Mad Canada Shadow Report

Reporting on Human Rights by the MCSR Group to the Committee on the Rights of Persons with Disabilities in Reference to the UN-CRPD

Table of Contents

A. Introduction (pg. 2)


B. Mental Health Legislation (pg. 5)


C. Testimonies (pg. 22)

• Personal testimony of former patient Irit Shimrat.
• Excerpt from “Escape from British Columbia,” by journalist Rob Wipond.
• Excerpt from the [US] Center for the Rights of Users and Survivors of Psychiatry’s “Joint Submission to Human Rights Committee [...] on nonconsensual psychiatric medication.”

D. Statistics in Context (pg. 27)

Includes some statistical comparisons to other groups, as well as available Canadian statistics, by province and territory, on the numbers of people considered mentally ill, being hospitalized, being medicated (by age, location), being detained and deemed incapable or put on CTOs (in Ontario). Also the use of restraint and seclusion (in Ontario) and of electroshock (across Canada).

E. Ongoing Online Survey of Rights in Media and Analysis (pg. 29)

In relation to colonialism, racialization, youth, and more.

F. Recommendations (pg. 30)

This section summarizes the data in this report and makes recommendations addressing issues specific to the report.

G. Appendix (pg. 32)

Our List of Issues (submitted to the Committee in July 2016) provides a context for this report.
Introduction


What is the Mad Canada Shadow Report Group?

We are a group of people who have used the Canadian mental health system. Our shadow report on the rights of people with psychosocial disabilities is informed by our “List of Issues” (see appendix), submitted to the committee in 2016. Our group originated at a Mad Pride event in 2013, at which a panel of four disability experts discussed the CRPD).

In Vancouver, in 2014, we held group interviews on human rights in mental health contexts, using guidelines established by Disability Rights Promotion International. Two national organizations directed by persons with disabilities – the Council of Canadians with Disabilities and the National Network for Mental Health – endorsed our work.

Our committee grew from an email list in 2013, to mad researchers holding a group interview in 2014, to several of us drafting a “list of issues” for the Committee to discuss with the Canadian government in 2015 (see appendix), to our recent efforts to collect public submissions of data and work with that data online. While we cannot claim universal representation, we believe we have a network of information that is vital to the CRPD in Canada.

Mad

Some of us identify as mentally ill; some call ourselves “mad” rather than “ill”; others accept neither label. We do not share psychiatry’s view that the denial of mental illness can be a symptom of mental illness. We demand our rights as people with psychosocial disabilities in the work of the CRPD. We defend our collective rights as inmates, patients, survivors, users, consumers, m/Mad people (and any number of other identifiers we have used).

To people who question the legitimacy or wisdom of not imposing state psychiatry, we say this: What is labeled as psychosocial disability is neither a weakness to exploit, nor a fearful evil poised to bring chaos. Rather, it signifies our strength – even when we are weak – and our depth, our connectedness to real life. We reflect the society in which we live, and the society cannot simply be assumed to be healthy in spite of us.

We oppose unjust practices and laws. We oppose sanism – a prejudice that accepts torture in the name of health. We oppose the legislated labelling of distressed individuals. We oppose the imposition of capacity tests for the purpose of unseating a person’s right to choose or refuse destructive treatments. We call for assistance general enough to be of benefit to distressed and oppressed persons, including those who need time to gain confidence in others, despite being told to ignore their own perceptions and place total trust in authority.

Herein we describe the effects of imposed and coerced treatments, or tortures, in personal testimonies. We identify legal roadblocks that deny our human rights. And we call for a repeal of mental health laws and
provisions in all Canadian jurisdictions, as set out in the UN-CRPD, in particular in Articles 12, 14 and 15, as well as in General Comment No. 1 and the Guidelines on Article 14.

Canadian

Many factors determine how we are “treated” in Canadian society. These include our national health care system, how populations enter and leave Canada, provincial, territorial, urban and rural practices, and the legislation of each province or territory. However, Canada is more than a conglomeration of statistics. It is also comprised of our experiences, not only of distress but also of such oppressions as racism and sexism, classism and ableism, ageism and mentalism (which differs from “stigma” as defined by medical practitioners).

Our experiences of distress and of mental health regimes depend on where we live, the language(s) we speak, the beliefs we embrace, and so many other factors according to which our views are considered sound or unsound. But healthist decisions that override our rights need to be faced directly, and the CRPD allows us a chance to address this issue. It is a mistake to think that suffering can simply be “fixed.” All of us are interconnected, and the concept of “health” is relative. This is not to say that we should all be treated the same.

Like lawmakers and practitioners in other countries, Canadians impose treatments without seeing them as impositions, especially after the deed is done. The torture of being made to take unhealthy medicines affects us all, including our allies who have not been forcibly treated, and even the system striving to make health central to social life. Each province has a mental health act and other laws that violate the UN-CRPD’s principles. Canada needs to fix that before trying to fix us.

Shadow Reporting

This report comes from the people who live in the shadows of mental health regimes. Having so few rights under common law, we continue to document our struggles. We document as we push for non-discriminatory practices, in many contexts. This process of documentation informs a history of community knowledge-building, including human rights reporting from the ground up. This requires input from us as people subject to mental health laws, as the Convention recognizes. But it also requires the participation of people who may have secondary or even distant connections with psychosocial struggles: we all need to document abuses like electroshock without informed consent.

The CRPD

We are grateful, not only to the people who have helped and commented on our work and the organizations that have supported it, but also to the Committee, for the chance to inform Canada’s governmental report. Canada signed the Convention in 2010 (see links on page 1), but holds reservations (especially regarding Article 12, which calls for universal rights of “capacity”). Our government has not yet ratified the Optional Protocol that would make CRPD principles more salient in the courts, though it has recently said it would.

The UN-CRPD provides a framework within which we can make recommendations on improving the lives of people with (psychosocial and other) disabilities. Canada’s report does not recognize that certain legislation and practices need to be changed, and that current legislation authorizes coercive and isolating practices, whereas compliance with the CRPD requires practices that are collective and supported. It is our hope that this report will help the UN help Canada to replace coercive and discriminatory laws and practices with social and
psychological means of voluntary assistance. The removal of coercions is necessary, as set out in General Comment No. 1 and in the Guidelines on Article 14.
Mental Health Legislation

The following material highlights legislation in Canada’s 13 provincial and territorial jurisdictions that violates CRPD principles. Most examples are not bilingual. For the purpose of concision, we have quoted only the provisions for detention and treatment decisions within each Act.

With regard to analysis of changes occurring in Canadian mental health law, the Law Society of Ontario’s project, “Canada’s traditional and current capacity laws,” attempts to synthesize various opinions, and their work is worth quoting here. The Society reports that even in Alberta and Québec, where the rights to supported decision-making and co-decision-making are recognized, traditional coercions are still well established. Here are some of the project’s findings:

“Supported and co-decision-making have been introduced only relatively recently and are limited in their application. For example, Manitoba’s recognition of supported decision-making in the Vulnerable Persons Living with a Mental Disability Act applies only to people with intellectual disabilities, British Columbia’s Representation Agreement Act only allows for supported decision-making arrangements with respect to some aspects of property management, and Alberta’s Adult Guardianship and Trusteeship Act’s provisions for supported and co-decision-making apply only to personal and not property decisions.” (retrieved 2017-01-12 from http://www.lco-cdo.org/en/disabilities-call-for-papers-bach-kerzner-parti-sectionv

There is of course much more being said about the UN-CRPD and Canada. For the purposes of this report, however, we want to establish that, legally, Canada is far from repealing coercive laws. And even where more progressive laws exist, practices lag far behind them, as the Québec Ombudsman’s office reports:

“Institutions followed almost all of the Québec Ombudsman’s recommendations with regard to complaints about the application of an Act respecting the protection of persons whose mental state presents a danger to themselves or to others [CQLR c P-38.001]. Nevertheless, the Québec Ombudsman sees the same grounds for [patient] complaint arise year after year. It believes that this breach in the application of the law on a day-to-day basis points to a major problem. While this type of complaint generally includes a medical component, namely questions regarding the decisions of psychiatrists, the Québec Ombudsman remains vigilant. To ensure that users’ rights are respected, it intends to ensure that institutions and their directors of professional services accept their obligations and responsibilities with regard to the respect of rights.”

1. British Columbia


22 Involuntary Admissions

(1) The director of a designated facility may admit a person to the designated facility and detain the person for up to 48 hours for examination and treatment on receiving one medical certificate respecting the person completed by a physician in accordance with subsections (3) and (4).

(2) On receipt by the director of a second medical certificate completed by another physician in accordance with
subsections (3) and (5) respecting the patient admitted under subsection (1), the detention and treatment of that patient may be continued beyond the 48 hour period referred to in subsection (1).

(3) Each medical certificate under this section must be completed by a physician who has examined the person to be admitted, or the patient admitted, under subsection (1) and must set out

(a) a statement by the physician that the physician
   (i) has examined the person or patient on the date or dates set out, and
   (ii) is of the opinion that the person or patient is a person with a mental disorder,
(b) the reasons in summary form for the opinion, and
(c) a statement, separate from that under paragraph (a), by the physician that the physician is of the opinion that the person to be admitted, or the patient admitted, under subsection (1)
   (i) requires treatment in or through a designated facility,
   (ii) requires care, supervision and control in or through a designated facility to prevent the person’s or patient’s substantial mental or physical deterioration or for the protection of the person or patient or the protection of others, and
   (iii) cannot suitably be admitted as a voluntary patient.

(4) A medical certificate referred to in subsection (1) is not valid unless both it and the examination it describes are completed not more than 14 days before the date of admission.

(5) A second medical certificate referred to in subsection (2) is not valid unless both it and the examination it describes are completed within the 48 hour period following the time of admission.

(6) A medical certificate completed under subsection (1) in accordance with subsections (3) and (4) is authority for anyone to apprehend the person to be admitted, and for the transportation, admission and detention for treatment of that person in or through a designated facility.

(7) A patient admitted under subsection (1) to an observation unit must be transferred to a Provincial mental health facility or psychiatric unit within the prescribed period after a second medical certificate is received under subsection (2) by the director of the observation unit unless the patient is
   (a) discharged, or
   (b) released on leave or transferred to an approved home under section 37 or 38.

31 Deemed Consent to treatment and request for a second opinion

(1) If a patient is detained in a designated facility under section 22, 28, 29, 30 or 42 or is released on leave or is transferred to an approved home under section 37 or 38, treatment authorized by the director is deemed to be given with the consent of the patient.

(2) A patient to whom subsection (1) applies, or a person on the patient’s behalf, may request a second medical opinion on the appropriateness of the treatment authorized by the director once in each of the following periods:
   (a) a one month period referred to in section 23 or 24 (1) (a);
   (b) a 3 month period referred to in section 24 (1) (b);
   (c) a 6 month period referred to in section 24 (1) (c).

(3) On receipt of a second medical opinion prepared as described in subsection (2), the director must consider whether changes should be made in the authorized treatment for the patient and authorize changes the director considers should be made.

32 Direction and Discipline of patients
Every patient detained under this Act is, during detention, subject to the direction and discipline of the director and the members of the staff of the designated facility authorized for that purpose by the director.

2. Alberta

**Mental Health Act**, RSA 2000, c M-13, retrieved on 2017-01-07.

Part I
Admission and Detention

Admission certificate
2 When a physician examines a person and is of the opinion that the person is
   (a) suffering from mental disorder,
   (b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and
   (c) unsuitable for admission to a facility other than as a formal patient,
the physician may, not later than 24 hours after the examination, issue an admission certificate in the prescribed form with respect to the person.

Effect of one admission certificate
4 (1) One admission certificate is sufficient authority
   (a) to apprehend the person named in the certificate and convey the person to a facility and for any person to care for, observe, assess, detain and control the person named in the certificate during the person’s apprehension and conveyance to a facility, and
   (b) to care for, observe, examine, assess, treat, detain and control the person named in the certificate for a period of 24 hours from the time when the person arrives at the facility.

4 (2) The authority to apprehend a person and convey the person to a facility under subsection (1)(a) expires at the end of 72 hours from the time when the certificate is issued.


Co-decision-making order
13 (1) An adult on the adult’s own behalf or an interested person may apply to the Court, in accordance with the regulations, for an order appointing a co-decision-maker for an adult.

(2) The following documents must be filed in support of an application for a co-decision-making order under this section:
   (a) subject to section 105, a capacity assessment report respecting the adult who is the subject of the application, and
   (b) any other documents prescribed by the regulations.

(3) If an application under subsection (1) is made by an interested person, a notice of the application in the prescribed form must be personally served, in accordance with the regulations, on the adult who is the subject of the application.

(4) The Court may, on an application under this section, make an order appointing a co-decision-maker for an adult if
(a) the Court is satisfied that

(i) the adult’s capacity to make decisions about the personal matters that are to be referred to in the order is significantly impaired,

(ii) the adult would have the capacity to make decisions about the personal matters that are to be referred to in the order if the adult were provided with appropriate guidance and support,

(iii) less intrusive and less restrictive alternative measures than the appointment of a co-decision-maker for providing assistance to the adult in making decisions about the personal matters that are to be referred to in the order, including the making of a supported decision-making authorization, have been considered or implemented and would not likely be or have not been effective to meet the needs of the adult, and

(iv) it is in the adult’s best interests to make the order,

(b) any individual who is proposed to be appointed as a co-decision-maker consents to the appointment, and

(c) the adult consents

(i) to the appointment of any individual who is proposed to be appointed as a co-decision-maker, and

(ii) to the order.

(5) In determining whether it is in the adult’s best interests to appoint a co-decision-maker, the Court shall consider

(a) subject to section 105, the capacity assessment report respecting the adult and any other relevant information respecting the adult’s capacity,

(b) the report of the review officer,

(c) any personal directive made by the adult,

(d) any supported decision-making authorization made by the adult,

(e) whether the significant impairment of the adult’s capacity to make decisions about the matters that are to be referred to in the order is likely to expose the adult to harm,

(f) the personal matters with respect to which the adult’s capacity to make decisions has been assessed as significantly impaired and with respect to which the adult needs or will likely need to make decisions,

(g) whether the appointment of a co-decision-maker would be likely to produce benefits for the adult that would outweigh any adverse consequences for the adult, and

(h) any other matter the Court considers relevant.

3. Saskatchewan


Admission on medical certificates

24(1) In this section, “physician” means:

(a) a physician who has admitting privileges to a mental health centre; or

(b) a resident in psychiatry under the supervision of a psychiatrist who has admitting privileges to a mental health centre.

(2) Every certificate issued for the purposes of this section is to be in the prescribed form and is to:
(a) state that the physician has examined the person named in the certificate within the preceding 72 hours and that, on the basis of the examination and any other pertinent facts regarding the person or the person’s condition that have been communicated to the physician, he or she has reasonable grounds to believe that:

(i) the person is suffering from a mental disorder as a result of which he or she is in need of treatment or care and supervision that can be provided only in a mental health centre;

(ii) as a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his or her need for treatment or care and supervision; and

(iii) as a result of the mental disorder, the person is likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration if he or she is not detained in a mental health centre;

(b) state the facts on which the physician has formed his or her opinion that the person meets the criteria set out in clause (a);

(c) show the date on which the examination was made; and

(d) be signed in the presence of one subscribing witness.

(3) On the issuance of the certificates of two physicians at least one of whom is a psychiatrist:

(a) a person who is not an in-patient in a mental health centre may be apprehended, conveyed and admitted to a mental health centre and detained there until the end of the 21st day following the day that he or she is admitted;

(b) a person who is an in-patient in a mental health centre may be detained there until the end of the 21st day following the date of issuance of the first of the certificates.

4. **Manitoba**

**Mental Health Act**, Mental Health Act, CCSM c M110, in force since Jun 12, 2014, retrieved on 2017-01-07.

Meaning of incapacity for personal care

3 For the purpose of Parts 8 and 9, a person is incapable of personal care if he or she is repeatedly or continuously unable, because of mental incapacity, to:

(a) care for himself or herself; and

(b) make reasonable decisions about matters relating to his or her person or appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Patient may be detained if danger

5(2) A person on the treatment staff of a facility may detain and, if necessary, restrain a voluntary patient requesting to be discharged, if the staff member believes on reasonable grounds that the patient

(a) is suffering from a mental disorder;

(b) because of the mental disorder, is likely to cause serious harm to himself or herself or to another person, or to suffer substantial mental or physical deterioration, if he or she leaves the facility; and

(c) needs to be examined by a physician to determine if an application for an involuntary psychiatric assessment should be made under subsection 8(1).

Determining competence to consent

8(2) In determining whether a person is mentally competent to consent to a voluntary assessment under clause (1)(c), the physician shall consider whether the person understands the nature and purpose of an assessment and whether the
person’s condition affects his or her ability to appreciate the consequences of giving or withholding consent.

Requirements for involuntary admission
17(1) After examining a person for whom an application has been made under subsection 8(1) and assessing his or her mental condition, the psychiatrist may admit the person to the facility as an involuntary patient if he or she is of the opinion that the person

(a) is suffering from a mental disorder;

(b) because of the mental disorder,
   (i) is likely to cause serious harm to himself or herself or to another person, or to suffer substantial mental or physical deterioration if not detained in a facility, and
   (ii) needs continuing treatment that can reasonably be provided only in a facility; and

(c) cannot be admitted as a voluntary patient because he or she refuses or is not mentally competent to consent to a voluntary admission.

5. Yukon Territory


Involuntary admission

13(1) The physicians who have examined a person pursuant to a recommendation and who have assessed the person's mental condition may admit the person as an involuntary patient of the hospital by each completing and filing with the person in charge of the hospital a certificate of involuntary admission in the prescribed form if the physicians believe on reasonable grounds

(a) that the person is suffering from a mental condition that, unless the person remains in the custody of a hospital, is likely to result in
   (i) serious bodily harm to the person or to another person, or
   (ii) the person’s impending serious mental or physical impairment; and

(b) that the person is not suitable for admission as a voluntary patient.

(7) An involuntary patient may be detained, observed, and examined in a hospital for not more than 21 days under a certificate of involuntary admission. S.Y. 2003, c.21, s.19;

Restraint

(7) Un patient en placement non volontaire peut être détenu, observé et examiné dans un hôpital pendant une période maximale de 21 jours en vertu d’un certificat d’admission non volontaire.
18(1) The authority given in this Act to detain a person is authority to keep the person under control to prevent physical harm to the person or to another person by the minimal use of any force, mechanical means, or chemicals that is reasonable having regard to the physical and mental condition of the person.

TREATMENT OF PATIENTS

21(1) Care and treatment under this Act requires consent or substitute consent under the Care Consent Act except where that Act provides that consent is not required.

(5) Despite anything in this section, no patient, whether voluntary or involuntary, shall without the consent or substitute consent of the patient and the consent of the board be given any of the following forms of treatment for the purpose of treating a mental disorder:

(a) a procedure that by direct access to the brain removes, destroys, or interrupts the normal connections of the brain; or

(b) a form of treatment designated in the regulations.

6. Northwest Territories

Mental Health Act, RSNWT 1988, c M-10, in force since Oct 1, 2015, retrieved on 2017-01-08.
b) l’admet dans un hôpital à titre de malade en cure volontaire, en conformité avec l’article 6;

c) demande qu’elle soit admise à titre de malade en cure obligatoire dans un hôpital, en remplissant et en déposant auprès du ministre la demande de certificat de cure obligatoire, prévue à l’article 15, s’il estime qu’elle ne devrait pas être admise à titre de malade en cure volontaire et qu’elle souffre de troubles mentaux d’une nature ou d’un caractère tel qu’ils auront probablement l’une des conséquences suivantes, si elle ne demeure pas sous la garde d’un hôpital :

(i) elle s’infligera des lésions corporelles graves,

(ii) elle infligera des lésions corporelles graves à autrui,

(iii) elle souffrira d’un affaiblissement physique imminent et grave.

TREATMENT

Examination to determine mental competence

19.1. (1) Before administering medical or psychiatric treatment to a voluntary or involuntary patient admitted or detained in accordance with this Act, the medical practitioner shall examine the patient to determine whether the patient is mentally competent to give a valid consent to the treatment.

New examination

(2) A new examination under subsection (1) is required each time that there is to be a significant change in the treatment administered to the patient.

Finding of mental incompetence

(3) Where, after an examination made under subsection (1), the medical practitioner is of the opinion that the patient is not mentally competent to give a valid consent, the medical practitioner shall

(a) make a finding of mental incompetence by completing the prescribed form and filing the form with the person in charge;

(b) inform the patient of the finding of mental incompetence and of his or her right to have the finding reviewed under subsection 26.1(1); and

(c) choose the substitute consent giver in accordance with section 19.2.

TRAITEMENT

Examen en vue de déterminer la capacité mentale

19.1. (1) Avant d’administrer un traitement médical ou psychiatrique à un malade en cure volontaire ou obligatoire admis ou détenu sous le régime de la présente loi, le médecin l’examine afin de déterminer s’il est mentalement capable de donner un consentement valable au traitement.

Nouvel examen

(2) Un nouvel examen est nécessaire chaque fois qu’un changement important est apporté au traitement administré au malade.

Détermination de l’incapacité

(3) Le médecin qui, après avoir effectué l’examen visé au paragraphe (1), est d’avis que le malade n’est pas mentalement capable de donner un consentement valable :

a) prononce son incapacité mentale, remplit la formule réglementaire et la remet au responsable;

b) l’informe de la détermination de son incapacité mentale et de son droit de présenter une requête en contrôle judiciaire en vertu du paragraphe 26.1(1);

c) choisit le subrogé en conformité avec l’article 19.2.
7. Nunavut

**Mental Health Act**, RSNWT (Nu) 1988, c M-10, in force since Jun 8, 2012, retrieved on 2017-01-09.

Examination and application for involuntary admission

13. (2) Where the criteria set out in subsection (1) are satisfied, but a medical practitioner is of the opinion that the person is not suitable for admission as a voluntary patient, the medical practitioner shall apply to admit the person as an involuntary patient to a hospital by completing and filing with the Minister an application for a certificate of involuntary admission as set out in section 15. R.S.N.W.T. 1988,c.43 (Supp.),s.3; S.Nu. 2012,c.17,s.19(10).

Appointment of representative

19.5. (1) A voluntary or involuntary patient who is mentally competent to do so may appoint a representative who is apparently mentally competent to give or withhold consent to treatment on behalf of the patient at any time when the patient is not mentally competent to consent on his or her own behalf.

8. Newfoundland and Labrador

**Mental Health Care and Treatment Act**, SNL 2006, c M-9.1, in force since Jun 5, 2014, retrieved on 2017-01-09

Certificate of involuntary admission

17. (1) A certificate of involuntary admission shall be in the approved form and shall contain the following information:

(a) a statement by a person described in subsection 17(2) that he or she has personally conducted a psychiatric assessment of the person who is named or described in the certificate within the immediately preceding 72 hours, making careful inquiry into all of the facts necessary for him or her to form an opinion as to the nature of the person’s mental condition;

(b) a statement by the person who has conducted the psychiatric assessment referred to in paragraph (a) that, as a result of the psychiatric assessment, he or she is of the opinion that the person who is named or described in the certificate

(i) has a mental disorder, and
(ii) as a result of the mental disorder

(A) is likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration or serious physical impairment if he or she is not admitted to and detained in a psychiatric unit as an involuntary patient,

(B) is unable to fully appreciate the nature and consequences of the mental disorder or to make an informed decision regarding his or her need for treatment or care and supervision, and

(C) is in need of treatment or care and supervision that can be provided only in a psychiatric unit and is not suitable for admission as a voluntary patient;

(c) a description of the facts upon which the person who has conducted the psychiatric assessment has formed the opinion described in subparagraphs (b)(i) and (ii), distinguishing between the facts observed by him or her and those that have been communicated by another person;
35. (1) Where a person is an involuntary patient, the attending physician or other person may, taking into account the best interests of the involuntary patient, perform or prescribe diagnostic procedures that he or she considers necessary to determine the existence or nature of a mental disorder, and administer or prescribe medication or other treatment relating to the mental disorder without the consent of the involuntary patient during the period of detention.

(2) For the purpose of subsection (1), in taking into account the best interests of the involuntary patient, the attending physician or other person shall consider

(a) whether the mental condition of the involuntary patient will be or is likely to be improved by the specified treatment;

(b) whether the mental condition of the patient will improve or is likely to improve without the specified treatment;

(c) whether the anticipated benefit from the specified treatment and other related medical treatment outweighs the risk of harm to the patient;

(d) whether the specified treatment is the least restrictive and least intrusive treatment that meets the requirements of paragraphs (a), (b) and (c); and

(c) the wishes of the involuntary patient expressed when the involuntary patient was competent.

(3) In the course of the application of diagnostic procedures or the administration of treatment, the attending physician and another health care professional involved in the treatment of the involuntary patient shall, where appropriate,

(a) consult with the involuntary patient and his or her representative;

(b) explain to the involuntary patient and his or her representative the purpose, nature and effect of the diagnostic procedure or treatment; and

(c) give consideration to the views of the involuntary patient and his or her representative with respect to the diagnostic procedure or treatment and alternatives and the manner in which diagnostic procedures or treatment may be provided.

9. Nova Scotia


Admission as involuntary patient

17 Where a psychiatrist has conducted an involuntary psychiatric assessment and is of the opinion that

(a) the person has a mental disorder;

(b) the person is in need of the psychiatric treatment provided in a psychiatric facility;

(c) the person, as a result of the mental disorder,

(i) is threatening or attempting to cause serious harm to himself or herself or has recently done so, has recently caused serious harm to himself or herself, is seriously harming or is threatening serious harm towards another person or has recently done so, or
(ii) is likely to suffer serious physical impairment or serious mental deterioration, or both;

(d) the person requires psychiatric treatment in a psychiatric facility and is not suitable for inpatient admission as a voluntary patient; and

(e) as a result of the mental disorder, the person does not have the capacity to make admission and treatment decisions, the psychiatrist may admit the person as an involuntary patient by completing and filing with the chief executive officer a declaration of involuntary admission in the form prescribed by the regulations. 2005, c. 42, s. 17.

Capacity to make treatment decision

18 (1) In determining a patient’s capacity to make a treatment decision pursuant to clause 17(e), the psychiatrist shall consider whether the patient fully understands and appreciates

(a) the nature of the condition for which the specific treatment is proposed;

(b) the nature and purpose of the specific treatment;

(c) the risks and benefits involved in undergoing the specific treatment; and

(d) the risks and benefits involved in not undergoing the specific treatment;

(2) In determining a patient’s capacity to make a treatment decision, the psychiatrist shall also consider whether the patient’s mental disorder affects the patient’s ability to fully appreciate the consequences of making the treatment decision.

10. Prince Edward Island

Mental Health Act, RSPEI 1988, c M-6.1, in force since Dec 6, 2013, retrieved on 2017-01-09.

Detention of patient in the interests of safety

5. (5) Where a member of the treatment staff of the psychiatric facility has reasonable grounds to believe that a voluntary patient seeking to be discharged

(a) is suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of the person’s own safety or the safety of others; and

(b) is refusing to undergo psychiatric examination, the member may restrain the patient and arrange for a physician to examine the patient within eight hours in accordance with section 6.

Involuntary admission

13. (1) A psychiatrist who has received an application for an involuntary psychiatric assessment of a person under subsection 6(1) and who has assessed the person may confirm the admission of the person as an involuntary patient of the psychiatric facility by completing and filing with the administrator a certificate of involuntary admission in the form prescribed by the regulations if the psychiatrist is of the opinion that the person

(a) is suffering from a mental disorder of a nature or degree so as to require hospitalization in the interests of the person’s own safety or the safety of others; and

(b) is refusing or is unable to consent to voluntary admission.
Substituted consent

24. (6) Where a patient is incapable and requires psychiatric or medical treatment, a substitute decision-maker, such as a guardian or a person who, in the opinion of the attending psychiatrist, is the most appropriate member of the patient’s family or other person who has a close relationship with the patient, may give or refuse consent.

(7) Where no appropriate substitute decision-maker is available or the substitute decision-maker requests it, the administrator shall send a copy of the certificate of incapacity to such public official as may be empowered with the duty of public guardianship or as may otherwise be designated by the Minister.

11. New Brunswick


8(1) Un psychiatre traitant, après l’observation, l’examen et l’évaluation de la personne visée à un certificat d’examen délivré en application de l’article 7.1 ou visée à une ordonnance pour examen rendue par un juge en application de la présente loi,

c) doit déposer auprès du président du tribunal compétent une demande d’ordonnance d’admission de la personne dans un établissement psychiatrique à titre de malade en placement non volontaire, établie au moyen de la formule que le ministre lui fournit, s’il est d’avis

(i) que cette personne est atteinte d’un trouble mental,

(ii) que le comportement récent de cette personne risque sérieusement de causer un tort physique ou psychologique imminent à elle-même ou à autrui,

(iii) que la personne n’est pas justiciable d’une admission à titre de malade en placement volontaire, et

(iv) que des mesures moins contraignantes seraient inappropriées.

8.01(1) Avant de déposer une demande auprès du président d’un tribunal en application de l’article 8, le psychiatre traitant doit, si elle est âgée d’au moins seize ans, évaluer la capacité mentale de la personne visée à la demande afin d’établir si, à son avis, elle est capable mentalement de donner ou de refuser de donner son consentement au traitement médical clinique de routine.


8(1) An attending psychiatrist, after observing, examining and assessing a person who is the subject of an examination certificate issued under section 7.1 or of an order for examination made by a judge under this Act,

c) shall file an application on a form provided by the Minister with the chairman of the tribunal having jurisdiction for an order that the person be admitted to a psychiatric facility as an involuntary patient if the attending psychiatrist is of the opinion that

(i) the person suffers from a mental disorder,

(ii) the person’s recent behaviour presents a substantial risk of imminent physical or psychological harm to the person or to others,

(iii) the person is not suitable for admission as a voluntary patient, and

(iv) less restrictive alternatives would be inappropriate.
8.01(1) Before filing an application with the chairman of a tribunal under section 8, the attending psychiatrist shall, if the person has reached the age of sixteen years, assess the mental competence of the person who is the subject of the application to determine if, in the attending psychiatrist’s opinion, the person is mentally competent to give or refuse to give consent in relation to routine clinical medical treatment.

12. Québec


CHAPITRE II
LA GARDE

SECTION I
GARDE PRÉVENTIVE ET GARDE PROVISOIRE

6. Seuls les établissements exploitant un centre local de services communautaires disposant des aménagements nécessaires ou un centre hospitalier peuvent être requis de mettre une personne sous garde préventive ou sous garde provisoire afin de lui faire subir un examen psychiatrique.

7. Tout médecin exerçant auprès d’un tel établissement peut, malgré l’absence de consentement, sans autorisation du tribunal et sans qu’un examen psychiatrique ait été effectué, mettre une personne sous garde préventive dans une installation maintenue par cet établissement pendant au plus soixante-douze heures, s’il est d’avis que l’état mental de cette personne présente un danger grave et immédiat pour elle-même ou pour autrui.

An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others, CQLR c P-38.001, in force since Jun 24, 2002, retrieved on 2017-01-10.

CHAPTER II
CONFINEMENT

DIVISION I
PREVENTIVE CONFINEMENT AND TEMPORARY CONFINEMENT

6. Only an institution operating a local community service centre equipped with the necessary facilities or a hospital centre may be required to place a person under preventive confinement or temporary confinement for psychiatric examination. 1997, c. 75, s. 6.

7. A physician practising in such an institution may, notwithstanding the absence of consent, place a person under preventive confinement for not more than 72 hours in a facility maintained by the institution, without the authorization of the court and prior to psychiatric examination, if he is of the opinion that the mental state of the person presents a grave and immediate danger to himself or to others.

DIVISION II
CONFINEMENT AUTHORIZED BY A COURT PURSUANT TO ARTICLE 30 OF THE CIVIL CODE

9. Only an institution operating a hospital centre, rehabilitation centre, residential and long-term care centre or reception centre that is equipped with the necessary facilities for receiving and treating mentally ill persons, may be required to place a person under confinement following a court judgment pursuant to article 30 of the Civil Code. 1997, c. 75, s. 9.

10. Where the court has set a duration of confinement exceeding 21 days, the person under confinement must be examined periodically to ascertain whether continued confinement is necessary, and reports of such examinations must be produced at the following times:

   (1) 21 days from the date of the decision made by the court pursuant to article 30 of the Civil Code;
   (2) every three months thereafter.


LIVRE PREMIER
DES PERSONNES

TITRE DEUXIÈME
DE CERTAINS DROITS DE LA PERSONNALITÉ

CHAPITRE PREMIER
DE L’INTÉGRITÉ DE LA PERSONNE

10. Toute personne est inviolable et a droit à son intégrité. Sauf dans les cas prévus par la loi, nul ne peut lui porter atteinte sans son consentement libre et éclairé. 1991, c. 64, a. 10.

SECTION I
DES SOINS

11. Nul ne peut être soumis sans son consentement à des soins, quelle qu’en soit la nature, qu’il s’agisse d’examens, de prélèvements, de traitements ou de toute autre intervention. Sauf disposition contraire de la loi, le consentement n’est assujetti à aucune forme particulière et peut être révoqué à tout moment, même verbalement.

Si l’intéressé est inapte à donner ou à refuser son consentement à des soins et qu’il n’a pas rédigé de directives médicales anticipées en application de la Loi concernant les soins de fin de vie (chapitre S-32.0001) et par lesquelles il exprime un tel consentement ou un tel refus, une personne autorisée par la loi ou par un mandat de protection peut le remplacer.


BOOK ONE
PERSONS
TITLE TWO
CERTAIN PERSONALITY RIGHTS

CHAPTER I
INTEGRITY OF THE PERSON

10. Every person is inviolable and is entitled to the integrity of his person. Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent. 1991, c. 64, a. 10.

DIVISION I
CARE

11. No one may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent. Except as otherwise provided by law, the consent is subject to no other formal requirement and may be withdrawn at any time, even verbally.

If the person concerned is incapable of giving or refusing his consent to care and has not drawn up advance medical directives under the Act respecting end-of-life care (chapter S-32.0001) by which he expresses such consent or refusal, a person authorized by law or by a protection mandate may do so in his place.

13. Ontario


Conditions for involuntary admission

20. (1.1) The attending physician shall complete a certificate of involuntary admission, a certificate of renewal or a certificate of continuation if, after examining the patient, he or she is of the opinion that the patient,

(a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person;

(b) has shown clinical improvement as a result of the treatment;

(c) is suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(d) given the person’s history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment;

(e) has been found incapable, within the meaning of the Health Care Consent Act, 1996, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained; and

(f) is not suitable for admission or continuation as an informal or voluntary patient. 2000, c. 9, s. 7 (2); 2015, c. 36, s. 1.

(5) The attending physician shall complete a certificate of involuntary admission, a certificate of renewal or a certificate
of continuation 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. R.S.O. 1990, c. M.7, s. 20 (5); 2000, c. 9, s. 7 (3, 4); 2015, c. 36, s. 1.


Capacity

4. (1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1996, c. 2, Sched. A, s. 4 (1).


Conditions de l’admission en cure obligatoire

20 (1.1) Le médecin traitant remplit un certificat d’admission en cure obligatoire, un certificat de renouvellement ou un certificat de maintien si, après avoir examiné le malade, il est d’avis que celui-ci remplit les conditions suivantes :

a) il a déjà reçu un traitement pour des troubles mentaux continus ou récidivants qui, lorsqu’ils ne sont pas traités, sont d’une nature ou d’un caractère qui aura probablement comme conséquence que le malade s’inflictera ou infligera à une autre personne des lésions corporelles graves ou qu’il subira une détérioration mentale ou physique importante ou un affaiblissement physique grave;

b) il a connu une amélioration sur le plan clinique de son état par suite du traitement;

c) il souffre du même trouble mental que celui pour lequel il a déjà été traité ou d’un trouble mental semblable;

d) étant donné ses antécédents de troubles mentaux et son état mental ou physique actuel, il risque probablement de s’inflicter ou d’infliger à une autre personne des lésions corporelles graves ou de subir une détérioration mentale ou physique importante ou un affaiblissement physique grave;

e) il a été jugé incapable, au sens de la Loi de 1996 sur le consentement aux soins de santé, de consentir à son traitement dans un établissement psychiatrique et le consentement de son mandataire spécial a été obtenu;

f) il ne convient pas de l’admettre à titre de malade en cure facultative ou volontaire ni de le maintenir en cure facultative ou volontaire. 2000, chap. 9, par. 7 (2); 2015, chap. 36, art. 1.
Capacité

4. (1) Toute personne est capable à l’égard d’un traitement, de son admission à un établissement de soins ou d’un service d’aide personnelle si elle est apte à comprendre les renseignements pertinents à l’égard de la prise d’une décision concernant le traitement, l’admission ou le service d’aide personnelle, selon le cas, et apte à évaluer les conséquences raisonnablement prévisibles d’une décision ou de l’absence de décision. 1996, chap. 2, annexe A, par. 4 (1).
Testimonies

Personal testimony on psychiatric treatment in Canada, by Irit Shimrat:

I will never forget, though I wish I could, what psychiatric brutality feels like. Being taken to hospital by the cops, by brute force, in handcuffs, though my only crime was confusion. Being stripped naked in front of male orderlies. Being shackled to a gurney on the psychiatric emergency ward. Having a nurse painfully jab me in the ass with a needle containing a drug that had immediate, nightmarish effects. Being ignored by chatting nurses as I whispered, then said out loud, then screamed that I had to go to the bathroom. Being left to lie in my own shit for hours, while they continued to discuss boyfriends and weekend plans.

Being wheeled to a concrete cell, furnished only with a mattress on the floor, a metal toilet, attached to a tiny sink; an observation window in the metal door; and a camera in the corner of the ceiling. Being left there for days, under the glaring fluorescent light, with someone coming in for a second, three times a day, to leave a sad, bland meal in a plastic tray on the floor and remove the previous tray. Performing for the camera and writing on the walls with my shit as the drugs that were supposed to knock me out made me crazier and crazier.

Finally being released onto the ward, but being slammed back into solitary confinement every time I “acted out.” Slowly and painfully learning to conform, so as to earn such “privileges” as being allowed to wear, first, real pyjamas (as opposed to open-backed hospital gowns), and then my own clothes; being allowed out for a cigarette; being allowed to make a phone call. Being mocked and mistreated by burned-out nurses.

Finally being allowed visitors, only to have them stare at me in horror and pity as I shuffled like a zombie, much too drugged to make conversation. Eventually learning the magic words that got me out: “I understand that I am sick and need to take these drugs for the rest of my life.” Drugs that had already resulted in dry mouth; flaking skin; extreme constipation; painful muscle spasms; inability to sit, stand or lie still. This is not to mention the drugs’ effects on my mind: the terror, the despair, my absolute inability to hang onto my self. The certainty – my only certainty – that I had died and gone to hell. That I was being punished for crimes I couldn’t remember. That I would never be able to live in the world again.

I was wrong in that certainty, but it’s been a hard road back, and I’ve had to travel it many times. Always, when I’m first back out in the world, I find myself suffering from the effects of institutionalization, terrified of the loneliness, of having to take care of myself, of not being able to make it outside the bin. I’ve had to suffer the withdrawal symptoms from whatever they were forcing me to take, which I stop taking as soon as I get out. I’ve had to punish myself, hit myself, scream at myself for having been such an idiot as to get locked up again. I’ve had to go through weeks or months of wanting to kill myself in order to make sure this never happened to me again. I’ve had to slowly rebuild my life. And I’ve had to live with the permanent effects, physical and emotional, of being poisoned with psychiatric drugs and traumatized by institutional cruelty.

My life has been a sheltered one, on the whole. I was born and raised in a comfortable middle-class family, with lots of parental love and support and no violence or neglect. I have never been raped or beaten or hungry. Nevertheless, I have gone crazy, several times, over the years, always in response to a degree of trauma. But being crazy wasn’t, in itself, a bad thing. If I had been allowed to go through it – if I had been treated with kindness and compassion, and encouraged to explore my thoughts and visions and make sense of them – my madness could have remained the wonderful experience that it invariably started out as. It could have enriched me.

The only really bad thing that has ever happened to me is psychiatry. It has damaged my body and mind, fractured my self-esteem, and forced me to re-invent myself, again and again, every time it tore me apart.
Excerpt from Canadian journalist Rob Wipond’s “Escape from British Columbia”

The following excerpt from an article published in the November/December 2016 issue of Focus Magazine provides a brief but insightful representation of what people feel as they lose their freedom of movement, their freedom of choice and their freedom to control over what happens to their own bodies – all in the name of making their thoughts and feelings “healthy” through psychiatric intervention. It depicts not only the need to escape intervention (and, in particular, drugging), but also the self-empowerment of survivors of unwanted psychiatric interventions. In this account, Sarah tries to evade state-imposed coerced psychiatric treatment.

Sarah requested an appeal. Her psychiatrist didn’t have to, but chose to stop forcibly medicating her. Faculties back intact, Sarah researched and discovered that Alberta’s laws were different. She began preparing an escape plan, just in case.

The review panel for Sarah’s appeal reached a 2-1 split decision– leaving Sarah incarcerated. She began a silent protest, giving staff handwritten objections when they handed her drugs. For two days, her tight-lipped protest also provided a cover for tonguing and not ingesting the pills. But her psychiatrist soon proposed an antipsychotic injection that would keep Sarah drugged for weeks. Sarah worried that her thinking would become so foggy she’d never be able to execute her plan. “I knew I had to leave,” she says.

Into a small satchel bag she stuffed a change of clothes. Cash she’d been withdrawing to avoid using a trackable credit card. Her iPad. She acted like she was going for a smoke break, walked to where she could get a taxi, and got out where she could disappear into a crowd. She changed her clothes in a public bathroom and threw out the ones she’d been wearing at the hospital. She cut off her hair. Then she bought a ticket for a red-eye bus to Alberta.

“It was the most nerve-wracking bus ride of my life,” says Sarah. “I had a feeling every time we stopped that there would be RCMP waiting for me.”

The driver announced when the bus had crossed into Alberta and begun the descent from the mountains. “I actually got very emotional as I crossed the border,” says Sarah. “I’d spent the entire night in the dark...It was really beautiful, early in the morning, the sun was coming up...I was crying, and there was somebody sitting a couple seats from me, said ‘Are you okay?’ And I was like, ‘Yeah, I’m fine.’”

But as the bus sped into Calgary, she saw her picture appear on the RCMP website as a “missing person,” along with a warrant for her arrest.

Excerpts from “Joint Submission to Human Rights Committee for its review of the United States in October 2013 on nonconsensual psychiatric medication” – a report produced by the Center for the Rights of Users and Survivors of Psychiatry, US.

This piece of research on how people undergo therapies only to become debilitated, blunted, confused and lost in the shuffle comes from an American description of the effects of psychiatrization. These experiences are echoed in the testimonies we hear in Canada, and, since psychiatric structures operate transnationally, we can draw on them as a basis for communicating the severity of injury, constraint, and self-restriction experienced by Canadian recipients of psychiatric treatment.
A. Research evidence

Neuroleptic Medications Are Known and Established to Cause Tangible Medical Harm.

This harm is significant, reinforcing the Special Rapporteur’s concerns that forceful use of neuroleptics, or their use over a person’s objections, amounts to torture or ill treatment. These harms include: Dysphoria, Tardive Dyskinesia (TD), Akathisia, Drug-Induced Parkinsonism, Dystonia, Adverse Cardiac Effects, Autonomic Side Effects, Metabolic Syndrome, and, rarely, Neuroleptic Malignant Syndrome (NMS). Additionally, there is concern that neuroleptic medication is at least partially implicated in a well-established 13-30 year loss of life for individuals with psychiatric disabilities. Lastly, research suggests that administration of neuroleptic medication causes permanent structural changes in the brain.

Neuroleptic dysphoria (ND) is an all-inclusive descriptive phrase that encompasses a variety of unpleasant subjective changes in arousal, mood, thinking and motivation induced by neuroleptic drugs. Also sometimes referred to as “neuroleptic-induced anhedonia” this reaction has been described with virtually all conventional neuroleptics, regardless of dose or type of medication. It has been estimated to occur in as many as 60% of persons treated with neuroleptics, and is acknowledged as a frequent reason for persons to refuse to take neuroleptics. The scientific literature has been aware of this phenomenon for nearly fifty years. It is believed to be related to the mechanism of action for these medications, and unavoidable given their intended effects on dopamine neurotransmission.

Akathisia is a very common effect of neuroleptic medication, occurring in as many as 49% of those receiving neuroleptic medications. Individuals experience a sense of inner restlessness, mental unease, unrest or dysphonia. Restless movements, such as rocking from foot to foot, walking on the spot, shuffling and swinging one leg on the other while sitting, may be associated with the subjective experience. Rapid pacing up and down is characteristic of severe cases; such patients may find it impossible to sit, lie or stand in any one position for more than a few minutes. It is the same experience that many withdrawing from opiates feel, except that it can become chronic in as many as a third of patients receiving neuroleptic medication. Unfortunately, akathisia is often misdiagnosed as psychotic agitation, with a consequent increase in the dose of antipsychotic, which only leads to further deterioration.

Tardive Dyskinesia (TD) is a movement disorder, occurring after months or years of neuroleptic treatment. It involves random movements in the tongue, lips or jaw as well as facial grimacing, involuntary eye movements, and random movements of the extremities. In addition to causing serious discomfort and impairment of mobility, TD can be extremely embarrassing to a person experiencing it, and frequently carries significant social stigma. The prevalence of tardive dyskinesia is estimated to be 10 to 20 percent of individuals treated with anti-psychotic medications. Once Tardive Dyskinesia develops, complete and persistent reversibility is rare, occurring in as few as 2% of cases. It is frequently lifelong and irreversible, even after discontinuation of medication.

Drug-Induced Parkinsonism has essentially the same symptoms as Parkinson’s disease. Parkinsonian symptoms induced by neuroleptics or dopamine depleting drugs cannot be distinguished clinically from those seen in PD. It occurs in 15 to 40 percent of persons taking neuroleptic medication, depending on medication and dose. The symptoms include showing little or no facial expression, soft or slurred speech, shaking hands, stiffness and slowing of movement, and difficulty writing.

Dystonia typically involves muscle contractions that result in abnormal postures, such as an inability to move one’s head due to neck contractions, difficulty swallowing, or a locking of one or both of one’s eyes to one side with an inability to redirect one’s gaze. Acute dystonia occurs within 48 hours of beginning neuroleptic treatment in 2.5% of those treated.

Adverse Cardiac Effects and Autonomic Side Effects from neuroleptic medications include cardiac
arrhythmia, prolonged QT interval, and significant reductions in blood pressure. In 1990 pimozide was reported to have caused 13 deaths among young patients in the United Kingdom who were using dosages in excess of 20 mg a day. In 1996 sertindole was responsible for 16 deaths from cardiac causes among 2,194 patients who participated in clinical trials.

Metabolic Syndrome typically results in significant weight gain and hyperglycemia, and has been shown to include a neuroleptic-increased risk of type 2 diabetes. A person administered second-generation neuroleptic medication has 3.6 times the risk of developing a metabolic syndrome. When it occurs, the onset of diabetes tends to occur within the first few months of treatment with these drugs. Type 2 diabetes is a lifelong condition, which persons with psychiatric diagnoses may already be at increased risk for, rendering the additional risk of this irreversible condition from neuroleptics all the more concerning in the context of force.

Neuroleptic Malignant Syndrome (NMS) is rare but potentially fatal. Prospective studies have provided disparate estimates of the frequency of NMS, ranging from 0.07% to 2.2% among patients receiving neuroleptics. The syndrome is a form of malignant hyperthermia involving muscle contractions and a life-threatening rapid rise in body temperature.

Persons in the public mental health system in the United States experience a 13-30 year loss of life expectancy. While the exact reasons for this loss of life expectancy are in dispute, it is likely that the harmful effects of neuroleptic medication, especially the cardiac and metabolic effects, are a contributing factor to this discrepancy between the normal lifespan and that seen by persons with psychiatric disabilities. Even if the contribution of the medications is only partial to this loss of life, the forcible administration of them is tantamount to the forcible deprivation of a significant portion of a human being’s life.

Lastly, there is strong evidence that neuroleptic medication produces irreversible changes in the human brain, becoming more pronounced the longer one is on them. Very few studies have been done on nonmedicated patients, and, tellingly, studies of neuroleptic changes to the brains of normal controls would be unconscionable. With the documented risk of changing the brains of human beings – indeed their very essences – free and informed consent of the person concerned is essential. Given the number and variety of irreversible negative effects from neuroleptics, along with the evidence of structural changes induced by them in the brain, the administration of neuroleptic medication by force is akin to maiming. Even if the claims of therapeutic purpose and effect are accepted at face value, it is still maiming if done over the objections of the one so modified.

Notes:

24 “Tardive Dyskinesia” National Alliance on Mental Illness <http://www.nami.org/Content/ContentGroups/Helpline1/Tardive_Dyskinesia.htm>
“Tardive Dyskinesia” Mental Health America <http://www.nmha.org/go/information/get-info/tardive-dyskinesia>


“Parkinson’s disease” Mayo Clinic <http://www.mayoclinic.com/health/parkinsons-disease/DS00295/DSECTION=symptoms>


Statistics in Context


Population estimated to be “mentally ill”: 6.7 million Canadians or 1 in 5. (MHCC, 2014)

“Hidden” homelessness (meaning not counted in state records, but living without shelter): 2.3 million or 8% (Statistics Canada, 2014)

Approximately 1 in 7 Canadians used ‘mental health’ services in 1996 and in 2010. (Health Canada, 2015).

Health care recipients largely did not report difficulty in accessing care (e.g., waiting lists): 71% (Statistics Canada, 2013)

Impaired driving incidents: 72,039, or 201 incidents per 100,000 population. (Statistics Canada, 2015)

“Daily or occasional smokers”: 18.1% (Canadian Institute for Health Information, 2015)

Homicides: 604 (Statistics Canada, 2015)

Hospital Deaths: 93 (Canadian Institute for Health Information, 2015)

“Aboriginal identity” population: 3.754% of total (Statistics Canada, 2006)

Suicidal thoughts amongst First Nations, Métis and Inuit young adults in 12 months: 5% on reserves, 2.5% off reserves; 20-25% in their lifetime. (Aboriginal Peoples Survey; Statistics Canada, 2012)

“Residents on antipsychotic drugs in long-term care homes without a diagnosis of psychosis”: 23.9% (Canadian Institute for Health Education, 2015). More used in Newfoundland and Labrador than other jurisdictions. See an opinion piece in the Globe and Mail, and a story on seniors taken off antipsychotics.

Year antipsychotics became the top-selling therapeutic class of prescription drugs: 2008, at $14 billion in sales (James Ridgway, Al Jazeera, 2011)

“The use of psychoactive drugs – including both antidepressants and antipsychotics – has exploded... [yet] the tally of those who are disabled...increased nearly two and a half times.” – Marcia Angell, former editor of the New England Journal of Medicine (quoted in the Ridgway article)

Antidepressant use rose 34% and plateaued among Ontario First Nations between 2000 and 2010. Antipsychotic use continued to grow in 2010, and to replace stimulant use for ADHD diagnoses across age groups and at the
same rates found among other Canadians (**NIHB Ontario Region**: Health Canada, 2010).

Rates more than doubled from 2005 to 2009 in youth (**Discover Magazine**, 2011). One in 12 youths were being given antipsychotics or antianxietants in 2016, and the rate of youth hospitalization increased by 42% between 2006 and 2016. (**Canadian Institute for Health Information**, 2016). Antidepressants were being prescribed to youth in Canada at a rate of 201 per 100,000 in 2013, with rates higher in Eastern than in Western Canada (**Canadian Journal of Psychiatry**, 2016). Mostly atypical antipsychotics were used, the rate of prescriptions for youth increased by 33% between 2010 and 2013.

Ontario’s **Psychiatric Patients’ Advocate Office** reported rights advice given to 19,000 people being made involuntary patients in 2015. 4,490 people were advised when declared incompetent to consent to treatment. 3,301 were advised when placed under a Community Treatment Order.

In regard to restraints, we have a national policy on **physical restraints** (as opposed to chemical restraints), and a report on the use of **restraints in Ontario** (2011). One in four patients are restrained or secluded, with 58% of them given “acute control medications” (i.e., presumably, major tranquilizers). The report suggests that most physical restraints are being used for “aggressive behaviours” in general, not psychiatric, hospitals. Consider also a progressive professional effort to eliminate or **decrease restraint use**.

The use of electroshock use (“electroconvulsive therapy”) is seldom documented by health officials. A recent **survey** of hospitals in 2015 noted: “Estimated national usage during the 1-year survey period was 7,340 to 8,083 patients (2.32-2.56 per 10,000 population) and 66,791 to 67,424 treatments (2.11-2.13 per 1000 population).” The study concludes: “The wide variation in protocols for number of treatments per course [anywhere from 2 to 30] indicates a need for better informed clinical guidelines.”
Online survey of rights: Media and Analysis

The following links highlight deaths and abuses in Canada related to “mental health” as reported in the media. Each name below indicates a person whose life has been eradicated. The issues related to these names and stories include: colonialism, racism, poverty, sexism, heterosexism, cis-sexism, prisons, schools, classism, religion, warfare, displacement, security, drug policy, parenting, intergenerational trauma, youths, ageism, ableism, and more.

Abuses and Deaths

Abdirahman Abdi (Links 1, 2)
Andrew Loku (Links 1, 2, 3, 4, 5)
Michael Eligon
Sammy Yatim
Robert Zieckanski
Lucia Vega Jimenez
Kulmiye Aginah
Ashley Smith

Inuit suicide rate (Link 2)

“Anawak, who is a residential school survivor, told the inquest that assimilation has replaced the traditional Inuit values of perseverance, always moving forward and never giving up, with ‘disorder, confusion, dysfunction and fear.’”

Poverty and homelessness

Recommendations

The context of “mental health” is not restricted to psychiatric facilities or even to psychiatric care. People whose lives are affected by war and displacement can easily find themselves in psychiatric care. The issues that underlie refugees’ experiences go beyond the realm of psychiatry. Nevertheless, even if “best practices” are found and applied in these and many other contexts, one needs to question whether present medical practices reflect “best practices” or even the “best interests” of the patient.

The Mad Canada Shadow Report group observes that a large number of people living in Canada, regardless of background, will be considered mentally ill (1 in 5). As the data shows, an increasing number of people, especially children and youth as well as our elders, are being mistreated in the name of mental health. A growing number of people are being prescribed antidepressants and antipsychotics, and this is a prevailing form of treatment for distress and difference regardless of context. By comparison, psychological therapies, including simple counselling for short-term grief, are not as readily available and are often unaffordable. Few successful therapeutic models (such as the use of pets or the provision of community activities, or, indeed, of shelter) are being resourced.

While some first-hand accounts of treatments laud biopsychiatric care, this response should not be used as a rationale for imposing such treatments. A growing literature that speaks to the iatrogenic effects of psychiatric drugs and electroshock indicates that psychiatric systems need to move toward social modes of assistance. Indeed, subjective responses, as presented in this report, indicate that biopsychiatric care often impedes or simply prevents recovery, and can constitute torture. The observation that many vested interests perpetuate the status quo returns us to the centrality of the need for empowerment by people with psychosocial disabilities. Only our input could conceivably fix the fixers.

Even in the those rare but highly-publicized cases in which a person becomes confused and does something violent (for example, because of “command hallucinations”), the immediate response should not be psychiatric treatment. Such treatment might increase the very behaviours it is supposed to prevent; indeed, violent incidents are commonly caused by the effects of psychiatric drugs, or by the effects of abrupt withdrawal from these drugs. It is not enough to blame “mental illness,” or to suggest that if more people battled stigma and embraced the medical explanation, these cases would cease to exist. The restrictions placed on persons with psychosocial disabilities go far beyond the needs of keeping society safe or helping people who are confused or distressed, or just different.

We recommend that Canada sign the UN-CRPD Optional Protocol and abandon its Reservations, Understandings and Declarations. Canada should adopt Article 12 and do away with substitute decision-making, in which biomedical treatment is often imposed despite the fact that such treatment is seen to be ineffective and unsafe in too many cases. We recommend that Canada resource supported decision-making for people with psychosocial disabilities, and ensure that individuals are never prevented from making their own decisions. Medical care decisions of any kind should only be made with the fully free and informed consent of the person concerned. We believe that all provisions in law that allow for forced treatment and detentions for assessment and treatment of people with psychosocial disabilities need to be repealed.
We recommend that Canada begin the process of truly implementing the CRPD, starting with the inclusion of people with psychosocial disabilities in reworking legislation and in the training of professionals. This should not be a matter of tokenism, as has occurred in the case of peer workers hired onto Assertive Community Treatment teams. It should stem from the research and direction of people who have experienced the rights violations that the UN-CRPD seeks to address. It should include the keeping of better statistics on the use of mechanical and chemical restraints and of electroshock, on the use of non-consensual treatments and detentions, and on hospital and care-facility deaths. It should research and promote other ways of understanding “mental health” in Canada.

We recommend that Canada address the strategy of policing mental health, especially where Black Canadians are concerned. Police responses that end in shootings have become routine; they must be replaced with de-escalation techniques and an interest in the person.

We recommend that Canada begin to address Inuit and Indigenous suicide rates by supporting these communities in their traditional ways of healing and living.

We recommend that Canada renew its support of women’s groups’ interests, to ensure that women with disabilities are given more voice, since they are more likely than men to deal with the psychiatric system.

We further recommend that Canadian professionals dealing with issues related to gender and sexuality be trained by LGB2TTIQQ individuals, so as to be better able to understand the lives and needs of those to whom they will be providing help.

Finally, we recommend that infants, children and young people, who are so disadvantaged in adult systems, need Canada’s protection from rampant medicalization, such as that which has led to the deaths of girls in detention, like Ashley Smith. In general, Canada needs to start listening to people with disabilities.
Appendix:

To the UN Committee on the Rights of Persons with Disabilities

Suggestions Regarding a List of Issues in Relation to the Initial CRPD Report of Canada

By the Mad Canada Shadow Report Group, July 2016

Articles 1, 2, 3, 4: Purpose, Definitions, Principles, Obligations

1. Please inform the Committee when Canada will comply with foundational principles in the CRPD by revoking its Reservations, Understandings and Declarations as well as signing the Optional Protocol.

2. Please inform the Committee of measures to review federal, provincial and territorial legislation, especially mental health legislation, and public policies for aligning it with the Convention, and to ensure that discussions in parliament and legislative assemblies on draft laws include the human rights approach to psychosocial disability as set out in the CRPD (art. 4).

3. Please provide information on mechanisms put in place at the federal, provincial, territorial and municipal levels to facilitate consumer and survivor representative structures in order to establish full participation in the implementation and monitoring of the Convention.

4. What administrative, financial, and/or legislative measures is Canada taking to consult with individuals with psychosocial disabilities and/or their representative organizations?

5. Please provide information about the situation of Indigenous persons with psychosocial disabilities and indicate what measures have been taken to ensure that Canadian psychosocial disability legislation and policies do not impede them.

Article 5: Equality and non-discrimination

6. Please provide information on the means by which Canada identifies and repeals legislation allowing for non-consensual interventions on persons with psychosocial disabilities.¹

¹ The UN CRPD Committee in its Guidelines on Article 14 says that forced treatment, as well as the use of restraints, is
Article 6: Women with disabilities

7. Is Canada training health care professionals to prevent the use of psychiatric diagnoses as a justification for depriving women of their right to give birth and care for their children?

8. How will the government legally protect women from having psychiatric labels used against them in assault, custody, or other legal disputes?

9. How will Canada ensure that Indigenous women with psychosocial disabilities are not prevented from exercising full development, advancement, and participation in all facets of Canadian society?

10. What specific measures are in place to address the disproportionate levels of systemic violence against women, and specifically Indigenous women and women with disabilities, as well as the special vulnerabilities of women with psychosocial disabilities?

Article 7: Children with disabilities

11. Please provide details on how Canada accommodates and fully meets the needs of children with psychosocial disabilities, including autism and multiple disabilities, while addressing such problems as the overmedication of youth in schools, youth homes, and other facilities.

12. Please provide details on how issues concerning Indigenous children with psychosocial disabilities will be addressed, especially in relation to suicide, self-harm, adoption, psychiatric diagnoses, treatments, and detention.

Article 8: Awareness-raising

13. Please provide details of any measure taken to promote awareness of CRPD-based human rights beyond the medical model in the training and education of mental health practitioners, including therapists, social workers and general practitioners.

14. Please provide plans to promote a CRPD-compliant human rights model for addressing psychosocial distress and difference (“mental health”) through mass media campaigns. Are any initiatives in this regard planned or implemented in close consultation with organizations of persons with psychosocial disabilities? Are any plans being made to provide, or restore, funding of such organizations?

inconsistent with the prohibition of torture and other ill-treatment in article 15. Also refer to General Comment 1, paragraph 42, indicating that forced treatment is ill-treatment or torture.

2 Please refer to the CRPD Committee's training documents, to Guidelines on Article 14, and General Comment 1.
15. Please describe communications measures that would help Canadians to prevent discrimination based on psychiatric labelling (e.g., micro-aggressions, employment barriers, incarceration, and eugenics). Biopsychiatric diagnoses are known to increase the stigma they supposedly combat when they are used to explain behavioural differences and distresses in persons with psychosocial disabilities.\(^3\)

**Article 10: Right to life**

16. Please indicate what the Canadian government is doing to prevent loss of life, reduction of life expectancy, iatrogenic disablement, shortened life span, diagnostic categorization of lived experience resulting in blunted affect and reduced participation, imposition of living arrangements, and other common documented results arising from coercive treatment and civil commitment.

**Article 12: Equal recognition before the law**

17. Please indicate how Canada will relinquish its opposition to Article 12 allowing for universal enjoyment of the right to decide what is done with one’s body and mind, including the imposition of treatment in the service of criminal or civil constraints.

**Article 13: Access to justice**

18. Please advise whether Legal Aid is provided in all provinces and territories for persons with psychosocial disabilities who may be unable to represent themselves or may be unable to afford the cost of legal representation for all legal issues (e.g., family law, human rights, guardianship, involuntary treatment and commitment, tenancy, employment, etc.).

19. Please provide details of any legislative and other measure put in place to ensure that persons with disabilities who have been deprived of their liberty in the context of psychiatric and/or criminal proceedings, especially Indigenous and racialized people who are overrepresented in correctional and psychiatric systems, benefit from the same procedural guarantees as all other persons and are provided with the required reasonable accommodations. Please note that “not criminally responsible” findings are contrary to CRPD principles, as evidenced in Kenya’s Concluding Observations.

20. Given the need for independent advocacy by organizations not receiving mental health funding, will the government work with the Department of Justice and/or other bodies to establish advocacy services with input from persons with psychosocial disabilities?

**Article 14: Liberty and security of the person**

21. Please inform the Committee of measures to review federal, provincial, and territorial mental health legislation and public policies in order to discontinue involuntary treatment and committal. Also, what legislative measures are being taken to ensure free and informed consent as set out in Article 14?

22. Please explain how persons with psychosocial disabilities will be streamed out of prisons after being put there for the purpose of care. Rather than simply being coerced into psychiatric treatments, will they be offered non-coercive services, including safe, affordable housing, employment assistance and self-help alternatives?

23. Please indicate how people in forensic psychiatric facilities (especially youth, Indigenous, and racialized people) will be protected from rights abuses like those that led to the death of Ashley Smith.

**Article 15: Freedom from Torture or cruel, inhuman or degrading treatment or punishment**

24. Please provide details on administrative and other protocols in place to provide legally sound, substantive proof that people are giving informed consent to treatment, as well as medical or scientific experimentation.

25. Please explain how Canada will implement measures to prevent the continuation of placing persons with psychosocial disabilities in coercive environments for the purpose of subjecting them to non-consensual or coercive treatments. This occurs even with the use of therapeutic contracts that assume no power differentials in therapeutic care. Often, people who ask for treatment or services can only get them through coercive systems.

26. Please indicate how the government will collect and act upon indications from mental health organizations, and from organizations of persons with psychosocial disabilities, that certain therapeutic interventions are harmful, restrictive, and/or ineffective.

27. How will information be provided to the public and to health practitioners regarding iatrogenic harm (medically induced illness or disablement) or adverse effects from medications, electroconvulsive therapy, and other therapies? If iatrogenesis isn’t addressed, how can Canada ensure free and informed consent, and avoid “soft” coercions such as outpatient committal?

28. Please describe how Canada will address discrimination based on the physical disablement of persons with psychosocial disabilities (e.g., tremor due to tardive disorders). These effects are often attributed to mental illness, creating a cycle of dependency and disablement. What measures are being taken to identify iatrogenesis as a physical problem rather than “all in the mind”?

**Article 16: Freedom from exploitation, violence and abuse**

29. Please explain what measures are in place to gather the testimony of survivors of violence and abuse in the context of mental health care, in order to understand and effectively assist survivors, especially those with differences that have been targeted, such as people from LGB2TTIQQ communities.
30. Please describe methods of monitoring and ensuring human rights adherence in mental health treatment facilities, including transition services for transgender people, and of ensuring consultation with and leadership by persons with psychosocial disabilities.

31. Please provide information on violence against persons with psychosocial disabilities (for example, immigrants who are assaulted or killed by police), and on mechanisms for providing redress for victims and their communities. These mechanisms should accommodate differences such as gender, sexuality, culture and age.

32. Please explain how mental health service providers are being educated to recognize and report exploitation, violence, and abuse of persons with psychosocial disabilities in context of psychiatric services and therapeutic services.

33. Please inform the Committee whether all services and programs designed to serve persons with psychosocial disabilities are effectively monitored by independent authorities, specifying who the independent authorities are, and how they can effectively monitor services and programs such as forensic psychiatric facilities or psychotherapy sessions.

34. Please inform the Committee as to what kind of policies and legislation are in place to ensure that instances of exploitation, violence and abuse are identified, investigated, and prosecuted. This includes bribes (such as offering housing in exchange for compliance) or ignoring complaints of patients who have been assaulted by staff.

Article 18: Liberty of movement and nationality

35. Please state what measures are in place to ensure there is no loss of voluntary, CRPD-compliant services for persons with psychosocial disabilities when moving within a province or territory, or moving from one province or territory to another within Canada (e.g., educational accommodation standards, income support levels, medical costs, rehabilitation, homecare, etc.).

Article 19: Living independently and being included in the community

36. Please provide details on what will be done to eliminate legal measures that constrain persons with psychosocial disabilities, such as mandated treatment in the community (i.e., Community Treatment Orders) and civil commitment, resulting in reduced participation in community activities, political and public life.

37. Please explain how Canada will strive to protect the autonomy of elders, youth and other citizens, by training service providers to avoid the use of overmedication and chemical restraints in managing and controlling persons on wards, in care homes, in schools and elsewhere.

38. Are there any plans to introduce independent living benefits for persons with psychosocial disabilities, including budgets for personal assistance?
39. How will Canada prevent the use of stringent behavioural and therapeutic conditions imposed in exchange for housing for people with psychosocial disabilities, including addictions? For example, can they ensure that databases like HIFIS are not being used to monitor behaviour and compliance in housing programs managed by public service providers?

**Article 21: Freedom of expression and opinion, and access to information**

40. Please provide details on how information will be gathered, reproduced and distributed to the public to allow for more free and informed decisions (e.g., by way of more critical information) regarding standard psychological and psychiatric interventions and treatments, and how persons with psychosocial disabilities can lead such projects.

41. Please indicate how critical information about treatments will be protected from being obfuscated by powerful stakeholders, including pharmaceuticals and psychiatric organizations.

42. Please explain how Canada will promote an equity and human rights model in line with the CRPD and Article 14 Guidelines for appreciating and understanding and accommodating distress and psychosocial differences, rather than imposing a biomedical model that perpetuates stigma.

**Article 22: Respect for privacy**

43. Given the sensitive and confidential nature of psychological counselling, how does Canada ensure that the medical privacy rights of persons with psychosocial disabilities are respected such that health care and other services are not predicated on sharing psychiatric or counselling information.

**Article 23: Respect for home and the family**

44. Please provide details of any measure taken to enable persons with psychosocial disabilities to form families and to become parents on an equal basis with others.

**Article 24: Education**

45. How are persons with psychosocial disabilities facilitated, encouraged and supported in pursuing advanced education, despite the debilitating effects of psychiatric treatment, labelling and prognostication?

46. How are persons with psychosocial disabilities being helped to educate each other and the public about the effects of psychiatric treatment and about alternatives?
47. How will Canada remedy barriers to education such as denying disability-based education grants if a disabled student cannot find employment to pay back student loans?

**Article 25: Health**

48. Please indicate how non-coercive and holistic services will be made available to Canadians in a timely manner, through public health coverage, in place of coercive and forced interventions, for example in regard to people with substance abuse issues, multiple diagnoses, and multiple disabilities.

49. Please show that Canada is committed to giving people involved in the psychiatric and/or criminal justice systems access to non-coercive services and treatments, especially in relation to substance abuse issues.

50. Please inform the Committee whether mainstream physical health services are accessible and free of discrimination based on psychiatric diagnoses.

51. Please explain how Canada will provide choice in treatments and prevent coercive biomedical treatments for psychosocial difference and distress, and in particular the framing of emotional and social problems as “mental health issues” requiring invasive interventions.

**Article 26: Habilitation and rehabilitation**

52. Please explain how Canadian mental health services will begin the process of helping and rehabilitating people with iatrogenic impairments resulting from biopsychiatric and other treatments (e.g., memory loss from ECT, diffused attention from neuroleptics, and suicidal or aggressive abreacts to antidepressants).

**Article 27: Work and employment**

53. What is Canada doing to abolish sheltered workshops?

54. How does Canada rehabilitate persons with iatrogenic injuries from psychiatric treatment to become employable and supported in seeking gainful employment?

55. What efforts has Canada made to promote the self-employment of persons with psychosocial disabilities?

56. How is Canada addressing the substandard accommodations for persons with psychosocial disabilities in advanced education and employment training?
57. What is the rate of employment and income for persons with psychosocial disabilities in private industry and the public service?

Article 28: Adequate standard of living and social protection

58. How is Canada meeting the needs of war veterans with psychosocial disabilities in regard to income, social protection, and peer to peer disability networks?

59. How is Canada addressing the disproportionate rates of suicide, addictions and psychosocial disabilities amongst Indigenous people in the three Territories and rural Canada?

Article 29: Participation in political and public life

60. Please show that Canada is committed to giving persons with psychosocial disabilities, including those being detained or constrained, access to political processes that affect them, as well as providing them with assistance in self-representation as a community.

Article 30: Participation in cultural life, recreation, leisure and sport

61. Please indicate how arts council funding in Canada is committed to giving persons with psychosocial disabilities access to cultural production, not only for the purpose of exploring life experiences attributed to “mental health issues,” but also, and especially, for examining human rights issues resulting from their incarceration and forced treatment.

Article 31: Statistics and Data Collection

62. Please inform the Committee of the number of persons with psychosocial disabilities currently institutionalized or deprived of their liberty under psychiatric and criminal proceedings, according to age, gender, and race.

63. Please indicate how Canada plans to obtain statistical data on coerced and forced interventions, such as: isolation; mandatory treatment in the community; the use of restraints, including chemical restraints; and the use of treatments with links to iatrogenesis, and especially electroconvulsive therapy and neuroleptic treatment, so that these abuses can be stopped, as per Article 14.

64. Please provide information on how statistics on coercive and forced treatment, as well as psychiatric diagnostic data, will be collected, shared with the public, and used in the establishment of free and informed consent, non-coercive and holistic treatments, and human rights monitoring in line with CRPD, General Comment 1, and Article 14 Guidelines in psychiatric, forensic, correctional, educational and other systems.
65. Does Canada plan to keep statistics on: women and girls sexually harassed/abused by psychiatric staff; women and girls psychiatrically incarcerated and/or forced to take psychiatric drugs due to non-conformist gender roles/behaviour; children psychiatrically incarcerated and/or forced to take psychiatric drugs due to psychiatric pathologization of normal childhood behaviour; suicides caused by psychiatric labelling/treatment; and Indigenous people kept from using traditional healing methods in lieu of psychiatric treatment?