Human rights and equity in mental health services

BY MARINA MORROW

Marina Morrow is a professor at the School of Health Policy and Management in the Faculty of Health at York University. She uses critical mental health and intersectional approaches in her work to better understand the social, political, and institutional processes through which health and mental health policies and practices are developed and how social and health inequities are sustained or attenuated for different populations. Marina strongly supports public scholarship and the work and activism of the Mad movement and Mad scholars. Marina is the lead editor (with Dr. Halinka Malcoe) of *Critical Inquiries for Social Justice in Mental Health* (University of Toronto Press, 2017).

Evidence abounds of the discrimination, stigma, and human rights violations experienced by people who access mental health care, and yet the system's response to this evidence has been poor. Rights violations and coercive practices in mental health care are evident in discriminatory behaviours, stigmatizing attitudes, and the implementation of mental health laws (Brophy et al., 2018; Newton-Howes & Ryan, 2017; Newton-Howes, 2019; Pūras, 2017). The *Canadian Charter of Rights and Freedoms* upholds the right to life, liberty, and security, and is meant to protect Canadians from cruel and unusual punishment (1982, s. 7). Canada is also a signatory to the UN *Convention on the Rights of People with Disabilities* (UNCRPD), and yet many of the routine practices in mental health care violate both the Charter and the Convention (Pūras, 2017, 2018). These practices exist despite a global push toward recovery and human rights–oriented paradigms in mental health (Mental Health Commission of Canada [MHCC], 2009, 2012; World Health Organization [WHO], n.d.). This article provides an overview of these tensions and the current silences surrounding human rights in the Canadian mental health policy context, and highlights examples of resistive strategies and community-based initiatives that give primacy to people's lived experiences.

MENTAL HEALTH, HUMAN RIGHTS, AND SOCIAL JUSTICE

The Canadian mental health care system has often been referred to as a two-tiered system, or as one of "the orphan children" of medicare (Romanow, 2002, p. 178). From the inception of medicare, key players like the Canadian Mental Health Association (CMHA) and, indeed, Tommy Douglas himself supported the idea that medicare should include coverage for mental health. Regrettably, political jockeying ultimately resulted in medicare covering only medicalized services, including psychiatry, and, in the case of severe illness, a variety of community-based support systems that remain difficult to access and that by all accounts are fragmented and poorly coordinated (Marchildon, 2011; Kirby & Keon, 2006; Flood & Thomas, 2017). Meanwhile, those with money can access private psychological services and a range of mental health supporting resources like housing, good nutrition, access to recreation, and other wellness-related goods. This funding arrangement means that mental health is primarily defined in medical terms, a fact that structurally and ideologically limits the ability of governments to respond to the wide range of social needs that undermine mental well-being. Effectively, the Canadian mental health care system sees the social and structural determinants of mental health as secondary to the biological and genetic causes of mental distress, despite there being little scientific evidence to support this unidimensional understanding of mental health (Malla et al., 2015).

Human rights abuses and coercion arise from an entrenched belief that people suffering from mental illness and distress (especially as manifested in psychosis or forms of socially unacceptable behaviour) are incapable of making decisions about their needs. That is, people suffering from mental illness and distress are assumed to lack insight into their own condition, and therefore the state must step in to constrain and treat them. While most would acknowledge that there are situations in which people may pose a risk of harm to themselves or others, the current method of constraining and forcibly treating people is a blunt instrument for dealing with a complex and nuanced human problem. Mental health laws that allow for committal and forced treatment function through the mechanism of mandatory detention (Reilly et al., 2018). Compliance with mandatory detention and subsequent treatment is often enforced through interdisciplinary mental health care teams in coordination with police. The grounds on which mandatory detention orders can be issued vary from region to region, but orders are generally based on risk assessments of harm "to self or others." While it is recognized that domestic mental health laws operate in contravention of the UNCRPD[1] (Pūras, 2017, 2018; Hoffman et al., 2016), there has been little political will to bring domestic laws in line with international law.

Besides mandatory detention orders, other potentially damaging practices continue to proliferate, including the use of seclusion and restraints in hospitals, electroconvulsive therapy (ECT), and

Human rights and equity in mental health, page 7

Human rights and equity in mental health services

continued from page 6

stigma and discrimination that result in real harms and deter access to supports (Brophy et al., 2016; Milne & Williams, 2000). Discrimination based on gender, racialization, citizenship, and colonization interacts with mental illness, and thus certain populations are disproportionately impacted by these practices and by mental health human rights violations (Halinka Malcoe & Morrow, 2017). For example, men who are racialized, migrant, and Indigenous are more likely to be issued mandatory detention orders (Van Veen et al., 2018) and to be subject to coercive practices such as isolation rooms and physical and chemical restraints (Singh et al., 2007). Treatments that have proved damaging to the brain such as ECT are used more frequently on older women (Milne & Williams, 2000).

EXPLORING TENSIONS AND SILENCES

Countering discrimination and human rights violations in mental health care is the ongoing quest for more just and equitable mental health services both in Canada and internationally (Friedli, 2009; WHO, n.d.). Sweeping Canadian mental health care reforms since the 1960s have shifted the focus from institutional care to the provision of care in the community and have shifted the care paradigm from a custodial model to a model in which care is user-driven and enacts the recovery principles of autonomy and choice (MHCC, 2009, 2012; Mulvale et al., 2007). Recovery as a philosophy of care is rooted both in the activism of people with lived experiences of psychiatric institutionalization (e.g., Deegan, 1988) and in professional practice (Cleary & Dowling, 2009; Davidson et al., 2011). Recovery posits that, regardless of people's limitations due to illness, all people can live meaningful lives if they are free from stigma and discrimination and are able to access care and supports that foster self-determination (MHCC, 2012; Onken et al., 2007). Moreover, the recovery movement calls attention to the larger social and systemic issues facing people, including discrimination and the need for economic security (see Jacobson & Farah, 2012; O'Hagan, 2004).

Arguably, neoliberal policy and discursive regimes have co-opted recovery, reducing it from a powerful psychiatric survivor political movement to an individualistic approach that largely ignores the social and structural factors that impact people's lives (Morrow, 2013; Morrow & Weisser, 2012). Dramatic cuts to the social welfare state and the entrenchment of reductionist business models in mental health services have meant that discussions of rights and discrimination are largely absent in Canadian mental health policy. Indeed, in a climate of scarcity of supports, the loss of rights is often silently taken for granted as a prerequisite for accessing mental health care.

While the tensions between care and control as manifested in services have been much remarked on (e.g., Morrow et al., 2008), little progress has been made in reconciling these tensions, and indeed current policy responses trend toward social control. For example, the increasingly widespread integration of police into mental health care is resulting in new forms of surveillance and containment (Van Veen et al., 2018).

COUNTERNARRATIVES AND RESISTIVE PRACTICES

Activists have raised concerns about forced treatment, isolation, and restraints since the early days of deinstitutionalization, often using first-person narratives of the impact of these experiences (Shimrit, 1997; Capponi, 1992, 2003). Community-based organizations that are led or informed by psychiatric survivors are also sites of resistance, offering models of support that are non-medical and non-coercive and educating people about their rights (e.g., the Gerstein Crisis Centre in Toronto and the West Coast Mental Health Network in Vancouver). Activists have also challenged the Canadian government to bring its domestic mental health laws into full compliance with the UNCRPD (Crawford et al., 2019) and have launched lawsuits against provincial mental health statutes (e.g., Council of Canadians with Disabilities, 2016). Researcher partnerships that give primacy to the knowledge and experience of psychiatric survivors are also playing a role in building an evidence base that supports equity and human-rights-informed care (Morrow et al., 2020). While resistance is strong, it is not well coordinated, and supports are needed to sustain concerted pressure on the Canadian government to recognize the depth of the harms caused by services that violate human rights and basic human dignity.

NOTES

1. When Canada ratified the UNCRPD in 2010, it reserved the right to retain substitute decision making, which allows for detainment under provincial mental health statutes.

REFERENCES

Brophy, L.M., Roper, C.E., Hamilton, B.E., Tellez, J.J., & McSherry, B.M. (2016). Consumers' and their supporters' perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings. *Australian Health Review, 40*(6), 599–604.

Brophy, L., Ryan, C.J., & Weller, P. (2018). Community treatment orders: The evidence and the ethical implications. In C. Spivakovsky, K. Seear, & A. Carter (Eds.), *Critical perspectives on coercive interventions* (pp. 42–55). Routledge.

Canadian Charter of Rights and Freedoms. (1982). Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c. 11.

Capponi, P. (1992). *Upstairs in the crazy house*. Viking.

Capponi, P. (2003). *Beyond the crazy house: Changing the future of madness*. Penguin.

Cleary, A., & Dowling, M. (2009). The road to recovery. *Mental Health Practice, 12*(5), 28–31. https://doi.org/10.7748/mhp2009.02.12.5.28.c6864

Human rights and equity in mental health, page 8

Human rights and equity in mental health services continued from page 7

Council of Canadians with Disabilities. (2016). http://www.ccdonline.ca/en/humanrights/litigation/Update-on-Charter-Challenge-BC-Mental-Health-Act-29Nov2018

Crawford, C., Hardie, S., & Wicklund, E. (2019). *Recommendations for action and people of concern: Shadow reports from Canada under the UN Convention on the Rights of Persons with Disabilities, 2016–2017*. Funded by the Canadian Centre on Disability Studies Incorporated operating as Eviance.

Davidson, L., Rakfeldt, J., & Strauss, J. (2011). *The roots of the recovery movement in psychiatry: Lessons learned*. Wiley.

Deegan, P.E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11.

Flood, C.M., & Thomas, B. (2017). Fragmented law & fragmented lives: Canada's mental health care system. In J.A. Chandler & C.M. Flood (Eds.), *Law and mind: Mental health law and policy in Canada*, Ottawa Faculty of Law Working Paper No. 2020-33. Available at SSRN: https://ssrn.com/abstract=3662667

Friedli, L. (2009). *Mental health, resilience and inequalities*. World Health Organization. http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

Halinka Malcoe, L., & Morrow, M. (2017). Introduction: Science, social (in)justice, and mental health. In M. Morrow & L. Halinka Malcoe (Eds.), *Critical inquiries for social justice in mental health* (pp. 3–33). University of Toronto Press.

Hoffman, S., Sritharan, L., & Tejpar, A. (2016). The UN Convention on the Rights of Persons with Disabilities and its impact on mental health law and policy in Canada. In J.A. Chandler & C.M. Flood (Eds.), *Law and mind: Mental health law and policy in Canada* (pp. 53–79). LexisNexis.

Jacobson, N., & Farah, D. (2012). Recovery through the lens of cultural diversity. *Psychiatric Rehabilitation Journal, 35*(4), 333–335.

Kirby, M.J., & Keon, W.J. (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada*. Standing Committee on Social Affairs, Science and Technology. Senate of Canada.

Malla, A., Joober, R., & Garcia, A. (2015). "Mental illness is like any other medical illness": A critical examination of the statement and its impact on patient care and society. *Journal of Psychiatry and Neuroscience, 40*(3), 147–150.

Marchildon, G.P. (2011). A house divided: Deinstitutionalization, medicare and the Canadian Mental Health Association in Saskatchewan, 1944–1964. *Histoire sociale/Social History, 44*(88), 305–329.

Mental Health Commission of Canada (MHCC). (2009). *Toward recovery and well-being: A framework for a mental health strategy for Canada*. https://www.mentalhealthcommission.ca/sites/default/files/FNIM_Toward_Recovery_and_Well_Being_ENG_0_1.pdf

Mental Health Commission of Canada (MHCC). (2012). *Changing directions, changing lives: The mental health strategy for Canada*. https://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG.pdf

Milne, A., & Williams, J. (2000). Meeting the mental health needs of older women: Taking social inequality into account. *Ageing & Society, 20*(6), 699–723.

Morrow, M. (2013). Recovery: Progressive paradigm or neoliberal smokescreen? In B. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian Mad Studies* (pp. 323–333). Canadian Scholars.

Morrow, M., Brophy, L., Edan, V., Hardie, S., Ibrahim, M., & Njenga, M. (2020). *Enhancing human rights and equity in mental health care* [SSHRC Insight funded research].

Morrow, M., Dagg, P., & Pederson, A. (2008). Is deinstitutionalization a "failed experiment"? The ethics of re-institutionalization. *Journal of Ethics in Mental Health, 3*(2). http://www.jemh.ca/issues/v3n2/index.html

Morrow, M., & Weisser, J. (2012). Towards a social justice framework of mental health recovery. *Studies in Social Justice, 6*(1), 27–43.

Mulvale, G., Abelson, J., & Goering, P. (2007). Mental health service delivery in Ontario, Canada: How do policy legacies shape prospects for reform? *Health Economics, Policy and Law, 2*(4), 363–389.

Newton-Howes, G. (2019). Do community treatment orders in psychiatry stand up to principalism: Considerations reflected through the prism of the Convention on the Rights of Persons with Disabilities. *The Journal of Law, Medicine & Ethics, 47*(1), 126–133.

Newton-Howes, G., & Ryan, C.J. (2017). The use of community treatment orders in competent patients is not justified. *The British Journal of Psychiatry, 210*(5), 311–312.

O'Hagan, M. (2004). Guest editorial: Recovery in New Zealand: Lessons for Australia? *Australian e-Journal for the Advancement of Mental Health, 3*(1), 5–7.

Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R.O., & Cook, J.A. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 31*(1), 9.

Pūras, D. (2017). UN General Assembly. *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. https://reliefweb.int/sites/reliefweb.int/files/resources/G1707604.pdf

Pūras, D. (2018). UN General Assembly. *Preliminary observations—Country visit to Canada, 5 to 16 November 2018: UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23896&LangID=E

Human rights and equity in mental health, page 10

Demedicalizing mental health

continued from page 9

nurse/social worker/police officer model (Toronto Neighbourhood Centres, 2021). Given the notable increase in police brutality and violence, which has especially affected marginalized groups and those with mental health issues, this project is not only timely but also a necessary activist response to the call to abolish carceral and punitive forms of justice.

The consequences of biomedical psychiatric hegemony in the health professions are both far-reaching and highly problematic for society. The reproduction of biomedical psychiatry through the cognate disciplines will continue to lead to violent and, at best, highly problematic practices aimed at "helping" while often producing the very opposite result. While the current evidence of the profuse medicalization of mental health in nursing education is rather clear (Adam, 2017; Adam et al., 2019; Adam & Juergensen, 2019), my hope is that the contributions of these projects, and my work more generally, will fuel the global psychiatric abolitionist movement and help to create more community-based alternatives to psychiatry.

REFERENCES

Adam, S. (2017). Crazy making: The institutional relations of undergraduate nursing in the reproduction of biomedical psychiatry. *International Journal of Nursing Education Scholarship, 14*(1). https://doi.org/10.1515/ijnes-2017-0071

Adam, S., & Juergensen, L. (2019). Toward critical thinking as a virtue: The case of mental health nursing education. *Nurse Education in Practice, 38*, 138–144. https://doi.org/10.1016/j.nepr.2019.06.006

Adam, S., van Daalen-Smith, C., & Juergensen, L. (2019). The indispensability of critique: Reflections on bearing witness to mental health discourse. *Canadian Journal of Critical Nursing Discourse, 1*(1), 39–48. https://doi.org/10.25071/2291-5796.18

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

Johnson, S., Adam, S., & McIntosh, M. (2020). The lived experience of postpartum depression: A review of the literature. *Issues in Mental Health Nursing, 41*(7), 584–591. https://doi.org/10.1080/01612840.2019.1688437

Toronto Neighbourhood Centres. (2021). *Rethinking community safety: A step forward for Toronto*. https://neighbourhoodcentres.ca/sites/default/files/2021-01/Rethinking%20Community%20Safety%20-%20A%20Step%20Forward%20For%20Toronto%20-%20Full%20Report.pdf

---

Human rights and equity in mental health services

continued from page 8

Reilly, R., Hastings, T., Chaimowitz, G., Neilson, G., Brooks, S., & Freeland, A. (2018). *Community treatment orders and other forms of mandatory outpatient treatment*. [Position paper, Canadian Psychiatric Association]. https://www.cpa-apc.org/wp-content/uploads/Mandatory-Outpatient-Treatment-CTO-2018-web-EN.pdf

Romanow, R. (2002). *Building on values: The future of health care in Canada*. Final report of the Commission on the Future of Health Care in Canada. https://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf

Shimrit, I. (Ed.). (1997). *Call me crazy: Stories from the Mad movement*. Press Gang.

Singh, S.P., Greenwood, N.A.N., White, S., & Churchill, R. (2007). Ethnicity and the Mental Health Act 1983: Systematic review. *The British Journal of Psychiatry, 191*(2), 99–105.

Van Veen, C., Ibrahim, M., & Morrow, M. (2018). Dangerous discourses: Masculinity, coercion and psychiatry. In J. Kilty & E. Dej (Eds.), *Containing madness: Gender and "psy" in institutional contexts* (pp. 241–267). Palgrave Macmillan.

World Health Organization (WHO). (n.d.). *WHO QualityRights initiative: Improving quality and promoting human rights*.