

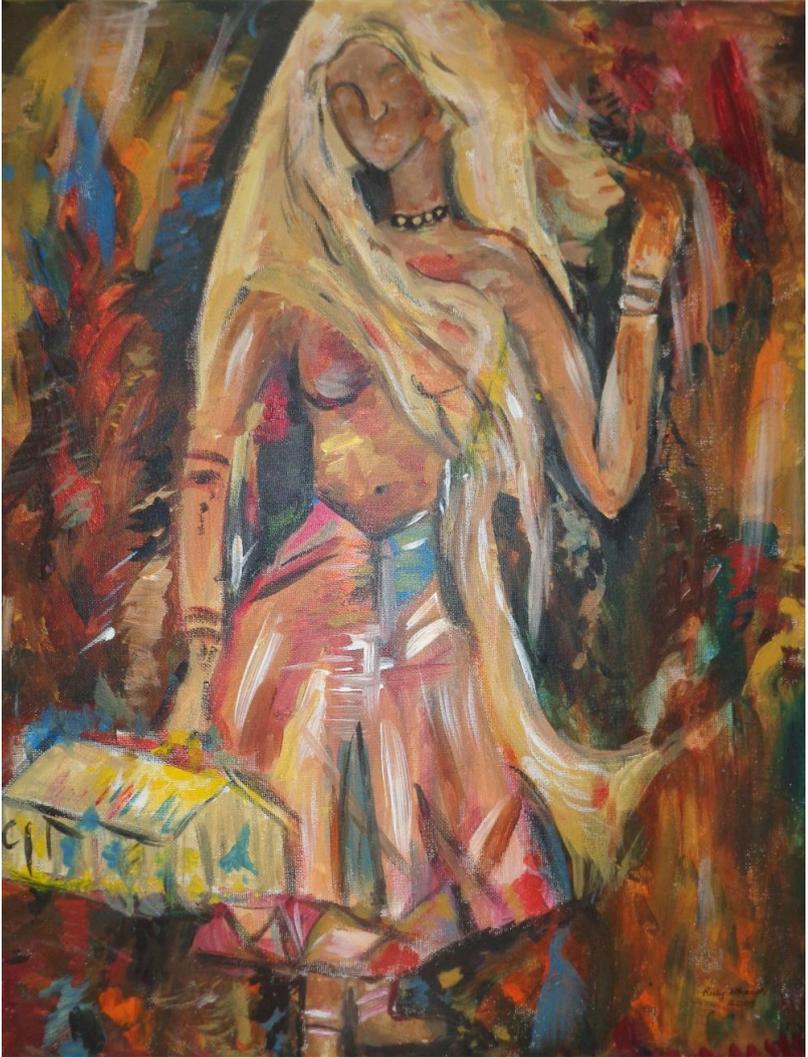
Examining Narratives of Cultural Diversity in Mental Health Law

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Abstract:

There is a currently a dearth of critical legal literature available which highlights the lived experiences of ethno-racial people with mental health disabilities who interact with civil mental health laws, and are subsequently subjected to involuntary detention and forced psychiatric medication amongst other severe consequences (Dhir 2008). Indeed, their voices are silenced and their narratives appear to be “invisible” in the justice system and the broader mental health system. To address the theme of justice, visibility, and visibility, in this paper I examine the narratives and lived experiences of the courageous ethno-racial participants of the mental health system who have chosen to have their voices heard. The narratives are drawn from empirical data collected through seven intensive interviews with ethno-racial people with mental health disabilities (in-patients and ex-patients), who experienced discrimination while institutionalized in Ontario’s civil mental health system and interacting with mental health laws. In Part I and II of this paper, the empirical data is presented and examined thematically vis-à-vis their experiences with the mental health tribunal’s (Ontario Consent and Capacity Board) pre-hearing, hearing, and post-hearing processes and the broader mental health system. Within each emerging theme, participants provide recommendations to address the inequities they have experienced within the justice system. In Part III of the paper, I argue that practitioners should adopt tenets of Therapeutic Jurisprudence to ensure that ethno-racial people with mental health disabilities are provided with procedural fairness, substantive

equality and therapeutic outcomes when confronted with multiple forms of discrimination in the civil mental health system.



(c) Ruby Dhand

Introduction

In *R. v. Swain* (2001), the Supreme Court of Canada acknowledged the discrimination and exclusion historically experienced by people with mental health disabilities (Swain 2001). As people with mental health disabilities continue to face discrimination while in the justice system, this is further complicated when intersections of race, culture, ethnicity, class, gender, disability, and other factors are involved. Despite an increasingly diverse society, there is currently a dearth of critical legal literature which highlights the lived experiences of ethno-racial people with mental health disabilities affected by civil mental health laws, and are subsequently subjected to involuntary detention and forced psychiatric medication amongst other severe consequences (Dhir 2008). Indeed, their voices are silenced and their narratives appear to be “invisible” in the justice system and the broader mental health system. Policy makers, lawyers and health care professionals often have the privilege of being viewed as “experts” in the debate of how to achieve equitable outcomes for ethno-racial people with mental health disabilities whereas the voices of those with lived experience of discrimination in the mental health system are rarely placed at the forefront (LeFrançois, Menzies and Reaume 2013).

Visualizing Justice

To address the theme of justice, visibility, and visibility, I examined the narratives and lived experiences of a group of ethno-racial participants of the mental health system who chose to have their voices heard. As Andrea Brighenti suggests:

Vision is a sense of power, or better, a sense which confers a sense of power. Everything *I see* is, at least potentially, within the reach of the *I can*. What is not seen is not thematized as an object in the domain of action. (Brighenti 2007: 328)

To analyze the multiple barriers to accessing justice that ethno-racial people with mental health disabilities face, I drew from the conceptual model of the “invisibility syndrome.” This model analyzes the impact of racism on an individual’s mental health because of its recognition of “the feeling people get when their

abilities, personality and worth are disregarded because of others' prejudice" (Franklin and Boyd-Franklin 2000; Greer 2008: n.p.).

When institutionalized in the Ontario civil mental health system and interacting with mental health laws, ethno-racial people with mental health disabilities experience multiple barriers to accessing language interpretation, culturally appropriate treatment and care, religious accommodation, and social supports. The mental health tribunal's processes often have anti-therapeutic outcomes for ethno-racial people with mental health disabilities as a result of racism, cultural misunderstandings, prejudice, systemic discrimination, and stereotypes. Drawing from the theoretical underpinnings of "invisibility," ethno-racial participants of the mental health system are left to feel powerless, violated, and pathologized by the paternalistic nature of mental health law (Goldsmith 2010). Consequently, it appears that the notion of justice is often "invisible" for ethno-racial people with mental health disabilities.

The narratives used in this paper were drawn from empirical data collected through seven intensive interviews with ethno-racial people with mental health disabilities (in-patients and ex-patients) who experienced discrimination while institutionalized in Ontario's civil mental health system and interacting with mental health laws. In Part I and II of this paper, the empirical data are presented and examined thematically vis-à-vis their experiences with the mental health tribunal's (Ontario Consent and Capacity Board) pre-hearing, hearing, and post-hearing processes and the broader mental health system. The themes and sub-themes which emerged include: the role of practitioners, language/communication, the pre-hearing process, the hearing, grappling with culture, adversarial environment, family involvement, the post-hearing process, human rights in the hospital, racism, access to culturally appropriate treatment and care, religious accommodation, social supports, power, education, and legislative reform. The narratives exemplify the intersecting and multiple forms of discrimination experienced by ethno-racial people with mental health disabilities interacting with mental health laws in the civil context and their understanding of the legal processes.

Within each emerging theme, participants provided recommendations to address the inequities they have experienced within the justice system. In Part III of the paper, I further analyze these recommendations and draw from a Therapeutic Jurisprudence (TJ) lens to conceptualize a holistic approach to justice (Wexler and Winick 1996). I argue that a TJ approach to justice will ensure that ethno-racial people with mental health disabilities are provided with procedural fairness, substantive equality and therapeutic outcomes when confronted with multiple forms of discrimination in the civil mental health system.

Methodology

The seven interviews described in this paper were conducted in 2011 in Toronto, Ontario through Osgoode Hall Law School and the Centre for Addiction and Mental Health as part of a broader study entitled, “Creating a Cultural Analysis Tool for the Implementation of Ontario’s Mental Health Laws” (Dhand 2014). I obtained ethics approvals from the Centre for Addiction and Mental Health’s Research Ethics Board and the York University’s Human Participants’ Review Sub-Committee in the Office on Research Ethics. After obtaining informed consent from the participants, I audiotaped, and subsequently transcribed, the interviews. I also took field notes after each interview and attended mental health tribunal hearings weekly for one year during the study. The results were coded, analyzed, and interpreted using Glaser and Strauss’ grounded theory approach (Glaser 1978; Glaser 1992; Glaser and Strauss 1967) and theoretical tenets from therapeutic jurisprudence, the social model of disability and intersectionality.

Participant Characteristics

I advertised the study at the Centre for Addiction and Mental Health (Canada’s largest psychiatric institution) to gain access to ethno-racial people with mental health disabilities who were in- patients and through service organizations to gain access to those who were ex-patients. The inclusion criteria for in-patients and ex-patients being interviewed were that they:

- 1) Be an ethno-racial person with a mental health disability in

Ontario.

2) Had been through a CCB hearing within the last three years (2007-2010).

3) Be over the age of 18 years.

4) Were willing to participate in the interview process.

5) Were able to speak English.

The specific participant characteristics are indicated in Table 1.

Glaser and Strauss' Grounded Theory Approach

The analysis of the data involved a number of stages. First, I transcribed the interviews verbatim in order to familiarize myself and engage with the data. Although this was an extremely time-consuming and challenging process, it became invaluable to the interpretation of the data afterwards. As some scholars suggest, the process of transcription itself is “a key phase of data analysis within interpretative qualitative methodology” (Bird 2005: 227) because it is an “interpretative act where meanings are created” (Braun and Clarke 2006: 86-88). In this respect, the transcription process

Table 1

Participant Characteristics

Characteristic	Value
Age Range (Years)	20 - 60
Duration of time institutionalized in the civil mental health system (Range in years)	1 - 25
Background	Ethno-racial
Gender	
Male	<i>n</i> = 3
Female	<i>n</i> = 4

enabled me to immerse myself into the interview data and fully appreciate the complexity of the data. Secondly, I continued to re-read and engage with the data and the secondary literature. As initial themes emerged, I continued to record these in my journal. This stage led to the analysis of the qualitative data using Glaser and Strauss' constant comparative method (Glaser and Strauss 1967), a valuable analytical procedure within the grounded theory approach.

Constant Comparative Method and Analysis

The constant comparative method consists of explicit guidelines to analyze qualitative data. These guidelines are described in Glaser and Strauss' constant comparative method. According to Glaser and Strauss, there are four steps to the constant comparative method:

- 1) Comparing incidents applicable to each category
- 2) Integrating categories and their properties
- 3) Delimiting the theory
- 4) Writing the theory

Although this method of generating theory is a continuously growing process—each stage after a time is transformed into the next—earlier stages do remain in operation simultaneously throughout the analysis and each provides continuous development to its successive stage until the analysis is terminated (Glaser and Strauss 1967).

This method enabled me to compare and contrast ideas within one transcribed interview to another. The result of this comparison, referred to as “coding” was written in the margins of each interview. A code is defined as “the essential relationship between data and theory” (Glaser 1978: 55). Glaser defines coding as “conceptualizing data by constant comparison of incident with incident, and incident with concept” (Glaser 1992: 38). Accordingly, there are two types of analytical coding techniques within the constant comparison method. These are 1) substantive coding and 2) theoretical coding. Substantive coding occurs when the researcher conducts a line-by-line analysis of the data to identify the key themes and concepts.

These themes and concepts are then translated into short code words or phrases (Chen and Boor 2009). This process enabled me to identify and recognize the categories and sub-categories (themes) emerging from the data. There was constant re-visitation to the data so that the categories and findings were refined until I reached “theoretical saturation” of each category. Theoretical saturation occurred when there was no new data found within a category (Glaser and Strauss 1967).

In the theoretical coding phase, I further examined the saturated categories and weaved them together to develop a general hypothesis and theory about the data. As Glaser describes, “the grounded theory mandates the [theoretical codes] to formulate a conceptual theory that explains how a problem is continually processed by the participants” (Glaser 1992: 38). This evolutionary and iterative process enabled me to examine the conceptual relationships between the categories, while continuing to constantly compare the data (Glaser 1978). I also responded to the meanings within the data by comparing and relating them to the tenets of the theoretical framework (which drew from therapeutic jurisprudence, social model of disability and intersectionality) along with the secondary literature. As Glaser recognizes, “in an emerging integration of categories and properties, [researchers] may begin to review the literature in the substantive field and relate it to their own work in many ways” (Glaser 1992: 32).

Part I: The Pre-Hearing Process

The Role of Practitioners

Participants suggested that all practitioners should probe further into the intersectional issues involved in their mental health tribunal cases. However, some respondents expressed a fear of disclosing intersecting aspects of their identity and their experiences of discrimination, because they did not want to inculcate stereotypes.

Accordingly, one of the participants described this problem as follows:

What may be deemed as crazy here in North America, is not necessarily deemed crazy in other cultures, it might just be that person expressing himself. And I've met someone who is from Africa and he was just crazy. But you know what, he believed in his culture, that that is revered. That is revered and you know, he would come in, and he would say things to me, he would make it known that he got ten goats and five wives, and he is being very vociferous about it, that to me is not being aggressive, that to me is not seen as aggressive behaviour or delusional behavior. That is part of his culture and instead of asking, I watched this go down with the worker who was with him. Instead of asking him: What about your culture? Trying to get to know where this is coming from, they just assumed that the person was angry, that they were aggressive and they won't calm down, and that they had to go basically. They couldn't get the service, they were saying, well – we have to leave now.

Thus, respondents recommended that practitioners must continue to challenge stereotypes when identifying and addressing the barriers and intersectional issues at play.

Language/Communication

Acceptance. Although all of the participants interviewed were able to speak English, they still experienced evident language and communication barriers throughout the mental health tribunal's pre-hearing, hearing, and post-hearing processes. For instance, some respondents could not understand concepts such as "rights," "treatment," "informed consent," and "mental health tribunal hearing," thereby misunderstanding the mental health tribunal's processes. Other participants felt that their intangible qualities such as their accent, mannerisms, body language, gestures, and demeanor were attributed to a perception of being less credible.

Some participants felt that language and communication barriers led to them being deemed as "non-compliant" and "incapable." Consequently, a few participants had their privileges within the hospital taken away and others experienced seclusion and restraint. To address these barriers, participants recommended that all

practitioners in the civil mental health system should understand and accept their intangible qualities and identities. One participant suggested as follows: “My cultural way of speaking English... I don’t want to change that. My accent should be accepted.” Other respondents suggested that there should be a greater emphasis placed on listening.

Obtaining Interpretation Services. Participants suggested that interpreters should be available within the hospital to meet the everyday needs of clients. Also, they recommended that service providers within the community should have on-site interpreters and case-workers from diverse backgrounds available. A participant reflected upon this recommendation as follows:

I think people’s solution is to stick a worker in there, thinking we have referrals; some agencies don’t even have referrals to interpreters. Some agencies didn’t even ask, do you want services from your community or are you comfortable here and how can you make. They just assume, that maybe they are comfortable with their own people. Well that is enough – if you are going to be serving a particular population or population of many different backgrounds, you should get to know and have different representations, whether if it is a non-profit, on your board, within a policy positions, within your management and also talking to the clients themselves, which doesn’t really happen so much because I find the language barrier that people just assume and they just don’t want to take the time to understand where a person is coming from.

Overall, participants recommended that interpretation services be available and accessible within the hospital and the community.

Cultural Interpreters/Consultants. When questioned about whether cultural interpreters/consultants would be beneficial, the majority of participants believed that they needed to have cultural interpreters/consultants support and guide them through the mental health tribunal’s pre-hearing, hearing, and post-hearing processes. Some participants also expressed the view that cultural

interpreters/consultants could help create networks for them in hospital and in the community.

Rights Advice. A number of participants did not understand the concept of rights and the process of rights advice. Questions arose such as: “What are rights? What does rights advice mean?” Some participants argued that rights advice should include a discussion of the dangerous side-effects of taking psychiatric medications. Accordingly, a participant stated as follows: “No one told me about the side effects of medication. They put me on lithium. This medication could give me kidney disease. But the lawyers still couldn’t fight it.” Consequently, participants recommended that rights advice should be given in person and in writing, with the written rights advice explaining the key concepts stated in plain language.

Psychiatrists’ Capacity Assessments. There were varied narratives that arose as participants discussed their experiences undergoing capacity assessments. Participants felt that psychiatrists and other health care professionals needed to resist the urge to pathologize their behaviors as deviant. Instead, participants recommended that there should be more questions within the assessments about their history and cultural background. Some respondents just wanted to feel more comfortable and have their stories and narratives understood and heard during the capacity assessments. At a general level, participants recommended that the capacity assessments should be a collaborative and holistic process. For instance, one participant recommended that the capacity assessments should include a caseworker, a social worker, a family member, and a service provider.

Part II: The Mental Health Tribunal Hearing

Process

Participants argued that it was an important right to be able to go before the mental health tribunal. They wanted to have their voices heard and have the opportunity to assert their rights. A participant described the importance of the mental health tribunal process as follows:

Well, it is a reasonable thing to do, especially if you have problems that concern law. You know, about getting my rights. It is all I want, my rights. If they can understand my problems, then it is very much easier on my mind. That was all I was concerned about... you know if the judges and the other lawyers understand what I am trying to get across, and why and how.

While discussing the mental health tribunal process, participants felt that the arguments made on their behalf regarding culture, religion, and other social factors were not acknowledged. A number of participants wanted to have their unique perspectives of mental health recognized. This is highlighted in the following narrative:

Going before the tribunal was an interesting process because they didn't understand my experience from a religious context. And so they kind of super-imposed their world view on to mine and not taking that into account, I felt very affronted by the whole process.

So they thought, well yeah that I am this, I am mentally ill or I have experienced an episode, and I would say, "No, my experience is based on a cultural standpoint. And so, you are not understanding me, and that is an issue for me. And so you are trying to do something to me without my consent, without even taking the time to understand my point of view and that was very disappointing." I tried the cultural argument consistently to the psychiatrist, to the teaching psychiatrist that came on board on the wing, to the hospital, to the resident psychiatrist that was there, I made it before the board, to my lawyer, to the patient advocate that came...everybody, I made these arguments to everybody. For me, the idea is not that their argument is not valid. Because, they are the protectors of society, order and all that nonsense. But at the same time, it is just an acknowledgement. If there was an acknowledgment, then it would say, it is okay, you are not totally crazy, your point of view is validated, but they didn't go there. And, so I think that has a lot to do with dominance. Dominant culture.

Going before the mental health tribunal is the perpetuation of dominant cultural ideas on to those who have variant ideas.

In order to address these concerns, participants recommended that their individual experiences must be taken into account throughout the mental health tribunal's pre-hearing, hearing, and post-hearing processes. Further, some participants recommended that there should be free education given to them about the mental health tribunal process and what to expect, since they often misunderstood the process itself.

Grappling with Culture

When asked about how the mental health tribunal dealt with their cultural and religious requests in the hearings, participants felt that the tribunal did not attempt to address or accommodate such requests. For instance, participants suggested that their requests for culturally appropriate treatment, religious accommodation, and ethno-racial service providers were often denied. Some indicated that the tribunal did not probe into their cultural and social context, nor their experiences of oppression and trauma, in the hearing.

Accordingly, a number of participants argue that if these types of requests and the intersectional and systemic issues are not addressed appropriately, the consequences are severe. Some people are repeatedly institutionalized. In the following narrative, one participant explained the severity of these consequences:

And also I find, I wonder though, with people who come before the board a lot, I just find that the justice system is biased, it is like that is expected behaviour of that person due to their racial background or the community they are from, and there isn't an attempt to break the cycle and help and see what is going on. So the person just becomes institutionalized, over and over again. Yes – it is a big problem because what happens is it ruins communities and then people they just give up. They don't, like I said it goes back to family dynamics and I don't think service providers what happens where the person may have immigrated here, but their parents are back wherever. Maybe it is the one mother who is supporting all their children. Those dynamics are

not taken into consideration. Why are these children up by themselves home alone or why is this person...why does the eldest have to take care of all of them while the mother works? They don't see different kinds of situations. There are different types of families that immigrate here in different situations and that is not taken into consideration.

Participants recommended that the mental health tribunals acknowledge and recognize its own institutional bias. The tribunals should use its discretion to grapple with the intersectional and systemic issues at play within these cases.

Adversarial Environment

Participants were uncomfortable with the concept of contesting their doctor's decision. For many, they were confused as to why they were in opposition to their doctor, whom they had bestowed trust and confidence upon. This was further complicated, given their general mistrust of the civil mental health system and the formal and adversarial nature of the hearings.

After the hearings, a number of participants felt that their relationship with their doctors had been compromised since they were mistrustful of their doctor's authority and advice.

Family Involvement

The issue of family involvement was contentious for participants, since there were circumstances where family members were supportive, but there were other situations where participants felt like they were in conflict with their families regarding specific treatment and care issues. Participants were unclear about the role that family should have in their treatment decisions and care. Specific concerns were raised regarding disclosure and the extent to which family members should be informed about their treatment and care decisions. A participant explained this tension as follows: "Although support can come from the family, the stigma can also come from family, so therefore we don't want to seek support within

family and we will look towards other communities to get the support.”

Some participants also felt that their family members were biased in favor of them receiving involuntary treatment and care. These dynamics were often heightened in hearings. A participant explains as follows:

I tried to make the cultural argument, even to my own family, that were privy to my experience, and they had insight to it because they saw me in an intimate context, at the end day, discounted what they were saying and hearing from me, that shows the other side to being on the other side. And I just was so pissed off by the whole experience.

In order to address these concerns, participants recommended that all practitioners should be aware of the types of family dynamics involved in a particular case.

Post-Hearing: Translation of Decisions

Participants indicated that the outcomes of the decisions were not explained to them and there was a lack of written reasons available for them. For instance, it was problematic that only one of the respondents for this study received written reasons for the decisions of the mental health tribunal. In light of these communication barriers, a number of participants did not appear to understand their treatment decisions, the concept of informed consent, the right to refuse treatment, the particular treatments they were taking, the side effects of treatment, and the overall outcome of their mental health tribunal hearings. Accordingly, participants recommended that there should be a simple one-page summary of the mental health tribunal’s written reasons available for them.

Human Rights in the Hospital

The theme of human rights in the hospitals was significant for the participants who were interviewed. There were descriptions of rights violations involving restrictions of their liberty and autonomy through the use of restraint, the lack of food options available, the lack of space available, the lack of privileges available within and

outside the hospital, the lack of monitoring of human rights abuses within the hospital, and the overuse of medical labels. Specifically, a number of participants perceived the process of obtaining hospital privileges as manipulative and arbitrary because they had to prove that they were taking their medications regularly to be given day passes and other privileges. Accordingly, one participant described this process to be an “affront to her dignity.” She suggested as follows: “I just want the freedom to smoke. To go out when I need to go out for it. And, also the freedom to bathe, go to church, do my laundry and little things around here.”

Participants felt that they should have more access to the Ontario human rights system. One participant stated: “Yes, I want to have access to human rights complaints system. I want to understand how to get these things...I need a lawyer to help me.”

Thus, participants recommended that there should be people appointed in the hospital to monitor the human rights abuses that occur within the hospitals and to support participants to file human rights complaints.

Racism. When discussing human rights concerns within the hospitals, a common theme amongst those interviewed were their experiences of racism. It was found that participants frequently experienced racism in their interactions with the civil mental health system including the mental health system and the legal system. For instance, participants described experiences of feeling isolated, alienated, and stereotyped based on racist assumptions throughout their interactions with the police and their experiences in the emergency department, in the psychiatrists’ capacity assessments, in hospital with health care professionals and during the mental health tribunal hearings. A participant explains her experience as follows:

For example, police or even providers, because of stereotypes, they see you and you may think you are crazy and you need the support, but they are afraid of you, and they link certain behaviours to your race such as anger, and they don’t want to service you. And I find when that happens though then the person, I mean when you are a racialized you know when you

are being discriminated and experiencing racism. People say “Are you sure you are being discriminated,” people know, you have been in the body you have been in for a long time, you kind of get a wind of the experiences that you encounter, so I just find that with that the service provider doesn’t necessarily genuinely engage with the person because there are those barriers, because they are not willing to understand what the person is going through, they are just going off stereotypes, they are going off behavior.

In this respect, another participant stated as follows:

I believe in this particular hospital, there is a lot of injustice going on, they don’t seem to regard the law and there is a lot of racism. There is no justice. This is too much for the mentally ill...they isolate them.

Consequently, it was suggested that all practitioners in the civil mental health system should be educated about the various cultural backgrounds, the histories, and the issues pertinent to treating participants.

Access to Culturally Appropriate Treatment and Care

Respondents found it frustrating that the mental health tribunal did not have jurisdiction to consider whether treatment plans were culturally appropriate. None of the participants interviewed were able to access culturally appropriate treatment and care. This affected how their cases were determined since a number of participants argued that they would be treatment compliant if they had more options for alternative and complementary treatments within the civil mental health system. For instance, a number of participants wanted to have more access to counseling and psychotherapy, along with alternative and complementary treatments such as meditation, yoga, homeopathy, naturopathy, and light therapy.

Within the community, some respondents felt helpless because they were not able to access such treatment given the immense stigma. One participant stated: “No, I don’t want to go to my community. There is shame.”

To increase access to culturally appropriate treatment and care, participants recommended that psychiatric hospitals continue to have more peer support groups. This includes recreational art programming that caters to different interests. Secondly, service providers need to have more interpreters and people from diverse communities available to support participants.

Religious Accommodation

When questioned about religious accommodation, participants identified problems with the lack of access to spiritual services and the inability to practice their religions freely within the hospitals or within their community. In this respect, one participant felt dismayed that the tribunal would not grant him the right to practice his religion. He argued that the tribunal did not understand the notion of religious rights or his right to have religious accommodation. He described his experience before the tribunal as follows:

I was doing serious religious practices at the time that cause an experience that was not understood within this cultural context by the tribunal and within the hospital. It was Hinduism at the time. And it was more of a mystical approach to it. But, if I were someplace else, it would have been understood. The practices include— meditation, insight, stuff like that, diet. It was a violation of my religious rights. I mean what are you doing? What are you guys doing here? I am practicing my religion.

In this regard, participants recommended that they should have more access to spirituality services within the hospital and the mental health tribunal should be more willing to grant such accommodation requests.

Social Supports

During the interviews, participants identified barriers to accessing social supports including adequate housing, community supports, and ethno-specific supports. For instance, a number of the

participants interviewed were often living in poverty when released into the community, given the lack of appropriate housing and community supports. The recommendations participants made to address these barriers included increasing the awareness about the current initiatives and resources, focusing on inclusion, and ensuring that ethno-racial communities are speaking to each other and creating networks. I raised the following questions: What are the specific supports that ethno-racial communities need? How can such services be mainstreamed? In this respect, a participant reflected upon these recommendations as follows:

I wonder why also, ethno-racial communities are not talking to each other. There is discrimination that happens in that dynamic too. I find because it is not being discussed, it is more issues with the mainstream and how that interaction happens, how that oppression happens. They don't necessarily address ethno-racial communities interacting with each other, in those oppressions that happen. They need to talk to each other, and refer and try to understand each other languages. Coming together to try to find, in the mainstream, in the grand scheme, having the supports. I just find it is not being addressed because it is a top down process and at the top are people who have no idea about what is happening in the community, and they are not interested in finding out, because our health care system is turning into a big business. So it is more – how can you make it more mainstream? How can we make it more blanket and more uniform? And with that, there are problems. With that type of policy, whom are you really serving? Who are the people that are really to be coming to you? They are going to be people that are marginalized, and most likely from a racialized community. Resources – I think there are a lot of resources. The issue is really knowledge of the people. The people need to have knowledge that the resources exist. It is question of them understanding that there are resources out there to help them. A lot of people don't even know about the patient psychiatric advocate's office, tribunal or that they can say no to their doctor for that matter. It is all about awareness.

Further, participants recommended that the provincial government should improve access to social supports for participants.

Power

During the mental health tribunal's pre-hearing, hearing, and post-hearing processes, participants expressed the view that they felt powerless in the system. They recommended that more participants should be appointed to positions in power within the mental health tribunals, the hospital, and community agencies. A participant argued as follows:

It is not just enough to hire a worker, say – a Somali worker in your agency. I think there needs to be a plan for having more of us at the table... at the tribunal, more faces and voices at the table in planning positions and policy positions because that, as much as we say that, I don't see that happening.

Accordingly, respondents warned that tokenism should be avoided when placing participants in positions of powers.

Education

In regard to education, participants suggested that more education was needed to challenge the institutional racism within the civil mental health system. Participants made specific recommendations to ensure that ethno-racial people with mental health disabilities are given free education about the mental health tribunal's process. They also recommended that researchers monitor the human rights abuses within the hospital and work to create change within the institutions.

Legislative Reform

Participants recommended that the principles of inclusion, respect, and cultural diversity should be included within Ontario's mental health legislation. They thought that the law should include factors of race, class, culture, ethnicity, and other social factors within the definition of mental disorder. In regard to the mental health tribunal's specific discretionary powers, a participant recommended

as follows: “The mental health tribunal should acknowledge the variant experiences. And see that as relevant to the experience and there is not just one way of looking at it. There are many ways of looking at it.”

Thus, participants thought the mental health tribunal should be required to inquire into and examine the intersectional and cultural arguments made on behalf of ethno-racial people with mental health disabilities.

Part III: Therapeutic Jurisprudence (TJ) and Cultural Competency

Therapeutic jurisprudence focuses on how the implementation of the law can produce therapeutic outcomes for clients (Hartley and Petrucci 2004). The founders of TJ, Wexler and Winick explain its purpose as follows:

Therapeutic jurisprudence proposes the exploration of ways in which, consistent with principles of justice, the knowledge, theories, and insights of the mental health and related disciplines can help *shape* the development of the law. (Wexler and Winick 1996: 126)

TJ encourages researchers to conduct empirical and interdisciplinary research to test the extent to which the implementation of the law results in therapeutic outcomes for clients (Wexler and Winick 1996). In regard to mental health law specifically, Perlin argues that TJ enables lawyers to overcome “sanism” which is described as “an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry...” (Perlin 2006: 74). Consequently, I used a TJ approach in conducting an analysis of the empirical data gathered for this paper.

The voices of ethno-racial people with mental health disabilities must be heard throughout the mental health tribunal’s pre-hearing, hearing, and post-hearing processes. In order to address the evident inequities ethno-racial clients confront within law and psychiatry, I argue that all practitioners should consider adopting tenets of TJ. For instance, TJ can be used to encourage lawyers and adjudicators to

recognize the intersectional concerns facing an ethno-racial client and therefore consider the extent to which cultural evidence is relevant to the case.

Lawyers and health care professionals should also be more aware of the impact that race, culture, ethnicity, power, and privilege have upon their relationship with clients. These issues are often not addressed in legal and medical curricula. Hartley and Petrucci argue that a “cultural[ly] competent TJ” can be incorporated into the curricula through

...an exploration of issues of power and oppression in perpetuating institutional racism; an exploration of one’s racial identity development status and a challenge to one’s personal racial beliefs and biases; and a skill building practical component to increase culturally competent interactions.
(Harley and Petrucci 2004: 171)

If TJ is considered in the mental health tribunal’s pre-hearing, hearing, and post-hearing processes, there is a possibility that these processes will be less adversarial and the narratives of ethno-racial people with mental health disabilities will be considered and accepted. As highlighted in the narratives presented in this paper, the impact of power, racism, and discrimination upon the lived of ethno-racial people with mental health disabilities must not be ignored. I argue that practitioners should attempt to combat the systemic racism inherent in law and psychiatry and develop an understanding of how the perception of mental health disability can vary amongst ethno-racial communities. Further, practitioners should use alternative communication methods, self-reflection techniques, cultural analysis and equity tools, and cultural interpreter/consultants in order to acknowledge and validate these diverse perspectives and create substantive equality for ethno-racial people with mental health disabilities.

However, it is important to recognize the critiques surrounding the application of therapeutic jurisprudence principles to mental health law. Given the prevalence of the medical model of disability within the mental health tribunal’s processes, Petrilu suggests the dangers

of using TJ are as follows: “A therapeutic approach may be conservative, or even paternalistic, particularly when people who can provide the best information about the therapeutic outcomes of legal/therapeutic interventions are excluded from participating in the analysis of what is in their interests” (Petrila 1996: 688).

Thus, before using TJ in this context, practitioners must ensure that ethno-racial people with mental health disabilities have a voice in the legal processes. They should be given deference as to what will constitute a “therapeutic outcome.” Further, as recognized by the critics of TJ, interdisciplinary research should be used to evaluate the extent to which TJ should be used in the mental health tribunal processes (Eastman and Peay 1999; Nolan 1998; Petrila 1996).

Conclusion

The narratives of ethno-racial people with mental health disabilities should not be invisible when considering debates pertaining to mental health law reform and improved mental health service delivery. In this paper, I examined empirical data obtained from seven intensive interviews with ethno-racial people with mental health disabilities (in-patients and ex-patients) who experienced discrimination while institutionalized in Ontario’s civil mental health system and interacting with mental health laws. The results were analyzed thematically as follows: role of practitioners, language/communication, the pre-hearing process, the hearing, grappling with culture, adversarial environment, family involvement, the post-hearing process, human rights in the hospital, racism, access to culturally appropriate treatment and care, religious accommodation, social supports, power, education, and legislative reform.

Within each theme, ethno-racial people with mental health disabilities provided their own recommendations of how to address the inequities they face interacting with Ontario’s mental health laws. The underlying analysis of the empirical research recognizes that the debate on the causes of these inequities is complex. Using therapeutic jurisprudence, practitioners should strive to uncover the multiple forms of discrimination and institutional racism within law and psychiatry impacting their ethno-racial clients. Although law

reform is a slow process, practitioners working in the mental health system can easily adopt tenets of TJ by acknowledging the unheard voices of ethno-racial people with mental health disabilities, ongoing cultural competency education and critical self-critique. Justice should no longer be an “invisible” outcome for ethno-racial people with mental health disabilities.

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