal and court, your predominant concern should be how to maximize the liberty of your client and how to fulfill your obligations under Rule 4.01 of the *Rules of Professional Conduct*, the commentary for which provides:

> The lawyer has a duty to the client to raise fearlessly every issue, advance every argument, and ask every question, however distasteful, which the lawyer thinks will help the client's case and to endeavour to obtain for the client the benefit of every remedy and defence authorized by law. The lawyer must discharge this duty by fair and honourable means, without illegality and in a manner that is consistent with the lawyer's duty to treat the tribunal with candour, fairness, courtesy and respect and in a way that promotes the parties' right to a fair hearing where justice can be done. Maintaining dignity, decorum, and courtesy in the courtroom is not an empty formality because, unless order is maintained, rights cannot be protected.
>
> This rule applies to the lawyer as advocate, and therefore extends not only to court proceedings but also to appearances and proceedings before boards, administrative tribunals, arbitrators, mediators, and others who resolve disputes, regardless of their function or the informality of their procedures.
>
> ….
>
> Duty as Defence Counsel - When defending an accused person, a lawyer's duty is to protect the client as far as possible from being convicted except by a tribunal of competent jurisdiction and upon legal evidence sufficient to support a conviction for the offence with which the client is charged. Accordingly, and notwithstanding the lawyer's private opinion on credibility or the merits, a lawyer may properly rely on any evidence or defences including so-called technicalities not known to be false or fraudulent.
>
> …
>
> The lawyer should never waive or abandon the client's legal rights, for example, an available defence under a statute of limitations, without the client's informed consent.

In light of the deprivation of the liberties which occur in both the civil and mental health system, advocates working on mental health issues should adhere to the commentary for defence counsel regarding their opinion on the merits of a particular case and the waiver or abandonment of a client's rights. Finally, be kinder than necessary, you never know what kind of personal struggle a person is facing.

As lawyers, we have the opportunity to change attitudes towards mad people by making courts see them as more than a diagnosis. We can do that allowing them to participate as full citizens in their matter by taking their instructions. By elevating the voices of mad people within the justice system and by insisting that they participate fully in legal and administrative proceedings affecting them, we will slowly change prevailing attitudes. It requires of us, however, to consistently challenge assumptions about how lawyers and judges do business and how our courts are physically and metaphysically constructed.