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Relationships of Force: Reflections on Law, Psychiatry and Human Rights

Aaron A. Dhir*

I would like to begin this evening by thanking the *Windsor Review of Legal and Social Issues* (“the Review”) for inviting me to deliver this year’s keynote address. It is truly an honour to speak at the law school where I spent the first three years of my academic career. I am forever grateful to Windsor Law for the support I received during my time here. Yours is a remarkable community of dedicated scholars and students who care deeply about issues of social justice and I am privileged to have worked, and to have made some of my closest friends, here. I am also incredibly humbled to be giving an address that has previously been delivered by such luminaries as Justice Peter Cory, Justice Kathryn Feldman, Justice Edward Ducharme and Professor John Whiteside. I am not even remotely qualified to follow in their very impressive footsteps.

The theme of the Review’s special issue is “Perspectives on Law and Psychiatry: Exploring the Legal and Social Issues Surrounding Mental Disability.” In commenting on this topic through the lens of human rights, I do not hesitate to state that the reality is unfortunate. In terms of equality seeking groups – whether ethnic and racial minorities, gays and lesbians, women, persons with physical and sensory disabilities – in my view, each has come leaps and bounds beyond persons who have been assigned a psychiatric diagnosis. These persons are routinely subjected to degrading and cruel treatment, sexually exploited and physically abused, neglected in austere institutional cultures, engaged in forced labour and are the subject of protracted liberty deprivations without access to due process.¹

In making these remarks, I of course do not mean to suggest that problems of intersectionality are not germane. On the contrary, the fusion of mental disability with discrimination based on sexual orientation, gender or race presents its own unique types of disadvantage.² Consonant with the critique presented by social

* Assistant Professor, Osgoode Hall Law School of York University. The following is a slightly revised version of the keynote address given at the *Windsor Review of Legal and Social Issues* 2008 banquet (March 27, 2008; Windsor, Ontario). I wish to thank Rosaleen Piluso, Editor-in-Chief of the *Windsor Review of Legal and Social Issues* and Mercedes Perez for her valuable suggestions on prior versions of this address.

¹ Eric Rosenthal & Clarence J. Sundram, “International Human Rights In Mental Health Legislation” (2002) 21 N.Y.L. Sch. J. Int’l & Comp. L. 469 at 472–473.

² See Bonnie Burstow, “A History of Psychiatric Homophobia” (1990) 8:3&4 *Phoenix Rising: The Voice of the Psychiatrized* S38; Lykke de la Cour, “‘She Thinks this is the Queen’s Castle’: Women Patients’ Perceptions of an Ontario Psychiatric Hospital” (1997) 3:2 *Health & Place* 131; Suman Fernando, “Imperialism, Racism and Psychiatry” in Phil Barker & Chris Stevenson, eds., *The Construction of Power and Authority in Psychiatry* (Oxford:

theories of disability, what is labelled as disability under the traditionally dominant medical model “is not generally selected through a neutral or disinterested process” but rather “through an apparatus of power.”³ Foucault referred to the dynamic between psychiatrist and patient as “the confrontation of two wills...a battle...a *relationship of force*.”⁴ One problem arising from this is the connection between the subjective biases of clinicians and psychiatric diagnosis. For example, the literature reveals an increase in inaccurate diagnosis when cultural and social commonalities between the medical practitioner and the patient are more pronounced.⁵ So then, in the U.S. “...black men are hospitalized at a rate...greater than white men, and black women at a rate...greater than white women...[and, once hospitalized] black men are far more likely to be subject to seclusion than white men.”⁶

To some, the idea of rights violations in psychiatric facilities will seem counterintuitive. Indeed, viewing mental disability through a rights-based prism is a relatively new practice⁷ and “because psychiatric intervention is medical treatment, we [typically] assume that it has been undertaken for benevolent purposes.”⁸ Such assumptions have sometimes been shared by key players on the human rights stage⁹

Butterworth Heinemann, 2000) at 81; and J.H. Flaskerud & L.T. Hu, “Relationship of Ethnicity to Psychiatric Diagnosis” (1992) 180(5) *J. Nervous & Mental Disease* 296.

³ Gerard Quinn & Theresia Degener, *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability* (Geneva: Office of the United Nations Commissioner for Human Rights, 2002) at 15.

⁴ Michel Foucault, *Psychiatric Power: Lectures at the College de France 1973-1974* (New York: Palgrave MacMillan, 2006) at 10 [emphasis added].

⁵ Susan Stefan, “Leaving Civil Rights to the ‘Experts:’ From Deference to Abdication under the Professional Judgment Standard” (1992) 102 *Yale L.J.* 639 at 659.

⁶ *Ibid.* at 659–660.

⁷ Michael Perlin, “International Human Rights and Comparative Mental Disability Law: The Use of Institutional Psychiatry as a Means of Suppressing Political Dissent” (2006) 39 *Isr. L.R.* 69 at 72.

⁸ *Ibid.* at 70.

⁹ Consider the following remarks of Eric Rosenthal, Executive Director of Mental Disability Rights International:

Amnesty [International], I must say, once had a horrendous record with regard to people with mental disabilities. We heard earlier in this conference about the use of so-called “unmodified ECT.” That is ECT without muscle relaxants or anesthesia. There is actually an Amnesty International report from just over ten years ago that looked at that practice in Romania, and said that it was not a human rights violation because the intent of the medical practitioner was to help the patient, even though the practice of unmodified ECT causes tremendous pain and possibly life-threatening dangers. According to Amnesty’s way of thinking, this was not a human rights violation appropriate for international recrimination. It was merely a question of “medical ethics.”

and for decades the rights of mentally disabled persons were virtually ignored by the human rights movement.¹⁰ And yet, it is difficult to reconcile these assumptions with – for example – non-consensual medical experimentation on psychiatric patients in the United States¹¹ or the use of state psychiatry in the former Soviet Union and China as a means of suppressing political dissent.¹² The latter, unfortunately, is not yet a thing of the past. Psychiatric detention continues to be used as a tool of political oppression in China vis-à-vis members of the Falun Gong.¹³ In its most recent report, leading civil society organization Mental Disability Rights International documented instances of severe abuse in Serbian psychiatric facilities, including “filthy conditions, contagious diseases” and both adults and children who were “tied to beds or never allowed to leave [their] crib[s] – some for *years* at a time.”¹⁴ This follows the group’s prior accounts of rights violations in countries such as Romania, Turkey, Peru, Uruguay, Mexico and Hungary.¹⁵

Somehow, when it is a question of medical ethics, you can leave it to the doctors and police to fight it out amongst each other about how best to treat their patients.

See “The Application of International Human Rights Law to Institutional Mental Disability Law” (2002) 21 N.Y.L. Sch. J. Int’l & Comp. L. 387 at 392.

¹⁰ See Debra Benko & Brittany Benowitz, “The Application of Universal Human Rights Law to People with Mental Disabilities” (2001) 9:1 Hum. Rts. Brief 9, online: American University Washington College of Law <<https://www.wcl.american.edu/hrbrief/09/1mental.cfm>>. (“Full recognition of the rights of people with mental disabilities is still emerging as one of the newest goals of the international human rights movement.”)

¹¹ Daniel Pollack et. al., “The Capacity of a Mentally Retarded Person to Consent: An American and Jewish Legal Perspective” (2000) 20 N.Y.L. Sch. J. Int’l & Comp. L. 197 at n. 121.

¹² See Perlin, *supra* note 7 as well as Richard Bonnie, “Political Abuse of Psychiatry in the Soviet Union and in China: Complexities and Controversies” (2002) 30 J. Amer. Acad. Psychiatry & L. 136; Amy Young-Anawaty, “International Human Rights Norms and Soviet Abuse of Psychiatry” (1978) 10 Case W. Res. J. Int’l L. 785; and Robin Munro, “Judicial Psychiatry in China and its Political Abuses” (2000) 14 Colum. J. Asian L. 1.

¹³ Perlin, *supra* note 7 at 87–88.

¹⁴ Mental Disability Rights International, “Torment not Treatment: Serbia’s Segregation and Abuse of Children and Adults with Disabilities” (2007) at iii, online: Mental Disability Rights International <<http://www.mdri.org/projects/serbia/Serbia-rep-english.pdf>> [emphasis in original].

¹⁵ See “Hidden Suffering: Romania’s Segregation and Abuse of Infants and Children with Disabilities” (2006); “Behind Closed Doors: Human Rights Abuses in the Psychiatric Facilities, Orphanages and Rehabilitation Centers of Turkey” (2005); “Human Rights and Mental Health in Peru” (2004); “Human Rights and Mental Health: Uruguay” (2004); “Human Rights and Mental Health: Mexico” (2000); and Human Rights and Mental Health: Hungary” (1997), online: Mental Disability Rights International <<http://www.mdri.org/publications/index.htm>>. See also the reports of the Mental Disability Advocacy Center, including “Cage Beds: Inhuman and Degrading Treatment in Four EU

While the international human rights framework developed in the 20th century bears directly on these situations, the reality is that international human rights law has been largely ineffectual. The standard treaties have few provisions that relate directly to mental disability and “[h]uman rights oversight bodies that monitor the mainstream conventions and establish reporting guidelines have dedicated little attention to the rights of people with mental disabilities.”¹⁶ Change, however, may very well be on the horizon. On December 13, 2006, the United Nations General Assembly adopted the Convention on the Rights of Persons with Disabilities (“the Convention”),¹⁷ which will come into force after receiving twenty ratifications or accessions.¹⁸ I was fortunate to participate as a non-governmental organization delegate to two of the meetings that led to the development of the Convention¹⁹ and I hold out great hope that it will provide much needed assistance in the field of mental disability.²⁰

That being said, in some ways I am hesitant to even mention these jurisdictions, or the transnational system, for fear of succumbing to the dangerous

Accession Countries” (2003) (a report on the use of cage beds in the psychiatric facilities of the Czech Republic, Hungary, Slovakia and Slovenia), online: Mental Disability Advocacy Centre <http://www.mdac.info/documents/118_MDAC_Cage_Bed_Report.pdf>.

¹⁶ See Rosenthal & Sundram, *supra* note 1 at 474.

¹⁷ The full text of the Convention is available on the website of the Office of the United Nations High Commissioner for Human Rights. See Convention on the Rights of Persons with Disabilities, online: UN High Commissioner for Human Rights <<http://www2.ohchr.org/english/law/disabilities-convention.htm>>. For examinations of the European Convention on Human Rights’ applicability to mental health law, see generally P. Bartlett, O.Lewis & O.Thorold, *Mental Disability and the European Convention on Human Rights* (Leiden: Martinus Nijhoff, 2006); Lawrence O. Gostin, “Human Rights of Persons with Mental Disabilities: The European Convention of Human Rights” (2000) 23 Int’l J.L. & Psychiatry 125; T.W. Harding, “The Application of the European Convention of Human Rights to the Field of Psychiatry” (1990) 9 Med. Law 1078; and Gerard Quinn, “Civil Commitment and the Right to Treatment under the European Convention on Human Rights” (1992) 5 Harv. Hum. Rts. J. 1.

¹⁸ As per Article 45(1) of the Convention, *supra* note 17.

¹⁹ Specifically, I was a member of the Rehabilitation International delegation to the United Nations Working Group Meeting and the fifth Ad Hoc Committee Meeting respecting the Convention. Both meetings were held at United Nations Headquarters in New York from January 5–16, 2004 and January 24 – February 4, 2005 respectively.

²⁰ For discussions on the Convention and mental disability see Aaron A. Dhir, “Human Rights Treaty Drafting through the Lens of Mental Disability: the Proposed *International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities*” (2005) 41:2 Stan. J. Int’l L. 181 and Tina Minkowitz, “The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions” (2007) 34:2 Syracuse J. Int’l L. & Com. 405.

temptation of “othering.” It would be a mistake to secure our own identity by constructing a false dichotomy between ourselves and other rights-violating jurisdictions. This sort of misguided self-affirmation masks a more abrasive reality. The Ontario Consent and Capacity Board (“the Board”) is the tribunal charged by statute with receiving applications relating to involuntary committal, capacity to consent to treatment, capacity to manage one’s finances and other related issues. After having represented numerous psychiatric patients before the Board, I would argue that the fundamental liberty interests of persons with mental disabilities are violated in our own backyard. I should state from the outset that I view the Board, overall, as normally being quite conservative.²¹ However, consider the following comments from a Board decision released just four years ago with respect to a patient held at “Canada’s leading addiction and mental health teaching hospital.”²²

“The callous manner in which [the patient’s] rights to procedural fairness and natural justice were trampled from the moment of her...admission are difficult to envision in modern day Ontario. However, in this particular case, it seems that the administrative arm of the Centre for Addiction and Mental Health – Queen Street Site, as well as [the physicians] have chosen to operate as would a mental institution in the 18th Century. Procedural safeguards designed to ensure that [the patient] not be detained against her will without reviewing the procedural and substantive grounds of her detention were trampled again and again... [The patient] has...been unjustly detained in contravention of her *Charter* rights.”²³

²¹ See, for example, the critiques put forth in Aaron A. Dhir, “The Maelstrom of Civil Commitment in Ontario: Using Examinations Conducted During Periods of Unlawful Detention to Form the Basis of Subsequent Involuntary Detention under Ontario’s *Mental Health Act*” (2003) 24:2 Health L. Can. 9.

²² See the Centre for Addiction and Mental Health’s website, online: Centre for Addiction and Mental Health <<http://www.camh.net/>>.

²³ *In the Matter of S.K.*, Consent and Capacity Board Reasons for Decision TO 031454, January 4, 2004 at 20–21. One commentator recently argued that “Ontario’s experience discloses a high rate of compliance with [existing] international human rights standards” and implied that the Convention will be of limited assistance given that it “only provides general principles that are difficult to use to measure compliance of state parties.” See Joaquin Zuckerberg, “International Human Rights for Mentally Ill Persons: The Ontario Experience” (2007) 30:6 Int’l J.L. & Psychiatry 512 at 514, 527. In my view, this is shortsighted and there is much to be learned from the Convention at the domestic level. For example, while the commentator notes that the nature of the Board is in harmony with international standards, it is interesting to observe that the Board’s composition does not mirror the composition of the

How can we begin to understand this unfortunate reality? Professor Perlin has attributed such rights deprivations to two phenomena: sanism and pretextuality.²⁴ He defines sanism “as an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry...”²⁵ In other words, discrimination based on one’s mental state that stems from stereotypical, reductionist assumptions. Pretextuality is defined as “the ways in which courts accept—either implicitly or explicitly—testimonial dishonesty and engage similarly in dishonest and frequently meretricious decision-making, specifically where witnesses, especially expert witnesses, show a high propensity to purposely distort their testimony in order to achieve desired ends.”²⁶

For Professor Perlin, these concepts have infected all aspects of mental health law. But his analysis is particularly striking and instructive for all of us tonight for the following reason: the primary responsibility for the lack of rights realization lies not with judges, not with legislators and not with clinicians. Rather, it lies with us – the lawyers who represent, and will go on to represent, persons with psychiatric disabilities.²⁷ If we accept that these persons are amongst the most marginalized and devalued in our society, it follows that counsel representing them would advance their legal rights with diligence and resolve. Perlin, however, issues a seething indictment of patient’s counsel in cases involving mental disability rights.

Indeed, with noteworthy exceptions,²⁸ patient’s counsel can be equally guilty of sanist predilections. This problem manifests itself, for example, in the context of right to refuse treatment cases. In Ontario, the common law rule that individuals are

proposed Committee on the Rights of Persons with Disabilities. Article 34(4) of the Convention contemplates that in electing representatives to the Committee, States Parties will give consideration to, *inter alia*, the “participation of experts with disabilities.” In contrast, the Board typically sits as a panel of three (one lawyer member, one psychiatrist member and one lay member) and there is no requirement that persons with disabilities participate at all.

²⁴ Perlin, *supra* note 7 at 73. See also Michael Perlin, “‘You Have Discussed Lepers and Crooks:’ Sanism in Clinical Teaching” (2003) 9 *Clinical L. Rev.* 683; Michael Perlin, “‘Half-Wracked Prejudice Leaped Forth:’ Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did” (1999) 10 *J. Contemp. Legal Issues* 3; Michael Perlin & D.A. Dorfman, “Sanism, Social Science, and the Development of Mental Disability Law Jurisprudence” (1993) 11 *Behav. Sci. & L.* 47; and Michael Perlin, “On ‘Sanism’” (1992) 46 *SMU L. Rev.* 373.

²⁵ Perlin, *supra* note 7 at 74.

²⁶ *Ibid.*

²⁷ Michael Perlin, “‘And My Best Friend, My Doctor, Won’t Even Say What It Is I’ve Got:’ The Role and Significance of Counsel in Right to Refuse Treatment Cases” (2005) 42 *San Diego L. Rev.* 735 at 736–737.

²⁸ For example, the Toronto-based Mental Health Legal Committee is a group of lawyers and community legal workers who work tirelessly for the rights of mental health consumer/survivors.

presumed capable of giving or refusing consent to treatment is codified in the *Health Care Consent Act*.²⁹ This presumption is of paramount importance. As stated by the Ontario Court of Appeal in *Malette v. Shulman*, “[t]he right to determine what shall be done with one’s own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based.”³⁰ One year later, the Court in *Fleming v. Reid* transferred these sentiments to the context of mental disability as follows: “[m]entally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection...”³¹

In order to displace the presumption of capacity, the legislation requires that a two-prong test be met. First, the subject of proposed treatment must be unable “to understand the information that is relevant to making a decision about the treatment.”³² And second, she must be unable “to appreciate the reasonably foreseeable consequences of a decision or lack of decision.”³³ In *Starson v. Swayze*, the Supreme Court of Canada confirmed that in order to meet the second branch of the test, a patient need not agree with the clinician’s diagnosis and that there is room for “dissident interpretations of information.”³⁴ So then, denial of illness in and of itself is not to be equated with incapacity unless it is demonstrated that the denial is actually a function of the illness. In other words, a sufficient nexus must be established between the denial and the illness.³⁵

And yet, from the literature,³⁶ from my own experience, and from anecdotal evidence, patients’ counsel can sometimes substitute engaged lawyering with paternalism³⁷ and can fall into the trap of conflating the presence of mental disability with incapacity. With clinicians and adjudicators exhibiting the same tendency, we are left with the possibility of a sort of nightmare state where antiquated, sanist notions are left untested by rigorous advocacy.³⁸ The presumption of capacity

²⁹ S.O. 1996, c. 2, Sched. A, ss. 4(2).

³⁰ (1990), 72 O.R. (2d) 417 (C.A.) at 432.

³¹ (1991), 4 O.R. (3d) 74 (C.A.) at 86–87.

³² *Supra* note 29, ss. 4(1).

³³ *Ibid.*

³⁴ [2003] 1 S.C.R. 722 at para. 79.

³⁵ *Ibid.* Chief Justice McLaughlin, in dissent, disagreed with this proposition and cited the denial of mental illness as a clinical indicator of incapacity. See *ibid.* at para. 25.

³⁶ “The data suggests that, in many jurisdictions...counsel is woefully inadequate – disinterested, uninformed, roleless, and often hostile.” See Perlin, *supra* note 27 at 738 (regarding the civil commitment process generally).

³⁷ *Ibid.*

³⁸ *Ibid.* at 747–748.

becomes an “illusory safeguard”³⁹ and the tribunal hearing to adjudicate capacity becomes a mere ceremonial act, devoid of any real meaning.

The consequences of this for persons with mental disabilities are grave. At one level, the violation of an individual’s physical and psychological integrity through coerced treatment can be both degrading and humiliating and can have a profound effect on her sense of self. At another level, the psychiatric medications that form the subject of right to refuse treatment cases can have devastating consequences. Since their introduction to psychiatry in 1952, antipsychotic drugs have been the treatment of choice for those diagnosed with various psychotic conditions. However, studies have concluded that these medications, described as “one of the most behaviorally toxic classes of psychotropic drugs,” enjoy no more than a thirty-four per cent net effectiveness rate in terms of their ability to reduce relapse.⁴⁰ In addition to the questionable efficacy of these medications, their potential side-effects range from muscular, extra-pyramidal reactions to low blood pressure to sudden death.⁴¹ Further, the argument that newer, “atypical” medications possess therapeutic advantages not demonstrated by older medications is open to dispute. In that regard, it has been argued that these drugs provide no clear advantage and that any perceived advantage is solely attributable to the fact that newer medications are less potent.⁴²

So then, moving forward, how can you as counsel of the future avoid replicating the failures of the past? While numerous suggestions can be made, I will mention only two now.

First, those who undertake a patient-side mental health practice must go beyond the complex legislative framework and case law and must develop fluency in pharmacology and psychiatric diagnostics.⁴³ This is particularly important as you will not only be arguing your case, but also educating tribunal members and judges on issues that will often be foreign to them. The second suggestion is what one of

³⁹ *Ibid.* at 747.

⁴⁰ David Cohen, “A Critique of the Use of Neuroleptic Drugs in Psychiatry” in Seymour Fisher & Roger P. Greenburg, eds., *From Placebo to Panacea: Putting Psychiatric Drugs to the Test* (New York: John Wiley & Sons, 1997) 173 at 173–74, 192, 201–202.

⁴¹ See the Honourable Mr. Justice Robins’ discussion in *Fleming v. Reid*, *supra* note 31 at 84. See also, for example, Javier Ballesteros *et al.*, “Tardive Dyskinesia Associated with Higher Mortality in Psychiatric Patients: Results of a Meta-Analysis of Seven Independent Studies” (2000) 20 *J. of Clinical Psychopharmacology* 188 at 193; Peter Breggin, “Brain Damage Dementia and Persistent Cognitive Dysfunction Associated with Neuroleptic Drugs: Evidence, Etiology, Implications” (1990) 11 *J. Mind Behav.* 425; Robert Whitaker, “The Case against Antipsychotic Drugs: A 50-year Record of Doing More Harm than Good” (2004) 62 *Med. Hypothesis* 5.

⁴² See generally D.C. Smith, “Are Newer Antipsychotics Better?” (2001) 3 *Ethical Hum. Sci. Services: Int’l J. Critical Inquiry* 61 (discussing the shortcomings of some newer antipsychotic medications).

⁴³ Perlin, *supra* note 27 at 743.

Canada's leading mental health lawyers, and one of my mentors, has referred to as "empathic communication with your client."⁴⁴ It is crucial that you develop "a genuine sensitivity to your client's general quality of life as well as the current crisis she is facing, which is often multi-faceted."⁴⁵ While the potential for mental disability cuts across all divisions, this crisis situation will often take place within a context of poverty, estrangement from family, inadequate housing and employment and a low income (if any).⁴⁶

This second suggestion leads to my final point. The practice of mental health law is extremely demanding – physically, emotionally and psychologically. To do it well requires heightened emotional maturity, compassion and a tireless commitment to realizing justice. It is not an area that will bestow much in the way of financial gain as almost all of your clients will be supported by legal aid.⁴⁷ It is also not an area that affords the sense of satisfaction which comes from winning cases frequently. In fact, as co-counsel for two intervener groups in *Starson v. Swayze*, we submitted statistics to the Supreme Court demonstrating that the Board overwhelmingly rejects patient appeals challenging psychiatrists' findings of treatment incapacity. In 2001, for example, there was a staggering ninety-four per cent rejection rate.⁴⁸

At this point, given the picture I have painted, most of you are probably wondering why on earth anyone would want to enter this area of practice. But please believe me when I say that the rewards are immeasurable. Mental health law is the height of "in the trenches" social justice litigation. And while sometimes your client will not acknowledge or appreciate the contribution you have made, other times the connection you forge is deeply impactful and will mean so much. In those situations, you may be the only one on her side and the only one who does not judge her reality. And in return, there is much to be learned from your client's experiences. The same practitioner I mentioned a moment ago remarked as follows on the impact of mental health work:

[W]hile I am not prone to being an emotional person...I have found that on occasion I have been moved to tears (sometimes during the course of a hearing) by the incredible vulnerability of my clients, and the often surprising and endearing kindness that psychiatric inpatients will show each other within the context of their confinement. It has been my

⁴⁴ Anita Szigeti, "Representing a Client who has a Mental Health Issue before the Consent and Capacity Board" (unpublished; October, 2007) at 7.

⁴⁵ *Ibid.*

⁴⁶ *Ibid.*

⁴⁷ *Ibid.* at 4.

⁴⁸ Memorandum of Argument of the Proposed Interveners, The Mental Health Legal Committee and The Mental Health Legal Advocacy Coalition (Motion For Leave To Intervene) in *Starson v. Swayze* at 11.

experience that I had learned more in the first few years I practiced in this area about human nature, good and bad, and indeed about myself, than I had been able to glean from the rest of my life experience up to that point...⁴⁹

I will conclude my remarks this evening by noting, with admiration, that next year will mark the 20th anniversary of the Review's first publication. Your journal was originally founded with seven organizing principles. The first four were as follows:

1. There is a need to examine legal issues that affect Canadians;
2. Law is not an end in itself but rather a vehicle for social change;
3. The study of law requires a multi-disciplinary perspective; [and]
4. Legal scholarship should promote an analytical, practical and empirical approach to the study of law...⁵⁰

Each of these principles is directly relevant to the field of mental health law. As compared with other fields, there is a dearth of progressive Canadian legal literature addressing the most pressing challenges facing those with psychiatric disabilities – let alone doing so from a critical, interdisciplinary perspective. Issues such as mandatory community treatment, hospitalized patients' right to sexual expression and corporate malfeasance in the pharmaceutical industry are underexplored and must become the subject of scholarly inquiry. In publishing this volume, the Review has taken an admirable step forward and is making a meaningful contribution to the evolving discourse. And I sincerely applaud you for it. Thank you so much.

⁴⁹ Szigeti, *supra* note 44 at 5.

⁵⁰ The Honourable Madam Justice Kathryn Feldman, "Remarks about the Value of Student-Run Law Journals: Opening Address at the First Annual Banquet of the Windsor Review of Legal and Social Issues" (2004) 17 Windsor Rev. Legal Soc. Issues 1 at 4.