

INTERROGATING SAFEGUARDS UNDER THE *MENTAL HEALTH ACT*: CRITICIZING
THE DECISION IN *THOMPSON AND EMPOWERMENT COUNCIL V. ONTARIO* (2013):
TOWARDS AN ALTERNATIVE UNDERSTANDING OF PSYCHIATRIC DISABILITY
FROM THE PERSPECTIVES OF CRITICAL DISABILITY THEORIES AND
CRISPITEMOLOGY

YOONMEE HAN

Supervisor's name: Dr. Rachel Gorman

Advisor's name: Dr. Jessica Vorstermans

Supervisor's signature: _____

Date approved: _____

Advisor's signature: _____

Date approved: _____

Final Draft of Master's Research Paper submitted to the Graduate Program in Critical Disability

Studies in partial fulfilment of the requirements for the degree of Master of Arts

Graduate Program in Critical Disability Studies York University Toronto, Ontario M3J 1P3

November, 2021

Acknowledgment

I could not have finished my MRP without supports I have received from many people.

First, I am truly grateful to my faculty members, my supervisor, Rachel Gorman and advisor, Jessica Vorstermans, for helping me through administrative works as well as academic advice and endless encouragements. I am indebted to, Nancy Viva Davis Halifax for inspiring classes and helping me to come back to the program. I am also eternally grateful to Greg Albo. Without Greg's accommodation, understanding and guidance, I could not have continued my degree.

I appreciate friends and colleagues who provided me proof reading and editing supports, specifically, Tracy Mack, Joshua Synenko, Patricia Ki, Rabia Khokhar, Cindy Jiang, Natalie Spagnuolo, Caroline Kovesi, and Kevin Jackson. Thank you, Tracy for dragging me out of bed, giving me food and drinks when I was sad and for your encouragement, solidarity, and advice during the hardest times. Thank you, Caroline for your moral support, edits, and friendship. Thank you, Kevin for reaching out to me, and sharing your koan with me; I miss Kevin as my disability justice activist, comrade and friend.

Also, thank you Patrick Sullivan for reminding me of the moto "just keep swimming" when I was lost.

Introduction

In April of 2011, Karlene Thompson and the Empowerment Council, Systemic Advocates in Addictions and Mental Health brought a legal challenge against the *Mental Health Act* (1990). They argued that community treatment orders (CTOs) enacted as part of *Brian's Law* (2000) are unconstitutional under the *Canadian Charter of Rights and Freedom* (1982). The *Mental Health Act* (MHA) allows for the involuntary hospitalization of persons diagnosed with a mental illness whom doctors believe are in danger of harming themselves or others. Community treatment orders entail forced psychiatric intervention in a community setting (Mfoafo-M'Carthy, 2010). In other words, a person subjected to a CTO must follow a treatment plan ordered by a psychiatrist as a condition to continue residing in the community. In *Thompson and Empowerment Council v. Ontario* (2013), the applicants argued that coerced treatment as outlined in sections 15(1.1), 16(1.1) and 20(1.1) of the *MHA*, and specifically, CTOs, violated sections 7, 9, 10 (a)(b), 12, and 15 (1) of the *Canadian Charter of Rights and Freedom* (*Thompson and Empowerment Council v. Ontario*, 2013). The applicants argued that the legislation violated their right to self-determination in making medical choices for themselves. As the legislation was crafted for the sole purpose of public safety, it presumes people diagnosed with mental illnesses to be public dangers – an assumption that discriminates against people labelled with psychiatric diagnosis, depriving them of their *Charter* rights to life, liberty, and freedom (*Thompson v Ontario*, 2016).

Ultimately, Thompson's legal challenge was unsuccessful, as the judges found that the *MHA* contains safeguards robust enough to serve the purpose of the legislation of protecting public health and safety. Such safeguards include a formal process for psychiatric assessment,

admissibility criteria for a CTO, and mandating that people being considered for a CTO be informed of their right to legal advice as well as their right to file a review with the Consent and Capacity Board (CCB). The court also reasoned that since only a well-trained psychiatrist may determine who meets the criteria for a CTO through individualized assessment, those who do not stand to benefit from a CTO will not be subjected to one. Accordingly, they believe these criteria prevent a breach of rights. After being defeated in the Ontario Court of Justice, the applicants filed an appeal in 2016, which was subsequently dismissed (*Thompson v Ontario*, 2016).

Like Thompson, I believe that the *MHA*, section 33.1, which refer to CTOs, infringe on an individual's rights to life, liberty, and security as outlined in the *Canadian Charter of Rights and Freedoms* (1982). Had the argument in *Thompson and Empowerment Council v. Ontario* (2013) been made more effectively, I believe that the court might have been required to introduce an amendment to the legislation to improve its safeguards and admissibility criteria. In opposition to what the court in *Thompson and Empowerment Council v. Ontario* (2013) and in *Thompson v. Ontario* (2016) found, I will argue that current safeguards fall short in averting a disproportionate balance between the legislation's stated purpose of public health and safety, and the denial of liberty, freedom, and autonomy of people diagnosed as mentally ill. I assert that unless more substantive safeguards are implemented, the deprivation of autonomy and resulting suffering of psychiatric inmates under CTOs cannot be justified in the name of public health and safety (Fabris, 2011).

I will contend that court arguments should have reflected a definition of people with disability that is not based on psychiatric reductionism but is grounded upon a post-modernist relational approach to disability. Also, by analysing the discourse of public health deployed in the Thompson's cases, I will argue that the concept of mental illness, which is recognized as

public health issue, is utilized in the court arguments, leading to the court decision that fundamentally violates the *Charter* rights of people with psychiatric disabilities.

Structure of the MRP

My Master's Research Paper (MRP) is comprised in two parts. First part explores definitions of disability, mad, and mad identity. I interrogate how mad identity can be organized in a way that avoids co-opting (Beresford and Russo, 2016) and subscription to white centered "disability nationalism" (McRuer, 2010; Chen, 2014). I use a Foucauldian framework and post-modernist disability theories to contextualize how my own mad identity intersects with other social oppressions within the academic and psychiatric system, which in turn reflect how biopower works at large. I reflect fluid, multi-layered and intersecting identity factors that comprise so many different mad experiences and positions related to the psychiatric power regime. In doing so, I will seek to find a way to link my position to anti-psychiatry movements as a mad ally. I will explore this possibility by using my personal narratives of getting labelled with a psychiatric diagnosis, and connecting this to the narratives of witnessing what many unhoused people in the Toronto shelter system go through under the current coercive mental health law: Community treatment orders (CTOs).

For the theoretical framework, I use critical disability theories and cripistemology (Johnson & McRuer, 2014) for my reflective autobiographic narratives. The post-modernist account of the relational concept of disability will inform how disabilities can be understood as phenomenological "becoming" (Roets & Braidotti, 2012, p.166; Shildrick, 2020). While it is complete on its own, this part of MRP is intended to serve as a theoretical groundwork for the legal analysis of *Thompson and Empowerment Council v. Ontario* (2013), that is conducted in the second part of the paper.

The second part is comprised of a legal case study. I critically analyze the discourse on mental illness deployed in *Thompson and Empowerment Council v. Ontario* (2013). I use the Foucauldian theory of biopower (Foucault, 1990), the medical model of disability (Barnes, 2020; Oliver, 1990), and postmodernist relational approach to disability (Goodley, 2013; Roets & Braidotti, 2012; Shildrick, 2020) as critical lenses to deconstruct the concepts of mental illness in *Thompson and Empowerment Council v. Ontario* (2013). Building on a Foucauldian theory of discourse and biopower, I argue that the notion of mental illness is operationalized throughout the legal discourses of public health. This demonstrates how the pathologized concept of mental illness is mindlessly prescribed in legal discourses, strengthening psychiatric power entrenched in mental health laws (Fennell, 2010). In response to this matter, I suggest that a relational concept of disability could be used as an alternative legal tool to unsettle the medico-legal power. This approach could shift epistemic grounds in the legal discourses, critiquing against CTOs in the Ontario *MHA* (1990). In doing so, I discuss the possibility of different outcomes of the court ruling, arguing that adopting a post modernist conceptualization of psychiatric disability could have led the court ruling to a direction that improves the rights of people labelled with a psychiatric diagnosis by adding renovative and substantial safeguards in *MHA* (1990).

This part of the paper has three subsections. In the first section, using the legal analysis of both *Thompson and Empowerment Council v. Ontario* (2013) and *Thompson v. Ontario* (2016), I argue that the judge erred in their conclusion that the legislation is not overbroad or grossly disproportionate, as safeguards are inadequate. In the second section, I argue that safeguards attached to CTOs and the court's discourse that defends CTOs are based on a medical understanding of mental illness. Since the medical model dominates legal interpretations of these safeguards, the safeguards disregard relevant socio-environmental factors and the embodied

experiences of persons labelled with a psychiatric diagnosis (Fabris, 2011). To conclude, in the third section, after introducing a socio-relational model of disability, I suggest how safeguards in the *MHA* can be amended in ways that uphold the rights of people diagnosed with mental illnesses within the limitations of the current legal framework. Throughout the paper, I will argue: 1) that CTOs' infringement on the rights of people labelled with a diagnose of mental illnesses cannot be justified by section 1. of the *Charter* and 2) that the coercive elements of *MHA* cannot be saved from breaches of fundamental justice without additional safeguards implemented to mitigate the impacts of rights violations and discrimination against persons diagnosed with mental illnesses.

Terminology

In my MRP, I interchangeably use the following terms: 'people with psychiatric disability', 'people diagnosed as mentally ill', 'people labelled with a psychiatric diagnosis', 'mad people', 'psychiatric survivors', 'people who are psychiatrized' and 'people experiencing mental distress and mental difference'. While all of these terms refer to those who are psychiatrized and disfranchised by medio-legal power dynamics and under broad socio-economic oppressions, it is important to note that when certain terms, such as 'mental illness', 'the concept of mental illness', 'a diagnosis of mental illness', and 'mental health system' are employed in this paper, these wordings are based on the understanding of the concept of mental illness as a clinical construct, that is used to pathologize, contain, and subjugate the population deemed to be deviant in the view of psychiatric power regime (Burstow, 2013). Therefore, I tried to refrain from using taken-for-granted verbiages, namely 'mental illness' and 'mental health problem' since these specific terms are historically used to naturalize the biomedical epistemology of mental illness

and that have been used to medicalize and criminalize people experiencing mental distress¹ (Burstow, 2013). Instead, I refer to the population in specific ways as ‘people who are diagnosed as mentally ill’ or ‘who are labelled with a psychiatric diagnosis’, to emphasize the fact that the concept of mental illness is imposed onto the people experiencing mental distress by psychiatry and society at large. Furthermore, in line with these critiques of Critical Disability Studies (CDS) and Mad Studies scholarship, which is made in response to the medicalization of ‘mental distress’ and psychiatric violence against the population, and in light with the mad movements’ reclaiming of the word ‘mad’ (LeFrançois, Menzies & Reaume, 2013), I intentionally used politicized terminologies such as ‘people with disability’, ‘people experiencing mental distress and difference’, ‘psychiatric survivors’, ‘psychiatrized people’, or ‘mad people’. When I refer to a person as a person with psychiatric disability, the concept of ‘disability’ is expected to have the politicized meaning of disability (mad) as a social category rather than an individual’s biomedical deficit (Barns, 2020; Oliver, 1990). While using a definition that departs from the biomedical ontology of mental illness, this framework is also utilized in association with a post-modernist approach to disability and madness that is conceptualized as relational.

While I interchangeably use those terms depending on the contexts of my argument throughout the MRP which differs in nuances, when I use the term, ‘mental illness’ and ‘mental health’ without referencing to any act of labelling with a psychiatric diagnosis, it is only used in reference to legal sections, policies, or legislations in a descriptive manner. The term, ‘mental difference’, is also used along with the term ‘mental distress’ to refer to the people who experience different patterns of thoughts and emotions, and different ways of being and thinking.

¹ Considering power dynamics that are implicated in the process of psychiatric knowledge production, Burstow (2013) points out that uncritically using languages such as ‘psychiatric consumers’, ‘mental illness’ and ‘mental health service users can result in co-option to psychiatric power regime.

Nevertheless, it is important to note that my understanding of the ‘mental difference’ is neither a pre-given nor acontextual state of mental being that is often ascribed to psychiatricized people through pathology. Rather, ‘mental difference’ is understood as a social category as well, which is created and consistently shaped through a normalization process unfolding in relation to what the ideal of rational and moral being entails. These conceptual challenges in CDS and Mad studies literature, the relevant usage of languages, and its historical and contextual associations will be further explained in the next section of the paper.

Part One: Exploring Disability Identity and Mad Politics Using Autobiography Narratives

Theoretical Framework: Disability Models and the Biopolitics of Mental Health

Disability studies scholars have criticized that disability policies, laws, and programs are fundamentally established upon medical reductionism (Barnes, 2020; Thomas, 1999). The medical model of disability assumes that disability is caused from individuals’ impairment and illness, which renders disability policy directions limited to medical intervention while the social model of disability draws an attention to inaccessible social and structural features constructed against people with disabilities (Oliver, 1990). The social model of disability has been widely adopted for disability justice movements and reflected in policy and laws including the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD) and court rulings of Supreme Court of Canada (Costa, 2013; Lewis, 2010).

However, this structuralist approach to disability falls short in supporting the politics of psychiatric survivors who have endured psychiatric abuse and human rights violations. In particular, the dualistic framework cannot provide theoretical grounds for the experiences of those who are caught in the power dynamics of psychiatry. The experiences of illness, mental distress or mental difference, and the negative effects of how it is perceived and treated within

the current health care system are important parts of disability identity (Crow, 1996; Wendell, 1996). While the social model emphasizes the social aspects of barriers and discrimination, this model, with its oversimplifying dualism (Shildrick, 2020), runs the risk of treating physical impairments or mental difference as a pre-given matter. Therefore, impairment and mental distress easily fall into a medical category separated from social matters.

In response to these critiques, post-modernist scholars offer relational and non-dualistic approaches to disability. This analysis goes beyond equality-based citizenship rights towards challenging normalizing forces, which constantly generates and reiterates who is normal and who is not, through the construction of the on-going cultural discourses of disability and impairment (Shildrick, 2020). Also, post-modernist thinkers have emphasized the embodied non-dualistic nature of disability and madness (Goodley, 2013; Roets & Braidotti, 2012; Shildrick, 2020). According to these thinkers, disability is theorized as occurring within biopower's cultural discourse and its material dispossession of bodies, which is happening in conjunction with the neoliberal doctrines of self-betterment and responsibility. In other words, disability and madness are defined as embodied experience through which a sense of self is formed and is morphed into a subjectivity via multiple cultural discourses and practices in relation to ableist norms (Shildrick, 2020; Goodley, 2004). These ableist norms, integral to the sense of neoliberal subjectivity, are not a fixed entity that is marked off in a dualistic sense, but those norms are malleable as ableist relations operate based on the neoliberal regulation regarding who is desirable and who is not. As Goodley (2004) addresses, "regimes of bio-power fed upon social and cultural discourses that, as key mechanisms in the process of social control, socially construct particular versions of self, personhood and subjectivity" (p.164).

Foucault (1990) describes how bio-power is exercised through administrative, institutional, and discursive processes that generate modern subjects. In the normalization process, a liberal subject is carved out according to the norms produced and enhanced by disciplinary techniques directly imposed on individual bodies and souls (Foucault, 1995; Waldschmidt, 2005). In this way, the modern subject is shaped and emerges along with the notion of imaginary ideal personhood, autonomy, agency, and subjectivity (Foucault, 1990). On the contrary, the apparatus of security operates in different ways in which the governing power engages with population. This mechanism considers the population to be a “thick natural phenomenon” (Foucault, 2007, p. 70) that has its own process of development within a given space. Governing power exercises the techniques of calculation and analysis to the point that the population comes to be a transformative phenomenon accessible to power. The axis that puts varied individual elements together to the collective unit of population is their commonality to have a biological desire to life (Foucault, 2007). The desire to life is the point where the governing power acquires the validity to intervene the collectivized population through various techniques, producing the concept of the general interests of the population (Foucault, 2007). In this sense, the “population is pertinent elements for mechanisms of power” (Foucault, 2007, p. 73) because the interests of the population converge with the economic-political thoughts of governing techniques. In this way, the governing power creates environments in which life is envisioned to be nurtured at the population level, and constitutes a basis for the modern collective subject’s biological claims for health care service in the framework of citizenship (Rose, 2007).

On the flip side of the security engines that produce modern citizenry based on their interests and desire to life, as Puar (2017) elaborates, the control and security apparatus of bio-

power, at the same time, creates debilitating effects on the population level, incorporating people into bio-medical industrial complex where

all bodies are medicalized and capitalized (Puar, 2017). In Puar's (2017) words, "an array of diverse switch points of the activation of the body, where bodies are positioned through openings and closings in order to ground practices of exploitation, extraction, dispossession, and expulsion commensurate with flexible modes of work and sociality" (p. 22). This is a process of the biopolitical circuit of inclusion and exclusion, through which, according to Puar (2017), "differential normativity" (p. 22) occurs, rendering certain bodies being incorporated into the neoliberal circuits of capital accumulation while others are left to have a "slow death" (Puar, 2017, p. 22). Since all bodies are considered as a prognosis of illness, people are encouraged to strive for better health outcomes and well-being by engaging in a variety of medical and non-medical means (Puar, 2017). Puar (2017) elaborates that "all bodies are being evaluated in relation to their success or failure in terms of health, wealth, progressive productivity, upward mobility, enhanced capacity" (p.15). In this way, certain bodies that can be enhanced to maximum capacity by participating in a biomedical industrial complex are successfully included in neoliberal society. On the other hand, bodies that are not aligned with the neoliberal drives and desires, fall into the institutional disciplines and legal controls.

Furthermore, the socio-economic inclusion of certain bodies occurs along with the biopolitics' ever-shifting discourses on public health. Biopower, as a ruling mechanism, operates as an axis that creates the modern subject through the discourses of public health that is organized in policy design. The discourses of public health are ordered in a way in which all bodies are transformed to statistical calculation, and medical scrutiny within the public health framework (Waldschmidt, 2005). These normalizing forces of public health, the discursive

production of normative citizens, and what is also termed “flexible normality” (Waldschmidt, 2005) constantly shape a new normal for neoliberal subjects. In this way, as Diamond (2013) points out, biopower creates biomedical subjectivity by incorporating citizens with disabilities into its “psy-regime” (Diamond, 2013, p. 65), that is constituted by the interests of governments, pharmaceutical industries (Washington, 2011), and medical professions.

As a result, some privileged people with disabilities, for example, white males who are educated and middle-class are included in neoliberal society, while disfranchised ‘others’ who cannot perform neoliberal betterment by utilizing biomedical labeling are further marginalized (Gorman, 2013). This analysis of biopower and governing techniques, as part of ableist and neoliberal relations, converges with what McRuer (2010) cautions about “disability nationalism”² (McRuer, 2010, p.166). While some people who identify as a person with a disability are seen as desirable and can be included in society through biopolitical integration and the language of citizenship rights, this inclusion is conditional to their productivity, continuing desirability, and compliancy to the biomedical system (Campbell, 2013). Moreover, this inclusion unfolds at the expense of other “bodyminds”³ (McRuar & Johnson, 2014, p. 157) that are debilitated to the point of disposal within geopolitical and global economic circulation. Accordingly, and in this context, a binary distinction of disabled/non-disabled or Mad/sane, based on identity politics, cannot sustain as a political drive (Diamond, 2013; Shildrick, 2020). In other words, the degree of debility and capacity impacts individuals differentially according to

² Expanding on the queer theories’ and post-colonial and transnational critiques on the liberal states’ incorporation of gay rights movement, McRuer (2014) termed, “disability nationalism” (p.166) to point out that disability relation needs to be examined in the geopolitical contexts of disability creation because, while disability rights movements are contained in the national boundary, and it is used to reinstate the victories of liberal nationalism, the biomedical and neoliberal economy circulates through global exploitation of labour creating debility on bodyminds of people outside of the Northern countries’ national boundary.

³ Margaret Price (2019) borrows the term bodymind from the work of Babette Rothschild in order to challenge a Cartesian separation of body and mind as well as the disconnection between psychical and mental disabilities employed in disability theories. (McRuer, 2019)

neoliberal and ableist relations at the global level, and the new norms for desirable citizens, being produced based on the biomedically enhanced capacity and desirability at the local level and widely circulate within disability communities. In this sense, the divisive question of who is 'us' in our community cannot be relied upon a singular experience of disablement or having diagnostic labels attached to a person.

Given this, the concept of disability subjectivity, also termed as crip-subjectivity (McRuer, 2014), can be reformulated in light of the post-modernist scholars' articulation of disability as a theory of complex embodied phenomenon (Shildrick, 2020). According to Shildrick (2020), the self's location is in the grids of biomedical industries, institutional practices, and cultural discourses that produce social norms and desires in relation to which subjectivity consistently emerges and transforms. In this sense, borrowing from Deleuze and Guattari's (1980) concept of "nomadic subjects"(p.166) which is constantly moving in flux, Roets and Braidotti (2012) suggest a possibility of thinking of disability subjectivity as a temporal and spatial "becoming" (p.166) which is happening as a political process in a moment and in relation to material and non-material others. In this way, disability can be thought of being within particular geopolitical and institutional relations and outside of national boundaries. Also, it can be thought as an assemblage of flexible and temporal experiences, which is, in their words, "forming subjectivity as transversal connections or assemblages with multiple others" (p.162). As Roets and Braidotti state, "this translates as an appeal for a re-conceptualisation of the nature of impaired bodies-and-minds as always in process, always in becoming and in relation to the collective" (p. 166).

This elasticity and temporality of disability as becoming, sheds light on the impacts of systemic and geopolitical oppressions imposed on different bodyminds (McRuer, 2019). An

embodied self is in a constant relationship with others, and is reflected upon the institutional, administrative, and contextual factors, creating cultural desires that not only shapes a subjugated disability subjectivity but also affects how subversive disability desires possibly emerge (Roets & Braidotti, 2012). This framework enables the inquiries of disabled and mad experiences in contextual ways, locating it within different modes and mechanisms of institutional oppressions. Moreover, and importantly, this understanding of disability helps to carve out a path for a collective disability and mad organizing that center around multiple intersections of racialized, gendered, and psychiatrized mad experiences. As Roets and Braidotti (2012) point out, “(i)mpaired bodies and minds can be recast as driving forces that constitute a network of interconnection with others implies not an us/them politics but one in which human beings border/cluster in the collective” (p. 167). Moreover, it is possible to think of the embodied self as a site for a collective and subversive becoming that embodies the politics of anti-sociality⁴ (Campbell, 2013, p.232). In this way, mad movements that adopt this approach to disability can organize as an alliance against multiple layers of power relations implicated in policy, public discourses, and institutional structures.

The Construction of Mental Illness

The concept of biological citizens became plausible along with a new perception of themselves as “neurochemical-selves” (Rose, 2007, p. 188). Neurobiology, otherwise known as “the truth game” (Rose, 2007, p. 26), changed the way people think about themselves by forming

⁴ Anti-sociality is forwarded by Campbell (2013). After criticizing identity politics’ growing integration into neoliberal economy, Campbell (2013) discusses the ontological meaning of disability by retheorizing it as a possibility of a radical state of being and living that reveal and contradict the injuries of neoliberal and ableist social relations. According to Campbell (2013), disability is articulated as “blemish” (p. 227) and thought to be in relation to “anti-sociality” (p. 232) and “radical passivity” (p. 221). This approach to disability and madness exposes and illustrates the negative, unpleasant, and even offensive anti-social aspects of disabled experiences, that is captured and reimagined as a resistance against institutional relations of power through disability and mad narratives (Campbell, 2013).

an understanding of human beings at a molecular level. In this mode, mood, behavior, personality, and the onset and the development of psychiatric symptoms are reformulated as alignments of and molecular occurrences in neurons, receptor sites, neurotransmitters, and genetic susceptibilities (Rose, 2007). To be specific, in the realm of psychiatry, the development of the Diagnostic and Statistical Manual for Mental Disorders (DMS-5) considers the molecular understanding of mental illness as coming from abnormality of chemical neurotransmissions in the brain and these findings in relation to the development of therapeutic intervention and of the psychopharmacology (Gambrill, 2014; Rose, 2007). Along with some discoveries in neuroscience, pharmaceutical companies and related bio-medical industries participated in new discourses about mental health, generating a “style of thoughts” (Rose, 2007, p. 201) which underlines the neurochemical mode of diagnosis and the effects of pharmaceutical drug. These theories have convinced people to reformulate their identity to the neurochemical selves through biomedical companies’ investments, and collaborating policy deregulation of the pharmaceutical companies’ direct consumer advertisements and health promotion campaigns (Rose, 2007).

However, the backbone of the mad movement was critiques against the bio-medical model of mental illness that sustained institutional psychiatry and psychiatric violence (Diamond, 2013). Uprising for psychiatric abolition, anti-psychiatry scholars point out that the concept of mental illness is a clinical construct (Beresford & Wilson, 2002; Burstow, 2013; Burstow, & LeFrancois, 2014; Szasz, 2003). Even though not grounded on a laboratory science, the diagnosis criteria are taken as a scientific truth feeding upon the discursive construction of mental illness and is deployed as a basis for policy design and legal decisions that are developed for psychiatric control (Burstow, 2013; Szasz, 2003). To be specific, the medical model provides a basis for the construction of mental illnesses, with its ever-growing and ever-changing

categories of mental illnesses (i.e. schizophrenia, bipolar, manic disorder, personality disorders and major depression). This categorization within the DSM-5 uses an analogous discourse by equating the categories of mental illnesses to pathological ailments. In this discourse, mental illness is thought to be originated from genetic-biology (Beresford & Wilson, 2002). However, the DSM-5 is a clinical invention that is based upon artificial classifications of perceived symptoms, and the practices of diagnosing somebody are relied upon clinicians' individual judgement. This classification, and the clinician's authority to diagnose someone as mentally ill, are heavily value-loaded, gendered, classed, and racially biased, rather than founded on laboratory neuroscience using a brain scan (Pilling et al., 2018; Wipond, 2013). Moreover, although this pseudo medico-science of mental illness does not have enough scientific evidence to prove what it claims, it is often used as a discursive strategy to criminalize and control people who are already socio-economically marginalized, gendered, and racialized (Beresford & Wilson, 2002).

The biomedical explanation of mental distress becomes official knowledge through the exaggerations and belligerent reporting in the news media, political campaigns, and governments reports (Wipond, 2013). This way, the biomedical paradigm became an official cannon, directing legal approaches and policies focusing on biochemical interventions by using psychotropic medications and institutional coercions (Beresford & Wilson, 2002; Morrow, 2017). Through this process, the notion of abnormality is ascribed to people who experience mental distress (White & Pike, 2013). In this paradigm, since mental and emotional distress are considered to be individuals' abnormal brain function and biomedical defects, public health discourses and related policies are crafted in limitation to medical intervention. Moreover, the policy efforts to 'correct' a person diagnosed with a mental illness, contribute to the legalization of coercive methods that

individually target the population through involuntary treatment orders such as CTOs under the MHA (1990) (Fabris, 2011).

The official knowledge of mental health, framed as a public health issue, is coupled with other neoliberal policies and propaganda aimed at reducing public spending on health care and social services (Morrow, 2004, 2017). The concept of neurochemical subjectivity is subsumed into a knowledge-power collaboration which enforces the medical model of psychiatric diagnosis based on biomedical reductionism. On the surface, the psychiatric consumer-led programs and advocacy movements arose, and they were included in the post-asylum discourses of policy designs (Morrow, 2004). However, as Morrow et al., (2008) mentions, the biomedical reductionism has continued to adopt a narrow pathological and neurobiological definition of psychiatric diagnoses, resulting in the disregard of the real problems this population faces in policy designs. They point out that “the overly simplified explanation of mental illness does allow optimism about treatment” (Morrow et al., 2008, p. 4), that justifies the continuation of coerced treatments to people labeled as having neurochemical disorder and contributes to the re-institutionalization of these people into psychiatric hospitals (Morrow et al., 2008). Importantly, Morrow et al. (2008) argues that the focus on biomedical treatments in policy frameworks do not consider the complex and embodied experiences of these individuals that require a set of comprehensive measures including substantial funding, housing, and other forms of social supports and alternative care programs. Instead of being responsive to a variety of requirements from people labelled with a psychiatric diagnosis, dominant service provisions and programs are confined within the limitation of the bio-medical understandings of psychiatric diagnoses.

White and Pike (2013) demonstrate how pathological interpretations of madness are produced through public discourse and are taken as official knowledge in mental health policy

and law. The mental health knowledge was constructed through government campaigns of mental health literacy programs, government reports, and public discourses in the mainstream media (Wipond, 2013). While it was intended to reduce stigma attached to ‘mental illness’ by using strategies to equate mental distress to a disease such as diabetes, Morrow (2004) contends that the bio-psychiatric sector influenced policy designs regarding which supports and medical care were made available to psychiatric patients through the differential public funding in the health care system (Morrow, 2004). In her words, “competing discourses in the mental health domain are tied intimately to structures of power in which bio-psychiatry has the most resources” (Morrow, 2004, p. 46). In this way, the public discourse of mental health was deployed to legitimize and strengthen the psychiatric power regime as it “performed social role as hegemony training” (White & Pike, 2013, p. 240).

Not everyone can afford quality services although the term ‘psychiatric consumerism’ makes it sound as though they can. Another problem is that the underlining hegemonic forces that dictate people to strive for psychiatric well-being and treatments, goes in hand and hand with a neoliberal doctrine of self-betterment and individual responsibility (White & Pike, 2013). For example, Armstrong (1995) addresses that the apparatus of medicine has moved from individual bodies within hospitals to the population within communities where risk factors and the onset of disease probabilities are calculated and predicted. In the apparatus of medicine, a subject is constituted as a “risky self” (Armstrong, 1995, p. 403) who bears the risk factors of illness throughout their life. Consequently, the population internalized their responsibility for their everyday choices in terms of medicine consumption, conscious food intakes, and having a healthy lifestyle (Armstrong, 1995). This is a point where subjectification takes place, in which “(t)he rhetoric of choice clearly resonates with the ethic of autonomy at the heart of advanced

liberal modes of subjectification” (Rabinow & Rose, 2006, p. 208). From this perspective, biopower, so comprised of interconnections between neuroscience and the interests of pharmaceutical and of bio-medical industries, began incorporating modern collective subjects into the structure of the “bio-economies⁵” (Rose, 2007, p32) by inducing a rhetoric about psychiatric drugs as being a reasonable and responsible choice. Accordingly, the pool of potential consumers for the psychopharmaceutical industry expanded to include the entire population. Alongside the rhetoric of psychiatric consumerism swayed the whole population, the psychiatric profession, or what Burstow (2013) called “a regime of ruling” (p. 81) is an ever-growing government endorsed industry where a lot of funding goes into, and accordingly, interlaced with the interests of many sectors of businesses and professions (Burstow, 2013). In this way, the biomedical discourses and the psychiatric epistemology of today are entrenched in welfare provisions and other sectors of institutional and community service settings (Wipond, 2013).

The public health discourse that is put forwarded through the bio-medical model of mental illness plays a pivotal role in the psychiatric integration of consumer/survivor groups into neoliberal economization while preventing any advance in policy or legal discussions outside of the purviews of medical hegemony. In other words, whereas medical epistemology is entrenched and enforced through law and institutional mechanisms in every corner of the society, any holistic and encompassing approaches to support people experiencing mental distress, including an increase in funding for social support and comprehensive housing policies remain fragmented

⁵ Rose (2007) borrowed the term of bio-economies and bio-capital developed by Sarah Franklin and Margaret Lock (2003) in their research on hybrids of “patenting, sequencing, mapping, branding, marketing, purifying, and publicizing new life forms” (Rose, 2007, p.225). Rose (2007) illustrates how the circulation of bio-capital and bio-economies are integral to the discursive development of bio-citizenship that is formed around the neurobiological self who embraces pharmaceutical medicine by their choice.

and disconnected in the mental health policy making (Morrow, 2004). Moreover, people who does not fit in the medicalized discourses of mental illness, nor in the description of the mental health campaign, are rendered as deviants. White and Pike (2013) succinctly point out that “those who do not on the surface reflect the desired, enlightened vision of mental illness and health are likely to remain in the shadows” (White & Pike, 2013, p. 246).

Mad Politics with Respect to the Biopolitics of Mental Illness.

Mad identity and mad politics should be discussed in context of how biopower operates in relation to institutional psychiatry, mental health policies and law, and within neoliberal and geopolitical relations. The positions of mad communities regarding the biomedical explanation of mental illness have diverged from anti-psychiatric roots that arose from de-institutionalization movement, along with the trends of the neoliberal integration of psychiatry and the trans-institutionalization of people diagnosed with mental illness (Burstow, 2013; Diamond, 2013). This divergence happened with the rise of new biopolitical tactics and developments of psychiatric discourse of mental health that normalize the medical epistemology of mental illness (Burstow, 2013). As I discussed in the previous section, the pathological explanation is advanced by the discursive techniques of mental health literacy campaigns and institutional practices, coupled with the rhetoric of psychiatric consumerism that is uncritically espoused by consumers accepting pathological terms such as mental illness (Burstow, 2013; White & Pikes, 2013). This naturalization of psychiatry has drawn more people into the psychiatric industrial complex as stakeholders, while creating a division in the disability and mad constituency (Beresford & Wilson, 2002).

Not only has the mad movement diverged over the medical epistemology of mental illness, but it has also been confronted by critics who point out that essentialist mad identity

groups that are formed on the basis of the psychiatric survivors' experience are white centered, and therefore, are incapable of imagining the varied experiences of racialized and gendered people whose marginality intersects with other forms of institutional, material and psychiatric oppressions (Diamond, 2013; Gorman, 2013). Diamond (2013) points out that an essentialized mad identity has been centered around the common experiences of being institutionalized and of having had a psychosis. Consequently, the identity-based mad constituency discounts racialized and gendered people's divergent experiences and their varied and complicated relationship with the psychiatric regime, which is deeply intermingled with their socio-legal status, material deprivation and institutional racism. It is therefore important for mad organizing to reflect that those psychiatric oppressions do not amount to a singular experience but are multilayered and intersecting with other forms of institutional and political oppressions. Diamond (2013) states that

“how the presence of this threat differs in people's lives, depending on their social locations and individual histories. As such, it also foregrounds how the psychiatric system is shaped by and interacts with other ruling institutions that are likewise complicit in processes such as colonization, capitalism, heterosexism, ableism, ageism, and patriarchy” (Diamond, 2013, p. 74).

In this regard, Diamond (2013) calls for a mad solidarity that goes beyond disability identity politics, envisioning it to become a basis for people with multiple markers of marginality and experiences to comprehend how psychiatric power plays out under broad socio-economic and legal systems (Diamond, 2013). Mad identity can be understood only through our understanding of institutional, transnational, and socio-cultural experiences which is embodied and intersected with other identity markers (Gorman, 2013). In other words, as Gorman (2013)

notes, “we cannot divorce our embodied experiences of madness from the social relations through which our consciousness about our embodiment is organized” (p. 274). In this sense, instead of orienting toward an exclusive mad identity formed around the middle-class white experiences of madness, it is important to think about how to understand diverse mad experiences of racialized gendered and classed people (Gorman, 2013).

In summation, within the discursive strategies of psychiatric biopower, the concept of mental illness is organised as a prognosis of disease that is calculable and manageable through public health polices and law. Consequently, psychiatry does not affect only a particular enclave of psychiatric survivors. Rather, it is embodied and embedded within the broad social relations of power, integrating people with disabilities into its psychiatric power regime. In this sense, as Shildrick (2020) contends, conventional identity politics and the disability rights movement that is based on the social model are limited in terms of addressing the impacts of psychiatric power dynamics. In response to these critiques, I believe that the analysis of cripistemology (Johnson & McRuer, 2014), which connotes the standpoints of disability and the process of embodied knowledge production, and the postmodernist relational approach to disability can be useful in terms of offering an understanding of and ways to fight against the complex dynamics of power.

In this section, I ascribe to the post-modernists’ suggestions of disability which theorizes disability as embodied “becoming” (Roets & Braidotti, 2012, p. 166). The concept of disability as a relational and embodied experiences means that disability is not a static identity selected by an enumerative categorization or identity politics. Rather, disability is a formation of self that is constantly happening and is lived and embodied in different temporal and spatial locations. Similarly, mad identity can be conceived as a non-dualistic and relational (Roets & Braidotti, 2012), and shaped in a process of forming subjectivity, which is also experienced and practiced

in relation to and interaction with others and within institutional structures. In other words, madness is a nomadic ‘becoming’ and subject formation in relation to sanism that manifests through other sociocultural embodiments (Roets & Braidotti, 2012). According to Roets and Braidotti (2012),

“(n)omadic subjectivity is about the simultaneity of complex and multi-layered identities, as 'here is a need to re-name the subject as a multiple, open-ended and interconnected identity that occupies a variety of possible subject positions, at different places (spatially) and at different times (temporally), across a multiplicity of constructions of self (relationality)” (Roets and Braidotti, 2012, p. 168).

In this sense, mad subjectivity is viewed as multiplicities and an array of consciousness, constantly shifting in relation to multiple material, non-material, human and non-human elements, and its effects on what constitutes madness under the neoliberal mode of production. Since mad identity is theorized as a phenomenon that manifests in a particular geopolitical context as a nexus to other forms of institutional and economic violence, mad politics that adopt this definition of madness can draw attention to biopower implicated in policy decisions. Mad narratives that reflect upon the anti-sociality (Campbell . 2013, p. 232) of diverse mad experiences focus on the disability and mad movements that cannot be assimilated or included in psychiatric consumerism under the current neoliberal and ableist relations. More to the point, mad subjectivity can be reflected upon multilayered socio-economic oppressions and how their mental distress is institutionalized within a racist, colonial, and patriarchal system.

In this fashion, cripistemology is coined as a hybrid collaboration among queer, feminist, and disability theorists and as an epistemological turnaround (McRuer, 2019) and an ontological reformation of disability (Campbell, 2013). Cripistemology’s adoption of autobiographic account

can illuminate how neoliberal biopower plays out on different “bodyminds” (McRuer, 2019, p. 153) in different institutional, administrative, legal, and cultural contexts. This is to stress the multilayered, complex and embodied experiences of disability that cannot be categorized and politicized based on the sameness of identity politics (McRuer, 2019). Indeed, with this theoretical approach, disability and mad communities can aim “the pursuit of temporary and partial affinities, ad hoc alliances that would give leverage socio-political claims without solidifying and policing the reductive coils of sameness to and difference” (Shildrick, 2020, p. 35). This theorization of disability, and “crip subjectivities” (Johnson & McRuer, 2014, p. 134), intently refuses to assimilate to the neoliberal and ableist relations. In doing so, it guides towards the formation of radical mad subjectivity as a basis for the development of an alliance against psychiatric hegemony.

Autobiographic Narratives:

A Cripistemologically Reflective Account on my Disability and Madness

Critical disability studies scholars have questioned the traditional ways of knowing, critiquing conventional positivist epistemology as a lineage of the colonialist project of knowledge production and “privilege building” (Chen, 2014, p. 181). In response to these critiques, cripistemology, (Johnson & McRuer, 2014) is devised to redirect the acts of knowledge production towards embodied knowing, unknowing and its interconnectivities to the socioeconomic and geopolitical relations (McRuer, 2019). In their roundtable discussion on cripistemology, Jack Halberstam (2019) addresses the importance of admitting the temporal, spatial and bodily limits of a subject in terms of accessing and producing knowledge while connecting the limitedness to a refusal to participate in neoliberal relations including positivist medical epistemology. He states that

“a cripistemology will surely begin and end with a subject who knows merely that his or her ability is limited and that the body guarantees only the most fragile, temporary access to knowledge, to speech, to memory, and to connection” (as cited in McRuer, 2019, p. 152).

This approach also brings attention to the political nature of knowledge production, legitimizing the experiences of people with disabilities and their (our) different ways of being and living, which have been trivialized as private matters by the conventional knowledge production (Chen, 2014; Johnosn & McRuer, 2014).

I employ cripistemology’s autobiographic narrative as one of my methodologies, not only “to produce first-hand, and in some cases, first-person knowledge” (McRuder, 2019, p. 158) of voices that have historically been ignored, but also to acknowledge my parameters of knowing and being as a person who has never been unhoused, incarcerated, detained, or forcefully injected with any psychotropic drugs. This exploration of not knowing and unbeing is important in my analysis of psychiatric coercion imposed on many unhoused people through legal and institutional violence. My situated knowledge, even though I position myself as a disability rights advocate and mad ally, is bound to this limit of my locationality and my institutional role as a frontline social worker. Moreover, this limitedness allows me to critically examine the formation of my mad subjectivity and mad allyship as a relation that is shaped during and through my research and advocacy work for unhoused people who are on a CTO. Following upon these discussions, I will narrate my experiences of becoming disabled under the institutional oppressions that have shaped my disability and crip (mad) subjectivity. I will show how my madness and disability is being shaped and practiced in relation to others who are decapacitated, unhoused, and coerced into the psychiatric regime.

As a racialized, gendered, disabled person, as well as, a new immigrant to Canada, I have experienced mental distress in the course of pursuing a post secondary education in Toronto through “academic ableism” (Dolmage, 2017). During the time spent as a student, I have struggled with a lack of energy, anxiety, anger, and the overwhelming sense of sadness that could be labelled as symptoms of depression. Being legally blind, I use text to speech and magnifying technologies and portable magnifiers that enable me to read and write academic materials, yet with different paces and speeds. I often miss deadlines as my reading speed is slower than my peers, and I require many breaks between readings due to fatigue. Often I have felt frustrated and angry when attempting to re-read by using a text to speech application while also managing an emotional meltdown after an interaction with a professor who refused to give me an accommodation.

During the first few years in the post-secondary program, I juggled with many life duties such as maintaining housing, dealing with landlord and roommate issues, navigating the Ontario Disability Support Program (ODSP), student loans, and adapting to the new language and academic environment. On top of that, I had to, through many trials and errors (including failing courses), learn how to manage my time, energy, and self care strategies in my own way, figure out how to use the university’s accessibility services, how to apply funding for adaptive technologies, and how to advocate for myself to receive accommodations, all of which culminate in what Dolmage (2017) calls “access fatigues” (p. 91). I struggled with intrusive worries and sadness in isolation. The institutionalized norms told me those feelings, such as internalized inadequacy and incapacity, and related cognitive and emotional dysregulations are not supposed to be spoken about in professional and academic realms (Chen, 2014; Johnson & McRuer, 2014). The internalized ableism, and the intense and sustained worry about academic penalties and

shame about not being able to live up to the academic standard pushed me to work harder at times which was quite debilitating. As Johnson and McRuer (2014) point out, the neoliberal compulsion to progress and “to get better and to be exceptional and to be sensational” (p. 138) debilitates many people with disabilities, and at the same time, operates as an imperative for people to be medicated and medicalized (Johnson & McRuer, 2014).

As I detailed, these embodied experiences and feelings cannot be separated from how I navigated within the ableist academic institutions as a legally blind person and an immigrant. I was suffering emotionally, yet I could not wrap my head around such a medicalized definition of depression, such as major depressive disorder. These feelings seemed to be related to my visual disability or the racialized dimension of my experiences rather than being medical. I made sense of it by thinking that this is who I am. I am sad because life is not fair, and it is what it is for an immigrant with low vision who is struggling to adapt. My situation is not unique as Gorman (2013) documented, many people of color and working-class students are less likely to seek academic accommodations using medical labels. Furthermore, my pain and fatigue seemed to be secondary to having visual disability as my physical pains cannot be separately diagnosed. While my optometrist acknowledged my eye condition by using a specific medical term noted in his letter, he was reluctant to include my fatigue and back pain. Yet, if it is not documented by a medical authority, patient’s sufferings are not considered authentic (Morrow, 2014). As Anna Morrow (2014) astutely explains in her essay on hysteria and disability⁶, my back pain and fatigue seemed only explainable through the pathological framework of mental illness (hysteria)

⁶ Analyzing Freud’s classic psychoanalysis texts on Dora from a lens of cripistemology, Morrow (2014) argues that somatic symptoms of undocumented disability are considered signs of mental distress that show the underling motives of a person with a disability wanting a secondary gain through exhibiting these symptoms. This is termed hysteria by Freud psychoanalysis, and represents the ableist view prevalence that if any physical symptoms that a female patient are not recognizable or chartable by a medical authority, it is considered an inauthentic expression or the manifestation of repressed desires of the client.

if it is interpreted as somatic symptoms of depression by a medical authority. Otherwise, those sufferings cannot be accommodated because it is not as chartable as my visual disability in the medico-institutional views.

However, even after determining to seek professional support, as a new immigrant who does not have strong social resources, getting a mental health service was not easy. Student counselling services lacked expertise in providing support to a racialized person who has a disability, chronic back pain, eye fatigue, anxiety, and struggles while working too hard to be an “exceptional” (Johnson & McRuer, 2014) “able-disabled person” (McRuer, 2019, p. 157). The student intern counsellor did not understand my troubling anger regarding institutional racism and ableism. Private counselling and physiotherapy services were unavailable as it could only be accessed through an insurance plan offered to full-time students. Alternatively, I voluntarily involved myself with the psychiatric system by getting a referral from a walk-in clinic as that seemed to be the only option for a person with low-income. I was on a wait list for almost a year until I was finally able to acquire an appointment with a psychiatrist. The psychiatrist, while prescribing anti-anxiety and anti-depression medications that were supposed to change the neurotransmission activities in my brain, could provide neither any referrals for counseling nor any other alternative services.

This autobiographical account is by no means intended to suggest that my ‘mental illness’ is simply caused by the ableist or disabling academic structure. The relationship between my emotional distress, systemic oppressions, and how ableism and systemic barriers interacted with my patterns of thoughts and neurotransmitters are not a clear-cut cause and effect. Rather, my persistent distress, disability, and how I reacted to, and interacted with, ableist institutional norms and policies are intersected, intermingled, unfolded, and lived through together. Having

mood problems, anxiety, selective mutism, withdrawal, suicidal ideations, and emotional upheavals, cannot be separated from the embodied experiences of marginalities and its patterns as I experienced them as deeply intersected and interacted. In this sense, relating back to what Shildrick (2020) and Johnson and McRuer (2014) conceptualize about disability as an embodied phenomena and relational becoming, my mad consciousness emerged, and is constantly emerging in the context of my gendered, disabled, and racialized aspects of being and living through these struggles. In this regard, I believe my disability-madness did not arise from any part of my biotic organs (neither cone cells nor neurotransmitters) as a somatic marker. Rather my disability occurs “at the places where bodily edges and categorical distinctions blur or dissolve” (Johnson & McRuer. 2014, p. 134).

The experience of mental distress and getting labelled with a psychiatric diagnosis felt debilitating at times, though, as opposed to what many other psychiatric survivors and mad people experience, I have never been forcibly incarcerated as none of my racial constitution or mental difference was perceived as dangerous to others or to myself. ⁷ Rather, my disability seems somewhat passable to the neoliberal socio-economic standard which is fed upon compulsive productivity and independence. These factors of privilege, including being able to maintain income and housing, and my capacity of being able to assimilate to the neoliberal relations as a wage earner, put me in a position of “able-disabled person” (McRuer, 2019, p. 157). I am situated in a place where I engage with the system as a psychiatric consumer rather

⁷ In *Mental Health Act*, section 15 (1)(a)(b)(d)(e) note that if the person is deemed by physicians to cause a bodily harm to other person or to the person themselves, the person is subjected to an order for psychiatric assessment which can result in the involuntary admission to psychiatric hospitals. In the same manner, under the section 16(1) and section 17 (a)(b)(c)(d)(e)(f) of the legislation, on the same ground of the reason that “where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person” (*MHA*, 2000), the justice of the peace and police are given the same power to order a psychiatric assessment for a person that can lead to involuntary hospitalization.

than being a survivor, even though the term of psychiatric consumer sits uncomfortably with what I experienced when I was seeking psychiatric services.

Psychiatric Coercion Against People on CTOs in the Toronto Shelter System

Since I started working as a shelter worker at homeless shelters and transitional housing for unhoused people in Toronto, my mad subjectivity has changed as my institutional role as a frontline worker is in the service of the institutional and psychiatry violence against unhoused people. As a frontline shelter worker, I witness psychiatric coercion inflicted upon shelter residents who are on CTOs as it is enabled through the *MHA* (2000), the *Health Care Consent Act* (HCCA) (1996), legal enforcement system, provincial and municipal housing by-laws, the Center for Addiction and Mental Health, community services, social welfare policies, and case management principles deployed in the City of Toronto homeless shelter system. In detail, I encountered numerous people in different shelters who frequently display a great deal of mental distress, grief, trauma, and experience psychosis on a regular basis. Some of the people came to the shelters with a psychiatric diagnosis while some came without any diagnoses. Even if a person does not have a psychiatric diagnosis, many shelter workers assume they have ‘observed mental illnesses’ due to perceived erratic behaviors. However, I have noticed that not many people are willing to, nor able to use their psychiatric diagnosis to access for mental health services. Rather, many psychiatrized people⁸ refuse to go to the psychiatric hospital when suggested, sharing negative and even traumatic memories associated with the legal enforcement officers or hospital workers during their past hospital stays. These people often embody multiple and intersecting minority identities such as: foreign born, refugee status, non-status, racialized,

⁸ Burstow & LeFrancois’s (2014) use the term, ‘psychiatrized’ people in order to address the power of psychiatry imposed onto the people rendering them as a pathological issue. In the context of psychiatry as an “epistemological violence of diagnosis” (p.3) imposed against people experiencing mental distress, the term ‘psychiatrization’ is utilized to refer to the power structure that conjures an influence over the everyday life.

gendered, trans-gender, non-binary, non-fluent in English, with multiple concurrent psychiatric diagnoses and medical diagnosis such as diabetes, alzheimers, addictions, or HIV.

Many of those who are in crisis are put in a shared open space with fifty to a hundred other people. This space is designed for surveillance as CCTV cameras are in every corner of the building for security and safety management purposes. The shelter program runs with a series of tight regulations and rules to contain as many residents as possible in a congregated setting. The emergency medical services, Toronto police service, and mental health intervention teams are frequently called upon when a shelter staff perceives a resident's behavior as bizarre or unfamiliar and they assume that this might lead to conflict, violence, or self-harm. Shelters are mostly understaffed and consist of frontline and relief staff who are mostly racialized and gendered. While staff are mostly burnt out from rotating and on call shifts as well as other caring life duties, they are incapable of providing an adequate care and support to each client on site. Only a couple of intensive case management workers and on call staffs are responsible for approximately two hundred residents at a time. As for the limited capacity of the shelter, staff are instructed to adhere to strict rules and procedures to keep people and their suffering at bay.

Under these institutional conditions, people with multiple psychiatric diagnoses or who are undocumented but have 'observed mental health conditions' deal with many external and circumstantial stressors and triggers intrinsic to sharing an open space with many other people in a crisis. Consequently, when shelter residents are triggered by each other, this often escalates to the point of having a physical altercation or relapsing back to substance use. If a client causes an altercation, they are discharged to another shelter where they can stay for a few days till the same issue reoccurs. When a similar issue arises, the person is sent back to one of the previous shelters where they were discharged for breaking rules. For many people that I encounter, this revolving

door is a cycle from shelter to shelter, or from a shelter to a hospital bed and then to a psychiatric ward and this repeat for years. For many people, it is systemically impossible to secure housing in Toronto as most of the unhoused people have either zero source of income or are on government assistance such as Ontario Disability Support Program or Ontario Works. This income does not provide even the bare minimum for someone to survive considering the exorbitant housing costs in Toronto.⁹

The shelter system is comprised of many institutional and community agencies and programs that are enabled through the institutional network of the *MHA*, legal enforcement, the case management system at the shelters, and through the psychiatry regime that many people are subjected to and coerced into. Psychiatric coercion through CTOs was paramount in controlling and containing many unhoused people throughout the shelters, supportive and transitional housing especially. While surviving on the street and through the shelter system, clients can easily fit in the classification of ‘mentally ill’ by the DSM definition of schizophrenia or schizoid-affective disorder, and many of them meet the admissibility criteria for a CTO as they have been rotated through many revolving doors of different shelters and hospitals, and consequently, end up having a recorded history of hospitalizations while failing to comply with treatment plans after being discharged from hospitals.

A client who regularly expresses that she has hallucinations and incongruent and disturbing thoughts has resided in the shelter for over a year without having any visible support network. During her stay at the shelter, I have witnessed her being forcefully hospitalized several

⁹ Under the *ODSP Act*, (1997) section 30(1), paragraph 1 of the ODSP General Regulation, the maximum amount of monthly support for basic needs for a single recipient without any dependant is \$672 and under section 31(2) the legislation, the amount for monthly income support for a shelter is \$497 (*Ontario Disability Support Program Act*, 1997), which amounts to a monthly income of total maximum \$1169. However, the average market rent in 2021 for a bachelor size apartment in Toronto is \$1,211- and one-bedroom apartment is \$1,431 (City of Toronto, 2021), which is way more than what is provided by ODSP for shelter and basic needs combined. Accordingly, people who are on ODSP are structurally unhoused and are pushed to have a slow death.

times and restrained. She was detained by police and returned to the site after being discharged from a hospital after a few days while other times she was in a psychiatric ward for about a month. A shelter bed was usually held for her until she returned. This cycle repeated until police were called for threatening behavior in the community. After she returned to the site from a hospital, the form 49¹⁰ was filled out by a case management worker on behalf, and she was put on a CTO as she finally met the criteria. However, after several months of being on a CTO that accompanied services from Assertive Community Treatment and housing workers at the shelter, she still was unable to find any accommodating housing. While a CTO can be agreed upon with a care plan including case management and community services, neither community-based treatment nor a housing accommodation is legally mandated as part of a CTO in the *MHA* (Mfoafo-M'Carthy, et al., 2018).

Another client who has resided in different shelters for years approached me one time for a chat. They said they felt lonely and isolated. During our conversation, they disclosed that they had been on a CTO for years. They said they did not want to be on medication because it blocked their thoughts and made them torpid and stuck and that they would rather experience psychosis. At that time, I was unable to refer them to any legal consultation that might help them revoke their CTO. Instead, I suggested that they discuss this issue with their doctor as their medication seemed to be causing suffering; however, due to Covid-19 they were unable to make an appointment with their doctor and the nurse who came to the site to give injections would not seriously consider this option. When I asked them if they were looking for any alternative support such as therapy or group counselling, they replied, "I have already been on a waiting list

¹⁰ Under section 33.1(4) section 33.1(8), "A Form 49 (Notice of Intention to Issue or Renew Community Treatment Order), is the initial notice given to the patient to let them know a physician intends to start or renew a CTO"(PsychDB, May, 15, 2021, <https://www.psychdb.com/teaching/on-mha/form-45-47-49>
cto#:~:text=A%20Form%2049%20(Notice%20of,start%20or%20renew%20a%20CTO.

for a long time, they tried to find it for me since I was in the middle school.¹¹” (Personal communication, April, 2021).

These interactions with people in the shelter system are relevant in my reflection on how I can practice and relate my mad subjectivity to psychiatric survivors who are being held and medicated in the shelter system, and how to form a relationship with them in a way that contributes to mad-disability collectives, without being subsumed into the institutional and hierarchical binary of service provider/client, mad/sane, abled/disabled, and researcher/researched. Reflecting upon my participation in homeless shelters that warehouse people and its complicit collaboration with CTOs and legal enforcement, I started wondering and interrogating what is construed, and subsequently, what is missing from the institutionalized epistemological framework of the legal, medical, policy, social welfare and case management principles, which comes to constitute unhoused people as improper, mentally ill, and in need of legal intervention.

During the round table discussion on cripistemology, after describing an interaction with a disabled client who is also black and male, Jennifer James asked “what aspect of his circumstance rendered him property of the state, and consequentially, subject to improper treatment at every turn? Illness? Race? Poverty? Masculinity? Age? Illiteracy? An incalculable combination?” (McRuer, 2019, p. 165) As Jennifer did, I also ask what rendered them being on a CTO that legally forces them to receive psychotropic medication against their will? Poverty? Homelessness? Trans-gender identity? Foreign status? Trauma? Substance use? Jennifer James further asked, “how would a cripistemology articulate the improper as a mode of politics rather

¹¹ “psychologists’ services — which can be instrumental in halting the progression of mental illnesses — are not covered under Medicare, and most provinces have not independently opted to fund these services. Family doctors often refrain from referring patients to psychologists, knowing the out-of-pocket costs render access unlikely.” (Flood and Thomas, 2016, p. 29)

than as an invitation for violence?” (p. 166) Exploring and contextualizing these inquiries, I attempt to build a connection between my mad identity, which is political ‘becoming’ through the formation of consciousness that came to being in the course of getting a psychiatric diagnosis as a way to survive in the system, and my experiences of witnessing the process in which unhoused people are psychiatrized under the same but differentially debilitated and hierarchically ordered in relation to a neoliberal mode of economization and exploitation of work. Having this in mind, my autobiographic narrative intends to challenge and unsettle psychiatric and legal institutions and underling assumptions and epistemologies that affects psychiatrized people in different positions and locations. In other words, despite the crisscrossing gap between how my mad subjectivity has come to being and how their madness is construed through the violent medico-legal system, I aim to find a place where my knowledge, which is lived in and through my bodyminds (McRuer, 2019), converges with the embodied knowledge, experiences, and insights of the unhoused people whose intersecting and multiple marginalities render them subject to a CTO. The convergence starts from sharing “what it means to be rendered invisible” (McRuer, 2019, p. 156) and unknowable to the medico-legal structure and leading to a place where conventional institutional and biomedical epistemologies that ground CTOs can be unsettled and unlearned.

The homelessness, housing insecurity, and precarious life conditions of people diagnosed as mentally ill and the legal management of them through CTOs under the MHA, are consequences of what happened during neoliberal transformations in the mental health policy making intended to contain the populations within the psychiatric power regime. Neoliberal policies such as fiscal austerity and regionalisation of funding structure for health and social services, which was the underlining causes of the deinstitutionalization of psychiatry in the

United States (Scull, 2021) and in Canada (Morrow, 2004), and reduced government funding for hospital beds in recent years, have rendered many people living in inner-city ghettos, residing in destitute rooming houses, boarding hotels, homeless shelters, or left them unhoused (Morrow, 2004; Rose, 1979; Scull, 2021). The literature indicates that there is a correlation between the reduced number of hospital beds, and the trends in which a number of people with psychiatric diagnoses increasingly become unhoused or incarcerated in prisons. While a mass population was deinstitutionalized from psychiatric institutions, no legal provisions for community resources and infrastructure for care services and supportive housing were followed after the mental health reforms (Scull, 2021; Winkler et al., 2016). In this sense, CTOs can be understood as being developed as a psychiatric instrument that was invented to contain previously institutionalized populations, whereby former psychiatric inmates were not guaranteed access to community based social services (Sealy & Whitehead, 2004) nor housing, and were transferred to other institutional facilities including nursing homes, prisons, and homeless shelters (McDonald, 2018; Morrow, 2004; Rose, 1979; Scull, 1977; Scull, 2021; Sealy & Whitehead, 2004; Searight & Handall, 1988).

Moreover, it is important to address the systemic and multi-factored reasons why people experience mental distress and is often accompanied with a label of mental illness, among unhoused people are so prevalent (Frankish et al., 2005). On the one hand, people experiencing mental distress, disability, and chronic illness, combined with other marginalizing factors become vulnerable to homelessness as policy measures for supportive and affordable housing fall short in securing housing for people with precarious incomes. On the other hand, unhoused people are more likely to experience chronic mental distress on a daily basis as the living conditions of staying in shelters or encasements are detrimental to physical and mental well-

being¹² (Omerov et al., 2020; Paudyal et al., 2020). Consequently, people who are experiencing housing insecurity and multiple forms of intersecting marginalities, combined with life experiences of trauma and systemic oppressions of poverty and police violence, are prone to fall into medico-legal control mechanisms such as CTOs under the *MHA*. Following this discussion, the next section of this MRP will discuss CTOs in detail and their legal implications on people experiencing housing insecurity.

Community Treatment Orders (CTO)

CTOs are implemented and maintained through the rhetoric of the community-based treatment model in public policy, which is envisioned to be the only viable solution for a more humane and less restrictive way of providing care to people diagnosed as mentally ill in comparison to previous institutional and in-hospital care settings¹³ (Mfoafo-M'Carthy & Shera, 2012; *MHA*, 2000). However, despite what was propagated through this discourse, people subjected to CTOs have testified that the law is unnecessary, disempowering, and it fundamentally infringes on their dignity and autonomy (Fabris, 2011; Francombe et al., 2018; Lawn et al., 2016; Mfoafo-M'Carthy et al., 2018). The irrevocable harms committed to people who mandated onto a CTO are inevitable due to its coercive and involuntary nature and human rights violation of their autonomy in making their own medical decisions (Fabris, 2011; Mfoafo-M'Carthy & Williams, 2010). In addition, the law is put in place without enough evidence for its

¹²It is true given the fact that, as I illustrated from my reflective narrative, underhoused people are consistently exposed to various external stressors and triggers due to transient, unstable, and congregated living environments in and outside of homeless shelters. Not to mention that mental distress and health inequity is derived from and exacerbated by systemic factors such as social isolation, stigma attached to being homeless, lack of resources and means to keep up with good hygiene, the lack of nutritious meals and medical care, shelters, and constant exposure to crime, violence, criminalization, legal control, community surveillance, and policies that enable the police force to act against this population, through for example the Ontario Safe Streets Act (Duchesne & Rothwell, 2016; Frankish et al., 2005; Kouyoumdjian et al., 2019; O'Grady et al., 2013; Omerov et al., 2020; Paudyal et al., 2020).

¹³ For example, it is stated in the *Mental Health Act* (2000), section 33.1(3) "The purpose of a community treatment order is to provide a person who suffers from a serious mental disorder, with a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility".

efficacy, protective measures, safeguards, and lack of substantive care provisions in terms of improving the health of people labelled with a psychiatric diagnosis (Dawson, 2016; Mfoafo-M'Carthy & Williams, 2010). It is predominantly a mechanism of social control and surveillance that has been implemented to contain people who are deemed to be deviant, unproductive and 'sick' in the view of society at large (Jager & Parron, 2020; Klassen, 2017; Veen et al., 2018).

CTOs were enshrined in the Ontario *MHA* legislative reform in the year 2000 through Bill 68, otherwise known as *Brian's Law*. This law was named after the 1995 murder of Brian Smith, which was committed by Jeffery Arenburg, who was diagnosed with schizophrenia (Walker, 2008). After the incident, the public discourse was constructed with stories of Brian Smith, narrated as an ideal citizen and cultural hero, while Jefferey was depicted as lacking humanity, morally questionable, and mentally ill with an emphasis that he refused to comply with psychiatric treatment (Walker, 2008). Constructing these public narratives under the political influences of a pro-CTO coalition, which consisted of medical professionals in policy making (Swigger & Heinmiller, 2014), the main theme and the basis of CTOs was recounted as 'balancing' community safety with a better system of patient care. This legitimized the coercive feature of the law as the only viable solution to improve the treatment of those who do not follow through with outpatient treatment, and who are consequently believed to potentially pose a danger to the public or to themselves¹⁴ (Walker, 2008).

As part of the Ontario *MHA*, CTOs legally mandate the psychiatric treatment for people who are assessed and viewed to need psychiatric treatment. The target population are those who

¹⁴ With the law being enacted, "(t)he lead paragraph in government policy report stated that the "new law enables community treatment orders for people with mental illness who pose a threat to themselves or others" (Government of Ontario, 2000)" while the purpose of the law was stated as to "ensure people with serious mental illness get the care and treatment they need in a community-based mental health system" (Government of Ontario, 2000b)."

are ‘seriously mentally ill’¹⁵ but repeatedly discontinue taking their psychiatric medications and thus, become subject to the revolving door syndrome (*MHA*, 2000). Under the legislation, a CTO can be issued by a doctor with consent from the person labelled with a psychiatric diagnosis or by a substitute decision maker (SDM) if the person is deemed, by the doctor, incapable of making a sound decision. Once a CTO is ordered, a community treatment plan can be negotiated with the client, doctors, a mental health care team and community service agencies providing community-based services and resources. This contract is effective for a six-month period and can be renewed by the opinion of a physician before its expiration or within a month after an expiry date. For a second renewal, the Consent and Capacity Board (CCB)¹⁶ is required to meet and extend the order (*MHA*, 2000).

The CTO’s key feature is legal coercion of psychotropic medication that is enabled through a state sanctioned authority that is given to physicians in collaboration with legal enforcement to issue a treatment order without or against their client’s will (Mfoafo-M’Carthy and Williams, 2010). Mfoafo-M’Carthy and Williams (2010) point out that coercion does not only stem from the legal authority given to doctors to socially control people who are considered as having a mental disorder. Even though it pretends that legal consent is provided as one of

¹⁵ The term, ‘serious mental illness’ (SMI) is often uncritically used in the literatures of psychiatry, social work, policy, and public discourse as a way to divide among the people labelled with a diagnosis of mental illness, implying that while people whose psychiatric diagnosis and behaviors are palatable to the psychiatry regime are accepted as psychiatric consumers, others whose diagnosis and behaviors cannot be managed by psychiatry are labelled as having SMI and are often used as a justification for psychiatric coercion and violence.

¹⁶ “The Consent and Capacity Board (CCB) is an independent adjudicative tribunal created under the Health Care Consent Act, 1996. The Board receives its adjudicative authority from the Health Care Consent Act, 1996, Mental Health Act, Substitute Decisions Act, Personal Health Information Protection Act and Mandatory Blood Testing Act. The CCB’s mandate is to adjudicate on matters of capacity, consent, civil committal, substitute decision-making and other issues affecting citizens of Ontario, the health care community and other government agencies. The vast majority of matters heard by the CCB involve reviews of a person’s involuntary status in hospital and/or reviews of a finding of incapacity to consent to a proposed treatment.” (Consent and Capacity Board, 2016, http://www.ccboard.on.ca/english/resources/How_do_I_Become_a_Member_of_the_Consent_and_Capacity_Board_updated_Dec_2016_Pro_FINAL.pdf)

measures implemented for the procedural justice in the *MHA*¹⁷ (Klassen, 2017), it is, in reality, profoundly coercive: if a person who is eligible for a CTO refuses to consent, physicians can issue a CTO by using a legal authority to determine if the person is capable of making such a decision (Klassen, 2017; Mfoafo-M'Carthy & Williams, 2010). Thus, the legislation is designed in a way that a refusal and non-adherence to a CTO can result in forced hospitalization as the individual can be deemed as incapable of making a competent decision under the *MHA* (Francombe, 2018; Klassen, 2017). Accordingly, people simply consent to a CTO to avoid forced hospitalization which is traumatic and dehumanizing (Daniel, 2018; Fabris, 2011). The law is also structurally coercive by inducing people to comply with a CTO because they are mostly issued in an environment where other options to obtain care and support are not available but then consenting to a CTO is offered as a condition to receive required services (Fabris, 2011; Francombe, 2018; Mfoafo-M'Carthy & Williams, 2010). While people who are already racialized and socio-economically marginalized do not have much access to adequate care, support, and resources for housing in the current system, a consent to a CTO occasionally allows them to receive necessary services that are otherwise not available (Mfoafo-M'Carthy & Williams, 2010).

Moreover, Klassen (2017) points out that CTOs are highly regulatory and punitive legal mechanisms which are “designed to enhance ‘good’ citizenship by holding individuals accountable for their ‘risky’ transgressions” (p. 366). Analysing policy discourses in regards to the eligibility of CTOs, Klassen (2017) argues that CTOs unfold with a construction of “a psychiatric subject” (p. 366) which is produced through legislative narratives regarding the population that lack insights to make good decisions due to their mental illness; thus, they are

¹⁷ “CTOs promote the pretence of consent-based regulation, but in practice non-compliant individuals highlight that the freedom of choice and the ability to express rational decisions is not absolute” (Klassen, 2017, p. 362)

framed as being in need of a paternalistic legal approach that requires and justifies forced medicalization (Blanchette, 2019). As I discussed in the first section of this paper, the major character of the apparatus of security in the time of neoliberalism is not directly coercing individuals into the circuits of production but enticing the collective population to be actively ‘selecting’ certain ways of living and thinking, by arranging settings on which the population is integrated into bio-economic and neoliberal market structure (Foucault, 2007). Similarly, “the neurochemical selves” (Rose, 2007, p. 188) are encouraged to consider the consumption of psychiatric drugs in the hopes that the drugs will eliminate their troubles believed to be caused by neurochemical dysfunctions in the brain, and therefore help to adjust and enhance their optimal functioning in the community (Rose, 2007).

People who refuse to be assimilated and integrated into this structure are articulated and constructed as psychiatric subjects through policy and legal discourses, and set apart from the general population. In this way, the psychiatric subjects are conceptualized as “‘at risk’ and ‘risky’” (Klassen, 2017, p. 366) whose ability to be rational, competent, and responsible by managing their “illness” are halted by what is considered as their mental illness. In other words, the psychiatric self is imagined as being located in a state of limbo where its neurochemical self is not yet actualized. Meanwhile, their autonomous subjectivity vacillates tentatively between being competent and incompetent, capable and incapable, waiting to be completed through medical mediation (Klassen, 2017). Thus, CTOs are positioned as a medico-legal rescue for people suffering from their ‘serious mental illness’ and ‘consequent poor judgements’ by directing them to take medication. Also, in doing so, the law is believed to be essential and with a good intention in bringing them back to being a rational, responsible, and moral self (Klassen, 2017).

This psychiatric integration through legal construct of the psychiatric subject is tied to how biopower operates based on the bio-medical epistemology of psychiatry, run in collaboration with the disciplinary mechanism of modern citizenry, legal surveillance, and medical regulation of the population via the constant assessment and evaluation of the population for a prognosis of illness and risk management (Puar, 2017). As Foucault (1976) explains, the juridical mechanism constructs legal subjectivity in relation to sovereign power which grants the legality of individuals, while the disciplinary mechanism produces docile subjects through disciplinary techniques operating in segmented spaces where individual bodies and conducts are administered and optimized according to given templates (Foucault, 1976). The CTOs are an example of this governing technique that targets people who are not granted with legal subjectivity because of their supposed mental illness, and due to their refusal and inability to be integrated into neoliberal sociality, and therefore under this framework, people having a supposedly serious mental illness fall into the paternalistic medico-legal control (Blanchette, 2019). In summation, the biopolitics of psychiatry conceived as a mechanism of social control, underpins the construction of public policy and legal debates around CTOs, solidifying a biomedical and paternalistic legal framework that produce the concept of people having a serious mental illness and thus need paternalist legal intervention (Klassen, 2017; White & Pike, 2013). As I touched upon in the section two, people subject to a CTO embody their disability and madness and emerge in relation to and within this complex melange of legal, medical, and institutional power relations, and through intersecting inter-institutional governing techniques and multiple modes of marginalization.

Throughout this MRP thus far, I have illustrated how psychiatric power and its discursive construction of people labelled with a psychiatric diagnosis are played out and manifested in the

construction of the mental health law, policies and programs and how that is grounded upon a biomedical understanding of mental distress and psychiatric reductionism. This hegemony directs policy making towards the neoliberal economic arrangement, where policies are developed with a focus on medical intervention and legal control of the people who are not easily assimilated to the neoliberal ways of thinking and being, while ignoring elements such as the impact of complex and multilayered socio-economic and historical harms, health inequity, and lack of housing and service provisions for people who experience multiple and intersectional forms of oppressions and mental distress. As Morrow (2012) points out, it is important to note that the public knowledge of mental illness, and the language that supports the psychiatric hegemony disguise the fact that there is no true choice for many people who do not have the privilege to control their psychiatric services under structural inequality and material deprivation. The enactment of CTOs is not detached from this context where psychiatric hegemony emphasizes the concept of self care and consumer choice while community-based resources and services for people experiencing mental distress barely meet the social needs of those under a CTO. In Ontario, there is no intrinsic connection between CTOs and the availability of community resources. Even though mental distress is conceptualized and propagated as a pathological issue, Flood and Thomas (2016) points out that

“funding for psycho-pharmaceuticals taken outside of hospitals, home care, and various community supports are not protected by the Canada Health Act (CHA); these are left to a patchwork of private insurance and provincial coverage, resulting in significant and persistent access gaps.” (p. 29)

In fact, in Canada, community-based mental health and social service infrastructures are immensely underfunded and inadequate to deal with problems that unhoused people experience

as they are classed and racialized, which leads to massive inequalities in service delivery and access in a community setting (Flood & Thomas, 2016; Morrow, 2004). As a result of the inadequate mental health policy, as I illustrated based upon my experience of interactions with unhoused and psychiatrized people warehoused in homeless shelters, marginalized populations are easily falling between the cracks of the mental health laws (Veen et al., 2018), and become subject to CTOs.

Although housing was recognized as a determining factor for maintaining mental health and quality life, affordable and accessible housing, and housing security is not considered a basic human right protected by the *Charter* in the view of the Supreme Court of Canada (*Tanudjaja v. Canada*, 2014) because, as the consenting judges, Feldman, Strathy, and Pardu (2014) argue in this case, the courts are not made to determine right infringements caused by multiple actions and inactions of governments, and that engaging inter-institutional policy makings in parliament is outside of its purview. Nevertheless, while housing and community-based services are not necessarily guaranteed by the *Charter*, CTOs, which is another inter-institutional and intra-legal governing mechanism, was determined to be constitutional, as the court decided in *Thompson v. Ontario* (2016) that the infringement of the rights of autonomy and self-determination of the people under a CTO is justifiable by the legal safeguards' admissibility criteria and procedural consent in the *MHA* and *HCCA* supposedly to protect this population. This decision, in my view, was erroneously made, first of all, on the basis of the flawed legal argument that employs the legal test of the principles of fundamental justice, which consist of arbitrariness, overbreadth, and gross proportionality (*Bedford v. Canada*, 2013). Secondly, the legal discourse that justifies CTOs reflects the bio-medical epistemology of mental illness and medical reductionism, which defines people labelled with a psychiatric diagnosis as mere medical concerns. Following this, in

the next part of the MRP, these legal discourses in *Thompson and Empowerment Council v. Ontario* (2013) and *Thompson v Ontario* (2016) will be critically examined and challenged, arguing that the ableist and biomedical model of disability is rooted in the legal discourses and is utilized to enforce psychiatric power and its violence against unhoused people labelled with a psychiatric diagnosis. Thirdly, I will demonstrate an alternative way of re-organizing legal thoughts and approaches in regards with psychiatric disabilities that can possibly bring legislative and legal changes for people subjected to CTOs.

Part Two: Problematizing the Court Decision in Thompson and Empowerment

Council v Ontario (2013)

The Principles of Fundamental Justice and Safeguards

Over the years, tests to ensure the principles of fundamental justice, consisting of arbitrariness, overbreadth, and gross proportionality, have been developed for human rights cases to determine whether right violations caused by legislation are justifiable under section 1 of the *Charter*. Assessing whether a particular law is overly broad in its effects or not requires determining if the legislation's purpose is rational in some cases but overreaches in its effects elsewhere (*Bedford v. Canada*, 2013). This legal test requires the court to determine if the "legislation is drafted more broadly than is necessary to attain its objective and thereby impinges upon a protected right or freedom" (*Thompson v. Ontario*, 2016, para. 37). The legal test for gross proportionality is applied to determine if the negative impacts of an impugned law are proportionately balanced with the importance of the legislation's purpose. It tests the validity of the impugned legislation by comparing "the law's purpose, 'taken at face value', with its negative effects on the rights of the claimant and asks if this impact is completely out of sync with the object of the law" (*Carter v. Canada*, 2015, para 89).

In 2013, in *Thompson and Empowerment Council v. Ontario*, the Ontario Court of Justice found that the *MHA*'s deprivation of rights to life, liberty and security of a person – or in this case, a person diagnosed with a mental illness - was justified under section 1 of the *Charter*. This decision was later upheld by *Thompson v. Ontario* (2016) because the majority found that this deprivation did not contradict principles of fundamental justice. The justices in *Thompson and Empowerment Council v. Ontario* (2013) and the *Court of Appeal* in 2016 argued that the rights infringements associated with the *MHA*, and CTOs specifically, were not overly broad because the negative impacts of the law were curtailed by the legislation's safeguards. These safeguards include psychiatrists' ability to 'target' the right population who hypothetically stand to benefit from the law (*Thompson and Empowerment Council v. Ontario*, 2013), and the existence of a rights advisory system that protects people from the law's potential abuses. Therefore, Judge Edward Belobaba stated that "CTO provisions ... contain strict parameters for their application, stringent procedural protections in terms of review and rights advice, and a requirement of consent" (para. 95). However, I believe the judge erred in their decision because they wrongly assessed these principles by inadequately applying tests for overbreadth and gross-proportionality. As a result, I argue that the court overstated the legislation's safeguards and that the *MHA* undermines the right to self-determination among persons diagnosed with mental illnesses. These errors ultimately prevented the case from providing legal protections for people diagnosed with mental illnesses.

Eligibility Criteria and Safeguards: Robust Enough to Balance Gross Proportionality?

Importantly, the court argued that the eligibility criteria for the *MHA* was good enough to prevent people who were not meant to fall into its grasp, in part because individual assessments must be conducted by "highly trained medical professionals" (*Thompson v. Ontario*, 2016, para.

38). Specifically, the respondents argued that subsection (33.1)(4) was sufficient in preventing the law from having potentially overarching effects (*Thompson and Empowerment Council v. Ontario*, 2013). Subsection (33.1)(4) of the MHA requires that the person in question (i) has been previously hospitalized with the same mental illness “on two or more separate occasions or for a cumulative period of 30 days or more during a three-year period,” or (ii) “has been the subject of a previous community treatment order under this section.” This criteria guarantees that a CTO is issued only for someone who has been repeatedly hospitalized and/or who has failed to take their prescribed medications after being discharged from hospital. Similar logic underlying the efficacy of safeguards were also brought forth in a 2012 case. In *Carter v. Canada* (2012) the court emphasized that “permitting physician-assisted death can be identified and very substantially minimized through a carefully designed system imposing stringent limits that are scrupulously monitored and enforced” (para. 883). In both the *Thompson and Empowerment Council v. Ontario* (2013) and *Carter v. Canada* (2012) cases, such rationales were grounded on a legal framework of informed consent and an absolute trust in the psychiatric system and physicians’ capacity to make accurate medical decisions without bias or error.

Balancing Negative Effects versus Legislative Purpose

I believe the court interpreted and applied the tests for overbreadth and gross proportionality incorrectly because they misinterpreted the potential negative effects of CTOs. Specifically, in *Thompson v. Ontario* (2016) rights abuse caused by a CTO was imagined only as a CTO being wrongfully applied to a population who may not benefit from it. Following this line of thought, so long as an individual assessment is conducted by credible medical professionals, and a formal mechanism to ensure rights protections -such as the CCB and legal advisory- exists, the legislation does not override its object, as negative impacts will be curtailed by the screening

process. Judge Edward Belobaba contended that the law was intended to help people who would respond well to psychiatric treatment and those who have a history of hospitalization. For example, he concluded that:

(T)he evidence shows there is a segment of persons with mental illness who respond to treatment while in hospital but who repeatedly stop taking medication after discharge, relapse and experience substantial mental and physical deterioration, and are readmitted to hospital. Ms. Thompson`s and Ms. Ness` histories demonstrate this pattern.

(Thompson and Empowerment Council v. Ontario, 2016, para. 94)

Further, the judge believed that according to the admissibility criteria and assessment process specified in the section 33.1 of the *MHA*, those who do not benefit from psychiatric drugs will supposedly be screened out by a medical assessment and will not be forcefully put on a CTO. Judge Edward Belobaba affirmed that:

The community treatment plan which underlies the CTO is individualized and tailored to the person`s circumstances. CTOs only apply to a class of individuals who suffer from a serious mental disorder and who, as a result of their serious mental disorder, have exhibited a pattern of recurrent hospitalizations that feature stabilization followed by discharge, discontinuation of treatment, relapse and readmission. *(Thompson and Empowerment Council v. Ontario, 2013, para. 95)*

When conducting a legal test for overbreadth, CTOs should be examined to see if coercion is essential for obtaining their objective, which is the public health and safety, or whether these “means are too sweeping in relation to the objective” (*Carter v. Canada, 2012, para. 975*). In this case, as reiterated by the court, the *MHA*’s objective is “not just about public safety but also about providing improved treatment for seriously mentally ill individuals – hence

the statutory focus on previous treatment, clinical improvement, substantial mental deterioration, inability to consent and the consent of the SDM” (*Thompson and Empowerment Council v. Ontario*, 2013, para. 81)

Since the legislation’s purpose is public health and safety, the coercive means used is to align with the legislative goal, which is to improve the health of people diagnosed with mental illnesses. Also, the court found that the negative effects are not disproportionate against the legislative goal, which is to improve public health and safety, because the negative effects of a CTO will be minimized by the safeguard in section, 31.1(1) of the *MHA* to screen out people who do not need medical treatments. However, I believe the Judge erred in his interpretation on what constitutes the legislation’s negative effects. The judge established that the purpose of the law is public health and safety as it is stated in the *MHA*, and based on which they made an argument about negative effects of the law, stating that it does not violate the purpose of the legislation. In contrary to what Judge Edward Belobaba argued, however, I contend that the negative effects of the legislation should be examined outside of the given parameters that focus solely on whether prescribed psychiatric medication is effective in improving the exhibited clinical symptoms and whether people mandated to be on a CTOs are in need of psychiatric intervention at all. The negative effects of the legislation should account not only for individuals wrongly put on CTOs, but anyone whose physical and psychological wellbeing and integrity are jeopardized by the coercive means of a CTO.

Presently, the logic underlying the *MHA*, which was also endorsed by the court, is premised on the belief that if the medical condition of a person with a psychiatric diagnosis shows clinical improvement through medication, other negative effects of this treatment are nullified. However, the fact that some people might benefit from medication in certain ways does

not negate the irreversible physical and psychological stress and trauma they may also endure as a result of being coerced into this ‘treatment’. Some testimonies from psychiatric survivors revealed how coercive practices, made without consent, left a negative psychological imprint on them even when their psychiatric symptoms seemingly improved while on a CTO. For example, a participant in a research study conducted analyzing the personal experiences of people mandated on CTOs stated that they:

still feel anger about it, that it took so many months and that my family sided on the side of the doctors as well. So, I don’t think if anything like that were to happen again, I don’t think I would agree to it because it was basically forced on me. It wasn’t really a mutual agreement. (Mfoafo-M’Carthy, 2010, p.114)

Another participant in a similar study shared how

(p)olice involvement, and then the neighbours are watching, then you’re scared, and you’re medicated. You wake up, and you don’t know where the fuck you are, and there’s dirty people around, and you’re not in your clothes. Or you get up, and you just take another medication, you know? (Schwartz et al., 2010)

Such lived experiences indicate that even though psychiatric symptoms may be mitigated through CTO compliance, when medical treatment is delivered forcefully and against one’s wishes, it may cause suffering, trauma, and creates a deep distrust in the medical and legal enforcement systems, as well as their community. Instead of understanding coercive treatments as beneficial unless proven otherwise, their negative impacts on health and wellbeing must be recognized. While psychiatric symptoms might improve, psychological trauma might also follow from a CTO. If the negative impacts of a CTO are caused by its means of coercion, then anyone who falls under the *MHA*, including those for whom it is intended, may experience this harm.

In contrast to the court's interpretation in *Thompson and Empowerment Council v Ontario* (2013), overly broad legislation has historically been measured in different ways, and not only as a question of whether it causes negative impacts on unintended groups. For example, in *R. v. Heywood* (1994), the court decided that section 179 (1)(b) of the Criminal Code was interpreted overbroadly because it was not drafted with sufficient precision. Here the court found that the section that criminalizes people previously convicted of specific sex offences if they are "found loitering in or near a school ground, playground, public park or bathing area" (*R. v. Heywood*, 1994, para. 776) was drafted geographically too broadly to ensure the minimal impairment of the *Charter* rights to liberty, freedom, and security of the person for sex offenders (*R. v. Heywood*, 1994). When testing the principle of overbreadth, although the court agreed that the legislation's goal of protecting children from being sexually violated was very important, the means implemented to achieve this purpose were neither indispensable to it nor justifiable under the section 1 of the *Charter* (*R. v. Heywood*, 1994). The legislation was not based on evidence proving a link between the probability of children being sexually assaulted and the areas listed in the provision, rendering this geography, or the means to prevent such assaults, too sweeping and broad. In this case, negative impacts of the legislation were interpreted as the violation of protected freedoms of the sex offenders, while the court recognized that there are alternative means to achieving the goal of preventing the sexual assault of children (*R. v. Heywood*, 1994).

In the same manner, it could have been argued in *Thompson and Empowerment Council v. Ontario* (2013) that the means of coercion applied in implementing CTOs are not indispensable to achieving the stated legislative purpose of protecting public health (Fabris, 2011), making the means of CTOs too far-reaching in relation to their objective. Given the negative impacts of CTOs, including the breach of the autonomy of people diagnosed with

mental illnesses as well as potential subsequent psychological trauma and suffering from police violence involved, defendants should have been made to prove there is no alternative or better means than coercion available to enforce CTOs. Importantly, there is no proven data that indicates that the results of compulsive treatment through CTOs is more efficient than the standardized outpatient system (Fabris, 2011; Mfofo-M'Carthy & Shera, 2012). Further, negative impacts of the *MHA* could be said to be so harmful that they contradict the legislative purpose of public health and safety. Judge Lynn Smith's point in *Carter v. Canada* (2012) is relevant here: "the real issue is whether the impact of the rights infringement is disproportionate to the likely benefits of the impugned law" (para. 993). Broader interpretations to ensure legislation is neither overly broad nor grossly disproportionate, such as weighing the balance between potential negative effects of legislation versus its purpose, could have changed the trajectory of the outcome in *Thompson and Empowerment Council v. Ontario* (2013).

Negative Impacts of CTOs Reinterpreted as Physical and Psychological Trauma

It has been recognized in previous court cases that the right to make medical decisions is integral to the autonomy of a person. Decisions that impact one's body fall under the section 7 of the *Charter* which pertains to the right to "life, liberty and security of the person" (1982). Legal intervention into an individual's medical choices risks damaging personal integrity and dignity. For example, in *Carter v. Canada* (2012), the right to make choices about one's body was interpreted as integral to the dignity and integrity of the person, as body choices reflect "their lifelong values" and "their life's experience" (*Carter v. Canada*, 2012, para. 1326). Here, the Supreme Court of Canada argued that rights to life, liberty, and security should be read together in a manner that emphasizes the values of self-determination and one's sense of self. Discussing the appellant, the judge stated, "(s)he does not want the manner of her death to undermine the

values according to which she has lived her life. She wishes to be able to die with dignity, maintaining intact her sense of self and personal integrity” (*Carter v. Canada*, 2012, para. 1302).

Moreover, the previous cases recognized the right to protection from government actions that may cause psychological harms. In *Carter v. Canada* (2012), the Honourable Madam Justice Lynn Smith further acknowledged that the right to security of the person includes the right to be free from psychological and emotional stress. This interpretation was also upheld in *R. v. Morgentaler* (1988), as stated in the following quote:

Not all state interference with an individual’s psychological integrity will engage s. 7.

Where the psychological integrity of a person is at issue, security of the person is restricted to “serious state imposed psychological stress” (p.56).

This case indicates that an individual’s rights to liberty, security and freedom encompass the rights not to be interfered by states’ action, that might cause psychological stress and trauma. The *Starson v. Swayze* (2003) case also sustained this decision, recognizing that forced treatment can cause trauma because it infringes on a person’s self-determination which is integral to reflecting who they are and what they value.

CTOs can irreparably damage a person’s mental and physical integrity because they involve both the deprivation of bodily choice when being forced to take prescribed medication, as well as actual physical and chemical restraints if the CTO is resisted (*Thompson v Ontario*, 2016). Fabris (2011) states that “this is the action of a drug on the emotional areas of a brain that leads to pacification, or simply the lack of energy to resist much at all” (p. 115). Considering his account of the impacts of neuroleptics medications– which include feeling dazed, being prone to fatigue, emotional numbing, restrained cognitional functions, and brain damage– the harmful effects of such medications intrude on the autonomy of a person and may alter their sense of self.

Following this, I conclude that since the *MHA* can trigger serious psychological stress and trauma, tests for overbreadth and gross proportionality should recognize and take into account the potential negative impacts of the *MHA* that involve violence and detain individuals, which specifically includes CTOs, due to the psychological and physical trauma. Safeguards requiring individual assessment to ensure the right population is identified and targeted through the *MHA* do not mitigate the potential physical and psychological stress and trauma imposed through mandating CTOs. Without proper safeguards to minimize detrimental effects on integrity, dignity, and health, the *MHA* can be seen as overly broad. It is also grossly disproportionate because negative impacts of CTOs on health, including causing trauma, are not aligned with the legislative purpose of the *MHA*.

Consenting to CTOs– Insufficient Safeguards

In *Thompson and Empowerment Council v. Ontario* (2013), Judge Edward Belobaba contended that both the *MHA* and CTOs are valid because the *MHA* requires consent from either the person being referred to a CTO or from a substitute decision maker (SDM) if they are assessed as being incapable. Moreover, when a person is considered for being mandated onto a CTO, they must be formally advised of their rights - including the right to a review by the CCB, which are also considered procedural safeguards. If a person disagrees with their SDM, they may still challenge their status of incapacity by requesting a secondary review through the CCB¹⁸. In *Thompson v. Ontario* (2016) it was concluded that these legal mechanisms are sufficient to protect persons from being unjustly subjected to CTOs. From the court's point of view, an applicant's right to challenge a status of incapacity prevents errors in this determination, meaning

¹⁸ *HCCA* (1996) section 50 (1) "A person may apply to the Board for a review of an evaluator's finding that he or she is incapable with respect to his or her admission to a care facility".

that only those who are truly incapable can be forcibly put onto a CTO (*Thompson v. Ontario*, 2016).

However, even though issuing a CTO technically mandates the receipt of consent from people labelled with psychiatric diagnoses under section 33.1(4)(C)(f) of the *MHA*, this supposed safeguard is superficial in terms of protecting their autonomy. This safeguard provision ignores the reality of people whose decision-making capacity is consistently compromised by external factors or socio-cultural environments such as material destitution and or previous histories of taking psychiatric medications that may have had decapitating effects on their ability to make choices (Fabris, 2011). Similarly, a person may accept a CTO because they want to obtain housing or other essential services like counselling or therapy which require CTO compliance.

To be specific, a person deemed capable of decision-making who chooses to comply with a CTO may do so out of fear of later being forcibly hospitalized if they reject it (Fabris, 2011). Under the updated version of the *MHA* (2000), if psychiatrists deem a person unable to care for themselves, and if their psychiatric condition is deemed to be deteriorating, then the person can be forcefully hospitalized. Here consent exists only as a nominal process because refusal to consent to a CTO can result in their decision making capacity being questioned under section 15 (1.1)(e) of the *MHA*. In this scenario, their right to consent can be transferred to a SDM who may decide to have them hospitalized under s. 57 (1) of the *HCCA*. In this sense, people diagnosed with mental illness are systematically deprived of other options, forced to choose between either consenting to a CTO or risking compulsory hospitalization under the *MHA* (Fabris, 2011). Specifically, the *HCCA* (1996) outlines the criteria for capacity stating that:

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.

In *Thompson v. Ontario* (2016), people diagnosed with a mental illness were exempt from certain Charter rights because their decision-making capacity was deemed to be lacking. The *MHA* (1990) grants psychiatrists the authority to assess a person's decision-making capacity (*MHA*, 1990, 2000). If this decision is challenged, an individual's status of decision-making capacity is then ultimately decided by the Consent and Capacity Board (CCB), as legislated by Ontario's *HCCA*. According to the *HCCA*, if a person is still deemed incapable of making decisions in this context, then they are deprived of their autonomy. Indeed, when a person is deemed incapable, under section 10 of the *HCCA*, this permits relatives, SDMs, or public guardians to consent to CTOs on behalf of people labelled with psychiatric diagnoses, even if this contradicts the person's wishes. This supposedly rights-based legal system in fact limits the rights of some people to make informed medical choices if they are deemed incapable of making sound decisions.

The Consent and Capacity Board's decision-making process remains problematic as it continues to rely on a binary demarcation of capacity/incapacity, which results in the total deprivation of autonomy for those deemed incapable of making informed decisions. The dichotomy between capacity/incapacity in terms of decision-making that upholds the legal framework of the *HCCA* (1996) is structured in a way that disempowers psychiatric survivors (Clough, 2017). The concept of decision-making capacity itself is constructed based on a sanist dichotomy that artificially constructs those considered to be 'insane' by contrasting them against a hypothetical 'logical' and 'autonomous' human being (Clough, 2017; Fabris, 2011); though it is the primary criterion used to determine the legal capacity of a person.

This statutory test primarily requires a psychiatrist, or the CCB, to decide whether or not a person demonstrates an ability to understand their own symptoms and all of the treatment options suggested. They must also show an ability to weigh the pros and cons of these options, such as the clinical consequences of not following a doctor's medical orders. A decision of incapacity is reached "when it can be shown that a person is unable to understand relevant factors and appreciate the reasonably foreseeable consequences of a decision or lack of decision can treatment be imposed" (*Starson v. Swayze*, 2003, para. 10). Fabris (2011) elaborates that "the splitting of social life and interaction into 'mad' and 'sound' (sane and insane, healthy and ill, rational and irrational) is necessary for the containment of certain acts and experiences" (Fabris, 2011, p. 29)

Moreover, this process reflects structural power imbalances, and allows significant room for subjectivity, including influence by the unconscious prejudices of psychiatrists and lawyers (Freckleton, 2010). According to the *HCCA* (1996), CCBs is composed of Medical Members (Psychiatrist, Physician, Nurse), Legal Members, and Public Member who is selected and appointed by the criteria¹⁹ (*HCCA*, 1996). Although it is stated that CCB requires members to have knowledge and expertise in the areas of institution and community involvement, and their familiarity to legislations including *MHA* and *HCCA*, it does not require any members of CCB to have to have had lived experiences of being labelled with mental illness or be a psychiatric

¹⁹ The qualification of Public Member is stated in the Consent and Capacity Board website that "experience in interpreting and applying legislation with specific knowledge of the Mental Health Act, Health Care Consent Act, 1996, Substitute Decision Act, Personal Health Information Protection Act, Mandatory Blood Testing Act, and Statutory Powers Procedures Act.

Understanding of the professional, institutional and community context within which the Board operates.

Demonstrated analytical, conceptual, problem-solving, and decision-making skills.

Ability to listen and communicate clearly and effectively". Member of CCB is selected by accessing their merits and competitiveness and appointed by the Lieutenant Governor in Council.

(http://www.ccboard.on.ca/english/resources/How_do_I_Become_a_Member_of_the_Consent_and_Capacity_Board_updated_Dec_2016_Pro_FINAL.pdf)

survivor (*HCCA*, 1996). Consequently, and through this merit-based selection process and qualification, it is structurally inclined to appoint people with professional backgrounds who are equipped with a medical model of disability, rather than allowing perspectives of psychiatric survivors to be brought to the table. Since most members of the CCB are professionals who do not have lived experiences of mental illness, pathologizing, ableist, and sanist psychiatric opinions and legal perspectives dominate the CCB tribunal's decisions regarding capacity/incapacity. Psychiatric opinions are accepted as factual evidence based on the belief that "the 'mad' can't speak for themselves" (Fabris, 2011, p. 27), as the testimonies from people labelled with psychiatric diagnoses are often considered manifestations of their mental illness (Blanchette, 2019).

Similarly, coercive treatment methods are justified by legislative processes that have been put in place with the intent to act as a series of legal safeguards for people labelled with psychiatric disorders. For example, the *MHA* contains a provision which requires doctors to write a report and issue a certificate when someone is deemed incapable and is subsequently hospitalized. Though legal requirements, a second psychiatrist's opinion must be sought out to determine incapacity (*HCCA*). After someone is deemed incapacitated, patients can obtain the right to appeal decisions through the CCB though, these *HCCA* (1996) provisions cannot protect people who are at risk of being categorized as incapable from falling into *parens patriae* jurisdiction, and consequently, having their rights stripped away. Rather, this law reinforces sanism that 'scapegoats' people who are deemed incapable of decision making, preventing consideration of alternatives to support decision making and that bolster their right to enjoy autonomy (Fennell, 2010). Considering these fundamental problems inherent in the framework of statutory capacity law, it is necessary to call the basic tenets of rights-based legalism into

question. Rights-based legalism represents a way to institutionalize and legalize the control of medical and legal powers. As Fennell (2010) contends, legalism often ‘sugar-coats’ compulsive psychiatric interventions using a rhetoric of “entitlement to medical treatment” (p.38).

Biomedical Reductionism in Court Discourse

The problems associated with the insufficient and limited safeguards under the *MHA* stem from the medical definition of mental disability enshrined in the law. Since people with mental disabilities are repeatedly recognized as having a pathological problem and are referred to as ‘mentally ill’ and ‘patients’ by judges, legal arguments can be made in support of compulsory treatments that infringe on human rights, and legal safeguards are devised from the same medical perspective. This narrow understanding of mental illness also limits legal interpretations of what mental health laws such as the *MHA* and the *HCCA* can or cannot do in the name of providing treatment.

In *Thompson and Empowerment Council v Ontario* (2013), Judge Edward Belobaba’s decision to uphold the constitutionality of the *MHA* was based on an argument that follows the medical model of disability. The court interpreted the purpose of the *MHA* as an essential tool to promote public health and safety; Judge Edward Belobaba stated that “(b)ox B provisions are not just about public safety but also about providing improved treatment for seriously mentally ill individuals” (para. 81). Since mental illnesses are medically defined as public health issues under the *MHA*, the judge concluded that the legislation was legitimate because it was enacted in order to provide medical treatments assumed to be necessary for people defined as mentally ill. Though compulsory treatment legislated by the *MHA* has been shown to breach section 7 of the *Charter* rights for people with mental disabilities (*Thompson v Ontario*, 2016), it is justified to accomplish the end goal of the *MHA*. In other words, as people with mental disabilities are

narrowly defined as patients in need of treatment under the *MHA*, people who are pathologized are stripped of their legality (Foucault, 1976) and the provision of such treatment, even if compulsory, is assumed to be necessary for therapeutic reasons (Klassen, 2017).

A medical definition of mental illness in *Thompson and Empowerment Council v. Ontario* (2013) was used not only to defend the legality of compulsory treatment in general, but to render the applicants' personal objections irrelevant as well. For example, Ms. Thompson and Ms. Ness' apparent progress/regress in symptoms of mental illness and the level of their community integration after being put on CTOs was interpreted primarily through a medical lens, using medical records to gauge the efficacy of anti-psychotic medication. The court also accepted evidence from psychiatrists demonstrating the clinical efficacy of anti-psychotic medication to support the *MHA*'s legitimacy (*Thompson v Ontario*, 2016). On the other hand, the applicants' personal experiences in relation to the negative effects from taking such medication were not taken into consideration. In this sense, the medical model of mental disability in the *MHA* leaves people diagnosed with a mental illness subordinated to paternalistic psychiatric power in the name of public health. This paternalistic view resulted in the court's decision to endorse CTOs even though the efficacy of anti-psychotic medication for many people has been left uncertain (Fabris, 2011).

Since the court also endorses the psychiatric system by expressing an absolute trust in medical professionalism, people with mental disabilities are presumed to be patients who need treatment unless proven otherwise. Accordingly, legal authority is granted to medical practitioners to diagnose and screen out people who may be subjected to CTOs based on the legal criteria in the *MHA* s 33.1(4). For example, Judge Belobaba (2013) stated that:

CTO provisions ... contain strict parameters for their application, stringent procedural protections in terms of review and rights advice, and a requirement of consent. The community treatment plan which underlies the CTO is individualized and tailored to the person's circumstances. (para. 95)

In his view, the criteria in s 33.1(4) of the *MHA*, allows for the admission of a person only when they have a history of hospitalization and psychiatrists have proved that their condition has improved after psychiatric treatment, are interpreted as safeguard provisions, along with medical authority codified in the law.

Similarly, the psychiatric power to determine the capacity/incapacity status of a person also relies heavily on a medical model of mental illness. The medical view of mental illness is grounded upon sound/mad and rational/irrational dichotomies (Clough, 2017) that is used to determine this status, and since rationality is medicalized, a capacity for sound reasoning is seen as an innate quality that can be assessed and discovered by psychiatrists' assessment. As touched upon in the previous section, when assessing the mental capacity of people subjected to a CTO, professional psychiatric knowledge and judgement are taken for granted as indisputable truths. This is quite apparent in the following statement from Justice Edward Belobaba (2016):

I am satisfied on the evidence before me that psychiatrists, as specialists in the treatment of mental disorders, are especially familiar with the phenomenon of mental deterioration. They view the term "substantial mental deterioration" to mean not just a trivial change in symptoms and/or functioning, but rather a significant increase in symptoms and/or a significant decline in functioning (e.g. difficulty in being able to go to work and hold a job, or completing basic activities such as feeding or hygiene). (para. 115)

While endorsing the ability of psychiatrists to diagnose mental illness by assessing the symptoms and functioning of a person, the judge completely ignores the relevant socio-economic factors that may have contributed to this reduced functioning of a person by conflating reduced social functioning with a symptom of mental illness.

Alternative Definitions of Mental Disability

In *Thompson v. Ontario* (2016), although Judge Belobaba acknowledged that “mental disorder corresponds to an enumerated ground and that persons with mental disorders have historically been subject to stereotyping” (para. 124), he concluded that the MHA does not breach section 15 of the *Charter* because it only applies to individualized medical assessments. However, this interpretation of the *MHA*’s constitutionality contradicts findings by the Supreme Court of Canada in a 1991 case. In *R. v. Swain* (1991), the court recognized that “the concept of ‘disability’ ... include[s] perceived disability stemming from others’ ‘subjective and erroneous perceptions,” and that “the mentally ill in our society have suffered from historical disadvantage, have been negatively stereotyped” (para. 933). Similarly, in the landmark decision in *Eldridge v. British Columbia* (1997), the court noted that paternalistic approaches to disabled people, along with their history of marginalization, must be recognized and considered when assessing discrimination. In this case, people with psychiatric disabilities were recognized as members of an identity group that shares a history of marginalization and subjugation, which had led to the unequal treatment and paternalistic attitudes they face today. The impacts of ableist and sanist social structures and paternalistic attitudes against this population was acknowledged in the case of *Eldridge v. British Columbia* (1997). The Judge Antonio Lamer Puisne stated that:

It is an unfortunate truth that the history of disabled persons in Canada is largely one of exclusion and marginalization ... As a result, disabled persons have not generally been

afforded the 'equal concern, respect and consideration' that s. 15(1) of the Charter demands. Instead, they have been subjected to paternalistic attitudes of pity and charity. (para. 56)

These precedent-setting cases interpreted disability more broadly than it generally is in court as they utilized more nuanced definitions of disability that recognized historical and social impacts on certain groups. However, in contrast to these previous *Charter* interpretations which recognized people with psychiatric disabilities as a marginalized identity group facing systemic discrimination and paternalistic attitudes, in *Thompson and Empowerment Council v. Ontario* (2013), the court privileged the medical model of disability when referring to psychiatric disability.

I believe that one of the reasons that the social model of disability was not taken into the consideration when determining CTO's legality is that the opponents failed to address the problems within medical epistemology entrenched in the purpose of the legislation. In opposition to Thompson's assertion that the legislation infringes on the *Charter* rights because the purpose of the legislation was primarily public safety assuming people labelled with a psychiatric diagnosis are potentially a danger to society, the court sensibly positioned CTOs as a legislation that provides health care based on the stated purpose in the *MHA* that is to attend to public health. Consequently, the legal debates of rights infringement and its target populations are specified and constructed to be those deemed to have medical concerns, which justified the medio-legal intervention in the name of the interests of those who are not capable of taking care of themselves and need paternalistic state intervention (Klassen, 2017). In line with these views, where people diagnosed with mental illness are reduced to a pathology that prevents them from managing their own illness (Klassen, 2017), there is no room for a social model of disability to

be included in the legal interpretation because the discourse of public health dominates, paving a path for the paternalist legal intervention. In addition, the social model of disability seemed unconvincing in the face of the bio-medical epistemology forwarded by the courts since the social model is rooted from the conceptual division that depoliticizes the experiences of mental distress. The identarian model's conceptual reliance on the binary division between disabled and able-bodied, fall short in protecting the rights of people with mental disabilities as their mental disabilities do not fit in the description of the conventional disability identities when it comes to sufferings from mental distress, poverty, and other marginalities (Sheldrick, 2020).

Consequently, the social model of disability lost its merit in *Thompson and Empowerment Council v Ontario* (2013), in relation to pointing out the inadequacy of safeguards for CTOs in the *MHA* that are constructed and maintained based on the legal inscription of capacity/non-capacity, the pathological construction of mad/sane, disabled/non-disabled, and healthy/ill.

Towards an Alternative in *Thompson and Empowerment Council v. Ontario* (2013)

In response to the legal problems in these cases, I believe that the relational and non-dualistic approach to mental disability must be considered to amend the mental health law in accordance with the United Nation's *Convention on Rights of Persons with Disabilities* (CRPD) and their requirement to ban involuntary psychiatric care on people with psychosocial disability (Davidson, 2020; Minkowitz, 2010). To be specific, the *CRPD* drafted a definition of psychosocial disability in order to encompass the social impacts of stigma, discrimination, exclusion, and environmental harms on people labelled with a diagnosis of mental illness (Chandler, 2016; Davidson, 2020). This definition indicates that coercive treatment on people with mental disabilities are recognized by an international legal framework as human rights issues, which thinks beyond the parameters of public health and its biomedical interpretation of

mental illness (Davidson, 2020). For example, “Article 14 of the CRPD requires states to ensure that persons with disabilities enjoy the right to liberty on an equal basis with others” and “Article 25 clarified that this applies [a]t all times, including in crisis situations (Davidson, 2020, p.165).” Additionally, the CRPD committee specifically required all signatory governments to complete the prohibition of any coercive psychiatric treatments and practices of substitute decision makers (Davidson, 2020). Davidson (2020) stresses that it is necessary for governments to amend their mental health legislation, adding safeguards and provisions to curb the use of psychiatric coercion so that the law complies with Articles 14, 15, and 25 of the *CRPD* that prohibit the infringement of liberty, integrity and autonomy of persons with psychosocial disabilities.

The *CRPD* advises to espouse a relational approach to mental disability in the mental health law to move forward in this direction. To be specific, the definition of people with mental illness in the *MHA* is self-referencing and based on the bio-medical understanding of mental illness as people (White & Pike, 2013). In contrast to this, the post-modernist articulation of disability emphasizes socio-material and cultural dimensions of becoming a person with a psychiatric disability as an embodied experience. This emphasis should be on the systemic violence this population experiences, their interaction with others, and in relation to ableism and sanism that underpins the structural inequity that prevents them from achieving mental and physical well-being. In this sense, if this approach, which integrally reasons the concept of disability as embodied and occurs from the experiences of bio-power, is taken into consideration in the interpretation of the *Charter* rights, a legal argument can be made based upon this will unsettle what the definition of mental illness in the *MHA* denotes and implicates about people with disability. These definition changes in relation to psychiatric disability seems to be a novel approach, although social aspects of having psychiatric disability were recognized by the courts

in the past, leading to form a baseline for positive legal reforms (Costa, 2013). Likewise, in the international legal contexts under the *CRPD*, Davidson (2020) notes that “in 2017, section 5 of Zambia’s *Mental Disorders Act* of 1951 was held unlawful by the country’s Constitutional Court partly due to its discriminatory language” (Davidson, 2020, p. 168). It could have been argued that CTOs are unconstitutional as the definition of mental illness in the *MHA* is in contradiction with the definition of mental disability that is recognized by the *CRPD* and previous *Charter* interpretations. Using this framework, the pathology of mental illness can be scrutinized as one of the epistemologies that was historically used to oppress and legally subjugate people experiencing mental distress and mental difference, that is intersecting with poverty, social isolation, and other forms of structural violence and injustice. Moreover, if the concept of psychiatric disability is recognized as a collective becoming in relation to social, institutional, and psychiatric power dynamic, the courts’ debates on the *MHA*’s safeguards using the *Charter*’s principles, could have led to a possibility of “the progressive realization” (p.167) of legal reforms to be in compliance with the *CRPD* (Davidson, 2020). These reforms and an alternative approach to mental disability that encompasses the social elements of people experiencing mental distress could have led the *Thompson and Empowerment Council v. Ontario* (2013) to a possible decision that renders CTOs unconstitutional without existing community-based services and housing, and that it is unlawful to impose coercion when a person who is subjected to a CTO has not been provided with any alternative services or housing prior to meeting the CTOs current admissibly criteria. Moreover, I believe that a relational approach to determining a person’s capacity for decision making could be substituted for the current binary construction of capacity/incapacity. Unlike a dichotomous view of disability/non-disability, a post modernist relational approach would not attempt to determine capacity using criteria as

narrow as section 4 (1)(2)(3) of the *HCCA*. Instead of relying on divisive legal criteria to determine legal status, a relational approach takes account of social, material, and historical contexts, and aims to assist people in decision making when needed. This may require implementing a variety of measures to maximize a person's autonomy during the course of their decision making (Clough, 2017).

Secondly, following the decision in *Thompson and Empowerment Council v. Ontario* (2013), which I clarified in the previous sections, that the safeguards in *MHA* and the courts' reasoning to defend the safeguards are flawed, this legal argument should have led the court to order an amendment of the legal safeguards. The legal reform to strengthen the *MHA*'s safeguards is essential in complying with the *CRPD* by adding concrete and targeted measures, that are intended to empower people with mental disabilities in the course of being involved in psychiatry and medical decisions and made in consideration with socio-economic and material factors that affect the sufferings of people with mental disabilities before considering to impose any forms of coercion. Davidson (2020) notes, "(t)he use of "holding" legislation with the intention of improving safeguards and strengthening rights while alternatives to coercion are scaled up is, in essence, "progressive realization" (p. 167). For example, an alternative to coercion would be incrementally realized by establishing a social service mechanism, that is cross referenced and relegated with other relevant areas of laws that direct housing, income support, and social services, and is inscribed in the safeguards of the *MHA* and *HCCA*. This safeguard codifies provisions of essential services, such as housing, counselling, and community support, to be provided and guaranteed as a pre-condition before any coercive intervention is legal under the *Charter* and *CRPD*. This intra-institutional and inter-legislative approach to the

legal case is technically plausible as the *MHA* (1990) is already cross-referenced and inseparable from *HCCA* (1996).

Moreover, if social factors such as homelessness, social isolation, lack of adequate income, poverty, and/or a history of institutionalization were legally recognized under the current legislation of the *MHA* (1990) and *HCCA* (1996) as impacting people's decision-making capacity, psychiatric opinions would carry only a secondary importance when assessing this. Instead, the assessment process for decision-making capacity, and subsequently, the right to make decisions about one's own treatment, would be focused on contextual questions such as: What has been done to assist the person in reaching their decision of either consenting to or refusing a CTO? What can be done to improve their self-determination in a particular context in order to maximize their decision-making capacity? What comprehensive and community-based efforts to support a person were made to minimize traumatic effects of intrusive psychiatric medication? If medication was used as a last resort, what was done to support the person before and/or during such coercive measures? These questions are essential in imagining the reconstruction of legal arguments. Decision-making capacity could then be reformulated into something that can be improved or decreased depending on the social, material, and institutional circumstances of a person with a psychiatric diagnosis. In this way, the lived experiences of people with psychiatric disabilities, including their interactions with the psychiatric system and its impacts on their decision-making practices, could be brought to the forefront of legal arguments about capacity and their related rights to make medical choices.

In Summation

This MRP has explored the definitions of psychiatric disability and mad politics in regards with how biopolitics conjure an influence over mental health laws and the daily

constitutions of mad people's experience under the Ontario health care system, which creates people who are excluded from conventional disability rights movements while being streamed into a medico-legal control device called CTOs. To formulate a mad politics based on collective ways of thinking and being against psychiatric and neoliberal violence, I used cripistemology's reflective autobiographic narrative that allowed me to critically scrutinize the dominant legal and psychiatric epistemologies and social structures where people become unhoused and psychiatrized. Based on this turnaround in perceiving and examining the psychiatric regime through which how biopower operates, I then argued (in the MRP's second section), that Judge Belobaba in *Thompson and Empowerment Council v. Ontario* (2013) was wrong in deciding that the *Mental Health Act* (1990) and CTOs specifically, do not breach the *Charter*, and that its safeguards are robust enough to protect against any potential abuse of the law. I argued that the court erred in their application of the fundamental principles of justice, and consequently were wrong in determining that the *MHA* is neither overbroad nor grossly disproportionate. For example, safeguards in the *MHA* are not intended to reduce suffering caused by forced treatments and hospitalization. Next, I argued that the Consent and Capacity Board, which is governed under the *Health Care Consent Act* (1996), does not safeguard the autonomy of people with mental disabilities because the board is structurally inclined to prioritize psychiatric and legal opinions over those of psychiatric survivors. Following this, in the third part of this section, I argued that the medical model of mental disability undergirds legal reasoning and safeguards, consolidating psychiatric dominance over people with mental disabilities.

In response to these problems, I used the concepts of a post modernist relational model of disability that were introduced in the previous sections of this MRP. If a post-modernist relational approach to disability had been taken in *Thompson and Empowerment Council v.*

Ontario (2013), a decision may have been reached in a way that required legal safeguard reforms in the *MHA* and *HCCA*. The significance of socio-environmental factors and the impacts of the psychiatric complex on the wellbeing and decision-making capacities of people with psychiatric disabilities would have been taken seriously. More detailed and substantive admissibility criteria under the *MHA* could be legally mandated, necessitating that a person with psychiatric disability has been provided with their chosen supports, adequate housing, community engagement programs and alternative therapies and services before any psychiatric intervention was forced upon them. In this way, instead of providing community services as a condition of consenting to psychiatric medication, new safeguards under the *MHA* would help prevent such coercive measures. These safeguards would ensure coercive treatments could not be imposed unless it was shown that other approaches and efforts to improving mental distress, such as housing and adequate income supports, had been exhausted to the point of necessitating psychiatric intervention in order to protect a person's safety. Unlike current CTOs, such legal reforms would contribute to guaranteeing access to much-needed community services and accessible housing to this population.

References

Academic articles and chapters

- Armstrong, D. (1995). The rise of surveillance medicine. *Sociology of Health & Illness*, 17(3), 393-404.
- Beresford, P. & Russo, J. (2016). Supporting the sustainability of Mad Studies and preventing its co-option. *Disability & Society*, 31, (2), 270–274.
- Beresford, P. & Wilson, A. (2002) Genes Spell Danger: Mental health service users/survivors, bioethics and control. *Disability & Society*, 17(5) 541-553.
- Blanchette, S. (2019). “A Feminist Bioethical and Mad Studies Approach to Resisting an Increase in Psychiatric Paternalism to Competent Mental Health Users/Refusers”. *Journal of Ethics in Mental Health*, 10.

- Brophy, L., & Ring, D. (2004). The efficacy of involuntary treatment in the community: Consumer and service provider perspectives. *Social Work in Mental Health*, 2(2-3) 157-174.
- Burstow, B. (2013). A rose by any other name: Naming and the battle against psychiatry. Menzies, R., Reaume, G., Lefrançois, B. (Eds). *Mad Matters: A Critical Reader in Canadian Mad Studies*. Toronto: Canadian Scholar's Press,
- Burstow, B. & LeFrancois, A, B. (2014). Impassioned Praxis: An Introduction to Theorizing Resistance to Psychiatry. *Psychiatry Disrupted: Theorizing Resistance and Crafting the (R)evolution*. McGill-Queen's University Press.
- Campbell, K. F. (2013). Re-cognising Disability: Cross-examining social inclusion through the prism of queer anti-sociality. *Jindal Global Law Review*, 4, (2), 209- 238.
- Chen, Y. M. (2014). Brain fog: The race for criptestemology. *Journal of Literary & Cultural Disability Studies*, 8, (2), 171-184.
- Crow, L (1996). Including all of our lives: Renewing the social model of disability. J. Morris (Ed.). *Encounters with Strangers: Feminism and Disability*. London, UK: The Women's Press, 206-226.
- Costa, L. (2013.) Mad Patients as Legal Intervenors in Court. Menzies, R., Reaume, G., Lefrançois, B. (Eds) *Mad Matters: A Critical Reader in Canadian Mad Studies*. Toronto: Canadian Scholar's Press, pp. 195-209.
- Chaimowitz, G.A. (2004) Community treatment orders: An uncertain step. *Canadian Journal of Psychiatry*, 49(9), 577-578.
- Chandler, J, A. (2016). *Law and mind: mental health law and policy in Canada*. Dawson, LexisNexis Canada
- Clough, E. (2017). Disability and vulnerability: Challenging the capacity/incapacity binary. *Social Policy & Society*, 16(3), 469.
- Corringa, D. & O'Reilly, R. & Sommerdyk C, & Russell. E. (2019). The lived experience of community treatment orders (CTOs) from three perspectives: A constant comparative analysis of the results of three systematic reviews of published qualitative research. *International Journal of Law and Psychiatry*, 66.
- Davidson, L. (2020). A Key, not a straitjacket: The Case for Interim Mental Health Legislation Pending complete prohibition of psychiatric coercion in accordance with the Convention on the Rights of Persons with Disabilities. *Health and Human Rights*, 22(1), 163-178.
- Diamond., S. (2013). What Makes Us a Community? Reflections on Building Solidarity in Anti-sanist Praxis. In Menzies, R., Reaume, G., Lefrançois, B. (Eds) *Mad Matters: A Critical Reader in Canadian Mad Studies*. Toronto: Canadian Scholar's Press, 195-209.

- Dolmage, T. J. (2017). *Academic Ableism: Disability and Higher Education*. University of Michigan Press.
- Fabris, E. (2013). Mad success: What could go wrong when psychiatry employs us as ‘peers.’ Menzies, R., Reaume, G., Lefrançois, B. (Eds) *Mad Matters: A Critical Reader in Canadian Mad Studies*. Toronto: Canadian Scholar’s Press, 130-140.
- Fabris, E. (2011). *Tranquil Prisons Chemical Incarceration under Community Treatment Orders*, University of Toronto Press; Toronto Buffalo London 2011.
- Fennell, P. (2010). Institutionalising the Community: The Codification of Clinical Authority and the Limits of Rights-Based Approaches. *Rethinking Rights-Based Mental Health Laws*, Hart Publishing Oxford and Portland: Oregon, 13.
- Flood, M, C. & Thomas, B. (2016) Chapter 2. Fragmented law & fragmented lives: Canada’s mental health care system. *Law and Mind*. .29-
- Foucault, M. (1990). *The History of Sexuality: An Introduction, vol. 1*, New York: Vintage Books.
- Foucault, M. (1995). *Discipline and Punish: The Birth of the Prison*, New York: Vintage Books.
- Foucault, M. (1997). ‘What is enlightenment?’ (pp. 303-319). *In Ethics, Subjectivity, and Truth*. Ed. Paul Rabinow. New York: New Press.
- Foucault, M. (2007). *Security, Territory, Population: Lectures at the College de France, 1977-78*. Palgrave Macmillan.
- Freckelton, I (2010). Extra-Legislative Factors in Involuntary Status Decision-Making. in *Rethinking Rights-Based Mental Health Laws*. Hart Publishing Oxford and Portland, Oregon 203.
- Francombe, K. & Pridhama,b, Arash Nakhost a,c,&. Tugg, L. &. Etherington, N. &. Stergiopoulos, V. &. Lawa, S. (2018). Exploring experiences with compulsory psychiatric community treatment: A qualitative multi-perspective pilot study in an urban Canadian context. *International Journal of Law and Psychiatry*, 57, 122–130.
- Gambrill, E. (2014). The diagnostic and statistical manual of mental disorders as a major form of dehumanization in the modern world. *Research on Social Work Practice*, 24(1), 13-36.
- Goodley, D. (2004). De/Constructing ‘Learning Difficulties’ in Educational Contexts: the life story of Gerry O’Toole. (From Barnes, C and Mercer G. (eds.) *Disability Policy and Practice: Applying the Social Model*. Leeds: The Disability Press, 175-190.
- Goodley, D. (2013). Dis/entangling critical disability studies. *Disability & Society*, 28(5), 631–644.
- Gorman, R. (2013) Thinking Through Race, Class and Mad Identity Politics. In Menzies, R., Reaume, G., Lefrançois, B. (Eds) *Mad Matters: A Critical Reader in Canadian Mad Studies*. Toronto: Canadian Scholar’s Press, 269-280.

- Gibbs, A., Dawson, J., Ansley, C., & Mullen, R. (2005). How patients in New Zealand view community treatment orders. *Journal of Mental Health*, 14
- Jager, F. & Perron, A. (2020). The social utility of community treatment orders: Applying Girard's mimetic theory to community-based mandated mental health care. *Nursing Philosophy*.
- Johnson, L. M. & McRuer, R. (2014). Cripistemologies: Introduction. *Journal of Literary & Cultural Disability Studies*, 8, (2), 127-147.
- Kerzner, L. (2006). Mental Capacity Through a Disability Law Lens. *Disability and Social Policy in Canada*. Toronto: Captus, 33.
- Klassen, L, A. (2017). Spinning the revolving door: The governance of non-compliant psychiatric subjects on community treatment orders. *Theoretical Criminology*, 21(3), 361–379.
- Lawn, S, & Delany, T, & Pulvirenti, S, M, & Smith, A., & McMillan, J. (2016). Examining the use of metaphors to understand the experience of community treatment orders for patients and mental health workers. *BMC Psychiatry*, 16(82).
- Lewis, B. (2006). A mad fight: Psychiatry and disability activism. *The disability studies reader*, 339-354.
- Lewis, O. (2010). Educational and proactive roles of human rights: An analysis of the United Nations *Convention on the Rights of Persons with Disabilities*. *Rethinking Rights-Based Mental Health Law*. Oxford and Portland, Oregon, 97-128.
- Mfoafo-M'Carthy, M. (2010). Experience is the best teacher. Community Treatment Orders (CTOs) among ethno-racial minority communities in Toronto: A Phenomenological Study. Factor-Inwentash Faculty of Social Work. *University of Toronto*.
- Mfoafo-M'Carthy, M. & Williams, C, C. (2010). Coercion and Community Treatment Orders (CTOs): One Step Forward, Two Steps Back. *Canadian journal of community mental health = Revue canadienne de santé mentale communautaire* · April.
- Mfoafo-M'Carthy, M. & Shera, W. (2012). Beyond Community Treatment Orders: Empowering clients to achieve community integration. *International Journal of Mental Health*, 41, (4), 62-81.
- Morrow, A. (2014) Cripistemologies: What disability theory needs to know about hysteria. *Journal of Literary & Cultural Disability Studies*, 8, (2), 185-201.
- Morrow, M. (2004). Mental health reform, economic globalization and the practice of citizenship. *Canadian journal of community mental health*, 23(2), 39-50.
- Morrow, M. & Dagg, B, P. & Pederson, A. (2008). Is deinstitutionalization a 'failed experiment'? The ethics of re-institutionalization. *Journal of Ethics in Mental Health*, 3(2), 1-7.

- Morrow, M. & Weisser, J. (2012). Towards a Social Justice Framework of Mental Health Recovery. *Studies in Social Justice*, 6, (1), 27-43.
- Morrow, M. & Malcoe, H, L. (2017). *Critical Inquiries for Social Justice in Mental Health*. University of Toronto Press: Toronto Buffalo London
- Minkowitz, T. (2010). Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities. *Rethinking Rights-Based Mental Health Laws*, Hart Publishing Oxford and Portland: Oregon, 13.
- O'Brien, A. & Susan J. & Farrell E. & Faulkner, S. (2009) Community Treatment Orders: Beyond Hospital Utilization Rates Examining the Association of Community Treatment Orders with Community Engagement and Supportive Housing. *Community Mental Health*, 45, 415–419.
- O Reilly, R. (2004) Why are community treatment orders controversial? *Canadian Journal of Psychiatry*, 49(9), 479-584.
- Oliver, M. & Barnes, C. (2012). Constructing disabled identities. *The New Politics of Disablement*. London: Palgrave MacMillan.
- Oliver, M. (1990). *The politics of disablement: A sociological approach*. New York: St. Martin's Press: 1-15.
- Rabinow, P. & Rose, N. (2006). Biopower today. *BioSocieties*, 1, 195-217.
- Price, M. (2010). *Mad at School: Rhetorics of Mental Disability and Academic Life*. The University of Michigan Press.
- Roets, G. & Braidotti, R. (2012). Nomadology and subjectivity: Deleuze, Guattari and Critical Disability Studies. *Disability and Social Theory: New Developments and Directions*, 161-178. Palgrave Macmillan, UK.
- Rose, M, S. (1979). Deciphering deinstitutionalization: complexities in policy and program analysis. *Milbank Memorial Fund Quarterly*. *Health and Society*, 51(4),429-460.
- Rose, N. (2007). *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton University Press.
- Puar, J. (2017). *The Right to Maim: Debility, Capacity, Disability*. Durham, NC: Duke University Press.
- Pilling, D, M, &, Daley, A., & Gibson, F, M., & Ross, E, L., & Zaheer, J, (2018). Assessing 'Insight', Determining Agency and Autonomy: Implicating Social Identities. *Containing Madness*.
- Schwartz, K. & O'Brian, A. & Morel, V, & Armstrong, M. & Fleming, C, & Moore, P. (2010). Community Treatment Orders: The Service User Speaks Exploring the Lived Experience of Community Treatment Orders. *International Journal of Psychosocial Rehabilitation*, 15 (1), 39.

- Shildrick, M. (2020). Critical disability studies: Rethinking the conventions for a post-conventional age. Nick Watson and Simo Vehmas. *Routledge handbook of disability studies*, 32-44. New York: Routledge.
- Szasz, T. (2003). Psychiatry and the control of dangerousness. *Journal of Social Work Education*, 39(3), 375-381.
- Szasz, T. (2008). *Psychiatry, the Science of Lies*. Syracuse University Press.
- Szigeti, A. (2001) Ontario's community treatment orders: How did we get there and where do we go now? An advocate's perspective. *Health Law in Canada*, 21(3). 66-83. 38.
- Swigger, A. & Heinmiller T, B. (2014). Advocacy Coalitions and Mental Health Policy: The Adoption of Community Treatment Orders in Ontario. *Politics and Policy*. April, 246-270.
- Thomas, C. (1999). Defining disability: the social model. In Carol Thomas (ed.) *Female forms: experiencing and understanding disability*. Philadelphia: Open University Press, 279-293.
- Veen, V, C. & Ibrahim, M. & Morrow, M. (2018). Containing Madness, Dangerous Discourses: Masculinity, Coercion, and Psychiatry. *Containing Madness: Gender and 'Psy' in Institutional*. Kilty, M, J. &, Dej., E. Palgrave Macmillan. 241-265.
- Washington, H. (2011). Flacking for big pharma: Drugmakers don't just compromise doctors; they also undermine the top medical journals and skew the findings of medical research. *American Scholar*, 80 (3), 22-35.
- Waldschmidt, A (2005). who Is normal? who Is deviant? "Normality" and "Risk" in genetic diagnostics and counseling. *Foucault and the Government of Disability*. Shelley Tremain. The University of Michigan Press.
- Walker, J. (2008). The legacy of a story: commemoration and the double-narrative of Jeffrey Arenburg and Brian Smith. *Disability Studies Quarterly*, 28(1).
- Wendell, S. (1996), *The Rejected Body: Feminist Philosophical Reflections on Disability*. Routledge.
- Wallenstein, S. (2013). Introduction: Foucault, biopolitics, and governmentality. *Foucault, Biopolitics, and Governmentality*. Sodertorn University.
- Wildeman, S. (2012). Insight Revisited: Relationality and Psychiatric Treatment Decision-Making Capacity. *Being Relational: Reflections on Relational Theory and Health Law*, Vancouver: UBC Press.

Laws, caselaw, and government literature

Canadian Charter of Rights and Freedoms, Part 1 of The Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11.

Criminal Code, RSC 1985, c C-46, s 318(1)(a).

Health Care Consent Act, SO 1996, c.2, Schedule A, ss. 1-37.1, s.70.1

Mental Health Act, R.S.O. 1990, c. M.7, s. 15 (1); 2000, c. 9, s. 3 (1).

Ontario Disability Support Program Act, 1997, S.O. 1997 c. 25, Schedule B

Bedford v. Canada [2013] 3 SCR 1101.

Carter v. Canada (Attorney General), [2012] BCSC 886

E (Mrs) v Eve, [1986] 2 S.C.R. 388 <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/170/index.do>

Eldridge v. British Columbia (Attorney General), [1997] 3 S.C.R. 624. <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1552/index.do>.

R. v. Heywood, [1994] 3 S.C.R. 761 <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1198/index.do>

R. v. Morgentaler, [1988] 1 S.C.R. 30 <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do>

R. v. Swain, [1991] 1 S.C.R. 933. Online <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/753/index.do>

Starson v Swayze, [2003] 1 SCR 722, online: <https://scc-csc.lexum.com/scc-csc/scccsc/en/item/2064/index.do>

Thompson and Empowerment Council v. Ontario, [2013] ONSC 5392.

Thompson v. Ontario (Attorney General), [2016] ONCA 676.

Canadian Charter of Rights and Freedoms, Part 1 of The Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11.

Current City of Toronto Average Market Rents & Utility Allowances. (2021). City of Toronto. <https://www.toronto.ca/community-people/community-partners/social-housing-providers/affordable-housing-operators/current-city-of-toronto-average-market-rents-and-utility-allowances/>