

Governing Madness: Coercion, Resistance and Agency in British Columbia's Mental
Health Law Regime

by

Gene Fraser
BA, Simon Fraser University, 1988
JD, University of Toronto, 1991

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in the Faculty of Law

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Supervisory Committee

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Supervisory Committee

Associate Professor Maneesha Deckha (Faculty of Law)

Co-Supervisor

Professor Pamela Moss (Faculty of Human and Social Development)

Co-Supervisor

Professor James Tully (Political Science)

Departmental Member

Abstract

Supervisory Committee

Associate Professor Maneesha Deckha (Faculty of Law)

Co-Supervisor

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Co-Supervisor

Professor James Tully (Political Science)

Departmental Member

Among the features that distinguish British Columbia's mental health laws from those in other provinces in Canada is that they accord a high level of discretion to psychiatrists to impose involuntary treatment on patients who have the mental capacity to withhold consent to this treatment. In this research I examine the nature of the medico-legal regime in British Columbia that permits this coercive treatment, describe how it came into existence, and explore how it works in the lives of specific patients. Michel Foucault's philosophy informs the historical, theoretical, and empirical dimensions of this research and provides a framework for a normative critique of British Columbia's mental health law regime.

In establishing the background to British Columbia's current mental health laws, I give a historical account of the social forces that produced this province's laws, which reflect a strong orientation toward neurobiological psychiatric ways of understanding and treating people diagnosed as having mental disorders. Foucault's writings on governmentality, discourse and human agency provide the theoretical basis in this research for understanding the operation of psychiatric power in British Columbia. These writings also inform the methodology for the analysis of institutional discourse, which I use in the empirical component of this research.

In order to conduct an empirical investigation of British Columbia's current mental health law regime, I gathered data from transcripts of three administrative tribunal hearings before the Mental Health Review Board of British Columbia and two other decisions from hearings before that board for which transcripts were not available. In these hearings, patients who had been subjected to involuntary psychiatric treatment orders under mental health legislation sought release from detention by challenging the psychiatrists who had issued the orders. The Review Board is legislatively empowered to affirm these orders or discharge the patients from involuntary psychiatric treatment. I use critical discourse analysis to analyze discursive exchanges between patients, psychiatrists and other participants at the hearings, exchanges that disclose power relations between the participants and have significant effects in shaping the outcomes for the patients.

My critical discourse analysis of the transcript data and Review Board decisions discloses discriminatory and prejudicial psychiatric practices shaped by British Columbia's mental health laws. This research lays the groundwork for a normative framework, based on Foucault's writings on ethics and relational agency, for understanding patients' rights to consensual medical treatment that overcomes problems associated with traditional liberal conceptions of individual rights and is a philosophically coherent basis for making recommendations to change British Columbia's mental health law regime.

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Acknowledgments

Many thanks to my committee members, Maneesha Deckha, Pamela Moss, and James Tully for their generosity, encouragement, guidance and especially their endless patience. Special thanks to Kwee Downie for her emotional support and the many hours she spent assisting me with word processing.

I am grateful to Allan Tuokko, the former Board Chair of the Mental Health Review Board of British Columbia, and Margaret Ostrowski QC, the current Board Chair, for their assistance with this project.

Chapter 1 Introduction

1.0 The Problem: Madness in British Columbia's Mental Health Law Regime

For decades the federal and provincial governments in Canada have commissioned numerous studies in apparent attempts to formulate mental health laws and policies that balance the rights of psychiatric patients with the power of the state to impose involuntary medical treatment on them.¹ Yet, the statements of the benevolent intent of these laws, as reflected in written texts, are often contradicted by the coercive means the state uses to enforce them and the harmful effects they have on the people they are supposed to assist.² Among provinces in Canada, this type of contradiction is seen most dramatically in British Columbia's mental health law regime, which, while being promoted as a benevolent system for the care of psychiatric patients,³ appears to have some of the most coercive laws in this country, and which many legal scholars believe violates fundamental human rights.⁴ Moreover, researchers have raised concerns about the harmful social effects of British

¹ See Archibald Kaiser "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health LJ 139 at 141.

² *Ibid* at 144.

³ See John Gray & Richard O'Reilly, "Clinically Significant Difference Among Canadian Mental Health Acts" (2001) 26:11 Canadian Journal of Psychiatry at 315.

⁴ A number of scholars across Canada have expressed concerns that provisions of British Columbia's *Mental Health Act* are contrary to the *Canadian Charter of Rights and Freedoms*. See especially Simon N. Verdun-Jones & Michelle S. Lawrence, "The Charter Right to Refuse Psychiatric Treatment: A Comparative Analysis of the Laws of Ontario and British Columbia Concerning the Right of Mental-Health Patients to Refuse Psychiatric Treatment" (2013) 46 U.B.C. LR 489. See also Peter J. Carver, "Mental Health Law in Canada" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 3d ed (Toronto: LexisNexis, 2007) 399 at 418; Sheila Wildeman, "Access to Treatment of Serious Mental Illness: Enabling Choice or Enabling Treatment?" in Colleen M. Flood, ed, *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) at 242; and Joaquin Zuckerberg, "Canadian Health Law and Its Discontents: A Reappraisal of the Canadian Experience" in Bernadette McSherry & Penelope Weller, eds, *Rethinking Rights-based Mental Health Laws* (Portland: Hart, 2010) at 307. See also Muriel Groves, *Suggested Changes to BC's Mental Health System Regarding Involuntary Admission and Treatment in Non-criminal Cases: BC Civil Liberties Association Position Paper* (Vancouver: BC Civil Liberties Association, February 2011). In this paper Groves argues that provisions of British Columbia's *Mental Health Act* related to non-consensual psychiatric treatment violate the *United Nations Convention of the Rights of Persons with Disabilities*.

Columbia's mental health law regime, as reflected, for instance, in significant increases in the past 15 years in the arrest and incarceration of persons thought to have mental disorders.⁵

What is the legal regime in British Columbia that permits such coercive treatment? How did it come into existence? And how does it work in lives of specific patients? My goal in this research project is to address these questions and offer a framework, supported by empirical research, for making recommendations for changing this system. The empirical investigation in this dissertation is on British Columbia's *Mental Health Act*⁶ and the data I use are from hearings before the Mental Health Review Board of British Columbia in which patients challenged psychiatrists' orders to impose involuntary medical treatment on them.⁷ The purpose of my dissertation is to explore some of the legal mechanisms through which psychiatric patients are constructed by 1) describing the medico-legal regime in British Columbia and 2) showing how these mechanisms operate in mental health review board hearings. My empirical research discloses discriminatory psychiatric practices related to the operation of British Columbia's mental health laws and this evidence supports scholars' argument that these mental health laws appear to be in contravention of the *Charter of Rights and Freedoms*⁸ (the "Charter") and the *United Nations Convention of*

⁵ Fiona Wilson-Bates, *Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources* (Vancouver: Vancouver Police Department, 2008). In this paper Wilson-Bates notes that police apprehensions of persons regarded as having mental disorders increased by 500% between 1999 and 2008 in Vancouver, BC (*Ibid* at 29). In a follow-up report, the unnamed authors note that between 2010 and 2012 these police apprehensions increased by 16%; and in 2013 there was a 23% increase over 2012. See *Vancouver's Mental Health Crisis: The Background, September 13, 2013* (Vancouver: Vancouver Police Department, 2013) at 1.

⁶ *Mental Health Act*, RSBC 1996, c 238.

⁷ For each hearing the Mental Health Review Board of British Columbia appoints three of its members to sit as an administrative tribunal called the "Review Panel".

⁸ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (UK)*, 1982, c 11 [*Charter*].

the Rights of Persons with Disabilities (the “UN Convention”).⁹ While I focus on the laws of British Columbia, my conclusions have relevance for jurisdictions across Canada because I use my findings to formulate ways of understanding human rights that have applicability to all mental health law systems in which the capacity of persons to consent to treatment decisions regarding their own mental health is an issue.

The view of human rights I advance in this dissertation is based on a relational conception of rights in which human agents are seen in terms of social relations rooted in cultural and historical contexts. I argue that this conception of relational rights overcomes the historical problems of “rights-based legalism” based on a traditional liberal conception of “negative rights”, found for example in civil libertarian mental health law advocacy, which places priority on an individual’s right to be free from state interference, and which does not accommodate conceptions of entitlements or “positive rights” to adequate social support or resources.¹⁰ The conception of relational rights in mental health law I offer in this dissertation is based on the philosophy of Michel Foucault who was one of the preeminent authorities on psychiatric medicine in the twentieth century.¹¹

The theoretical framework I use in this dissertation is interdisciplinary, drawing on qualitative empirical research methodologies, historical analysis and legal scholarship. In

⁹ *Supra* note 4; *Convention on the Rights of Persons with Disabilities*, 13 December 2006, GA Res 61/106, UN Doc A/Res/61/106 (entered into force 3 May 2008).

¹⁰ Bernadette McSherry & Penelope Weller, “Rethinking Rights-Based Mental Health Laws” in Bernadette McSherry & Penelope Weller, eds, *Rethinking Rights-based Mental Health Laws* (Portland: Hart, 2010) 1 at 6.

¹¹ Foucault’s status as an outstanding authority on psychiatry is described at length in Nancy Luxon, *Crisis of Authority: Politics, Trust, and Truth-telling in Freud and Foucault* (Cambridge: Cambridge University Press, 2013). It is also worth noting that Foucault’s first degree was in psychopathology, his practicum was in the leading psychiatric hospital in France, and he published several books over the course of his lifetime on the nature of psychiatric authority and power. See David Macy, *The Lives of Michel Foucault* (New York: Pantheon Books, 1993).

addition, Foucault's philosophy informs the conceptual basis for much of the framework I use to investigate and critique British Columbia's mental health law regime. The interdisciplinary focus of this dissertation provides a level of analysis of British Columbia's mental health law regime that is not available in the individual scholarly disciplines from which it draws. This framework has historical, theoretical, normative and empirical dimensions. In this chapter I describe each of these dimensions of my research and the chapters in which I explore them in turn.

1.1 Chapter Summaries

1.1(A) Historical Dimension

Chapter 2 is divided into two major sections. In the first section, I describe events since the mid-twentieth century that led to the emergence of a form of neurobiological psychiatry based on assumptions that mental disorders are manifestations of brain diseases, for which the primary treatment is psychiatric medication. I discuss how neurobiological psychiatry was reinforced by the widespread use of the third edition of the *Diagnostic and Statistical Manual of Mental Disorder (DSM-III)*, published in 1980. Together, the neurobiological model and the DSM-III (and later editions, most recently the DSM-5) have contributed to a medicalization of life, a proliferation of diagnostic categories of mental disorders, and a rampant use of psychiatric medications to treat these disorders. It is not my intention to impugn all forms of psychiatry and I acknowledge that some psychiatrists have made beneficial contributions in the lives of many people. Rather, the purpose of this dissertation is to disclose harms that result from certain forms of psychiatric thinking that are conjoined with coercive legal regimes.

In the second section of Chapter 2, I argue that psychiatric institutions and practices are inextricably linked with legal systems, creating forms of medico-legal discourses that shape individuals and the societies in which they live. I then provide a history of medico-legal discourses in British Columbia from the late nineteenth century to the present day related to laws and institutions for the civil commitment of persons thought to have mental disorders.¹² I demonstrate that the current mental health law regime in British Columbia is based on a particular amalgamation of neurobiological psychiatry and civil commitment criteria in the *Mental Health Act* that gives psychiatrists more discretion to impose involuntary treatment on patients than in any other province in Canada.¹³

Although the history in Chapter 2 is valuable for understanding the events that led to British Columbia's current mental health law system, it is important to provide a theoretical account of how power operates on and through human agents in this system. I set out this theoretical account in Chapter 3.

1.1(B) Theoretical Dimension

In Chapter 3, I explore Foucault's writings on governmentality and the relationship between power and knowledge in order to provide an account of *how* medico-legal

¹² The term "civil commitment" refers to the power of the state to detain and impose involuntary psychiatric treatment on people in non-criminal contexts. See Harvey Savage & Carla McKague, *Mental Health Law in Canada* (Toronto: Butterworths, 1987) at 74.

¹³ There were 8,000 civil commitment orders issued in British Columbia in 2003. Gerard Clements, *Guide to the Mental Health Act* (British Columbia: Ministry of Health, 2005) at 1. In British Columbia's mental health law regime, involuntary treatment is imposed on people when they are detained under civil commitment orders pursuant to the *Mental Health Act*. There is no detention without involuntary treatment. This differs from other mental health regimes, such as Ontario's, in which people can be detained without treatment if medical and legal authorities determine that they have the capacity to withhold consent to treatment. British Columbia's mental health legislation, whereby involuntary medical treatment is imposed on civilly committed patients who withhold capable consent to treatment, is unique in Canada. See Jocelyn Downie, Timothy Caulfield & Colleen Flood, *Canadian Health Law and Policy* 4th ed (Markham: LexisNexis, 2011) at 362.

discourses function in Western industrial societies and the way they shape human identity and social institutions. Foucault's concept of governmentality explains how governments function in neo-liberal societies through regulations, techniques, and professional codes that monitor and influence human conduct in dispersed networks of agencies in the community.¹⁴ Governmentality is particularly effective in explaining the influence of agencies, such as community psychiatric clinics, on patients who have lived in the community since large psychiatric institutions were closed in the late twentieth century in a process called "deinstitutionalization."¹⁵ While Foucault maintains that the power of discourses and social institutions shape human identity, people can resist these influences in ways that shape their own identities, thereby also changing social discourse.¹⁶ Thus, Foucault offers a vision of relational agency, in which people must always be understood in terms of the social, linguistic and cultural contexts with which they interact. I draw on this conception of relational agency as an essential feature of a normative critique of mental health laws and a theory of relational human rights.

1.1(C) Normative Dimension

In Chapter 4, I discuss Foucault's writings on genealogical critique, a practice whereby society's current ways of understanding itself are problematized by revealing how they are based on contingent historical and cultural processes.¹⁷ The normative element of

¹⁴ Michel Foucault, "Governmentality", translated by Rosi Braidotti. Reprinted in Graham Burchell, Colin Gordon & Peter Miller, eds, *The Foucault Effect* (Chicago: University of Chicago, 1991) at 88.

¹⁵ Nikolas Rose, "Psychiatry as a Political Science: Advanced Liberalism and the Administration of Risk" in *History of the Human Sciences, Vol 9(2)* (London: Sage, 1996) at 1.

¹⁶ Michel Foucault, *Politics, Philosophy, Culture: Interviews and Other Writings, 1977-84*, ed by Lorne Kritzman (New York: Routledge, 1989) at 332.

¹⁷ Michel Foucault, "What is Enlightenment?" translated by Robert Hurley and others in Paul Rabinow, ed, *Essential Works of Foucault 1954-1984, Vol. 1, Ethics* (New York: New York Press, 1997) 303 at 315.

Foucault's philosophy is based on a conception of freedom arising from human agents' capacity to engage in genealogical critique and, through this reflection, change social norms. This is not a notion of freedom as found in liberal political philosophy, related to a conception of the self as isolatable from social contexts and linguistic communities. Rather Foucault's vision of freedom is based on his conception of relational agency whereby humans are free insofar as they can reflect upon, resist and thereby transform the society in which they live. According to Foucault, the legitimacy of social authorities in facilitating this freedom arises from dialogic processes between institutions and human agents, exemplified in a type of risky, confrontational, truthful speech called *parrhesia*.¹⁸ Foucault offers a relational conception of human rights, which I use to understand the normative significance of *Charter* challenges to mental health laws in Canada.

In Chapter 5, I explore the discourse of human rights concerning psychiatric patients in court decisions involving the *Charter*. One of the features that distinguish British Columbia's *Mental Health Act* from other provincial mental health legislation in Canada is that it contains provisions that permit the involuntary imposition of psychiatric treatment on patients, even when they have the capacity to consent or withhold consent to treatment. I investigate whether these provisions violate the *Charter*. The only significant *Charter* challenge to these provisions in British Columbia's *Mental Health Act* is the 1992 case of *McCorkell v. Riverview Hospital*.¹⁹ Whereas the court in *McCorkell* decided that the *Mental Health Act* does not violate the *Charter*, I argue that recent developments in the

¹⁸ Michel Foucault, *Fearless Speech*, ed by Joseph Pearson (Los Angeles: MIT Press, 2001) at 11.

¹⁹ [1993] BCJ 1518, 81 BCLR (2d) 273.

case law, including the Supreme Court of Canada case of *Starson v. Swayze*,²⁰ indicate that these provisions would be less likely to survive a *Charter* challenge today on the grounds that they are discriminatory and violate patients' rights to security of the person under section 7 of the *Charter*. I also survey cases from the Supreme Court of Canada on section 15 equality rights under the *Charter*. I maintain that the joint operation of British Columbia's *Health Care (Consent) and Care Facility (Admission) Act*²¹ and the *Mental Health Act* creates discrimination against patients and is contrary to section 15 of the *Charter*.

I conclude that rights discourse generated by *Charter* litigation concerning patient rights can form part of the basis for effective discursive strategies to advance legal claims that have both legal and moral significance, provided they are based on a relational conception of human agency and rights as expressed in Foucault's philosophy. However, for these strategies to be effective there should be evidence to expose how mental health law operates and how it discursively shapes people's identities in the contexts of their lives. Empirical research can be a valuable source of this type of evidence.

1.1(D) Empirical Dimension

There are two chapters in my dissertation directly related to the empirical dimension of my research: the first sets out my research methodology; the second applies that methodology to data from Review Panel hearings. Before I summarize those two chapters, it is worth noting that there were four empirical research studies conducted in the 1980s and 1990s on decisions of Review Panels in British Columbia concerning patients who challenged

²⁰ [2003] SCJ No. 33, 2 SCR 357.

²¹ RSBC 1996, Ch. 181 [*HCCA*].

psychiatrists' orders that involuntary medical treatment be imposed on them. Three of those studies were done in the early 1980s²² and the other was done in the early 1990s.²³ These studies investigated, among other things, the characteristics of patients who apply for Review Panel hearings and their outcomes after being released. All of this research was quantitative and statistical, and concerned general characteristics of *populations* of patients.²⁴ It was not designed to explore *how* individual patients are treated by medico-legal institutions or to examine in detail the way psychiatrists and Review Panels apply the statutory provisions of the *Mental Health Act* in their decisions regarding these patients. In contrast, my research methodology was designed to investigate how British Columbia's mental health legislation operates, how persons and institutions use this legal discourse, how all this affects patients, and how patients themselves use discourse to resist these laws. The analysis of discourse is therefore at the centre of my methodology for doing research on British Columbia's mental health laws.

When describing my empirical research methodology in Chapter 6, I first examine Foucault's writings on the nature of discourse and the way it shapes human thought, identity and social institutions. Foucault's work has been an important influence on the

²² J. Gray et al, "Review Panels for Involuntary Patients: Which Patients Apply" (1985) 43 *Canadian Journal of Psychiatry* 573; J. Higenbottam et al, "Variables Affecting Decision Making of a Review Panel" (1985) 30 *Canadian Journal of Psychiatry* 577; R. Ledwidge et al, "Controlled Follow-up of Patients Released by a Review Panel at One and Two Years after Separation" (1987) 32 *Canadian Journal of Psychiatry* 448 at 448.

²³ Isabel Grant, James Ogloff & Kevin Douglas, "The British Columbia Review Panel: Factors Influencing Decision-Making" (2000) 23 *Int'l J L & Psychiatry* 191 at 191.

²⁴ In addition, the Review Panel hearings in the 1980s and 1990s occurred before deinstitutionalization had taken full effect in British Columbia and concerned patients who had spent long periods of time in large psychiatric hospitals. *Ibid* at 179. In contrast, the vast majority of patients who have these hearings today live in the community and have never been in hospital for more than a few months. Wilson-Bates, *supra* note 5 at 15. As I explain in Chapter 7, the fact that patients now spend much more time in the community or for short stays in psychiatric wards of general hospitals may be a relevant factor in explaining the nature of their complaints before Review Panels and may limit the relevancy of the earlier research cited above.

development of empirical research for the study of discourse. Although Foucault did not advance an empirical research agenda for the study of discourse, his thinking has been influential in the development of a methodology called “critical discourse analysis,” which I adopt a modified form of for my research. Researchers using this methodology draw from a variety of techniques for analyzing discourse. They share the view that discourse is a social practice and that:

discourse is socially constitutive as well as socially conditioned – it constitutes situations, objects of knowledge, and the social identities of and relationships between people and groups of people. It is constitutive both in the sense that it helps to sustain and reproduce the social status quo, and in the sense that it contributes to transforming it.²⁵

In addition, researchers using critical discourse analysis recognize that issues of power pervade discursive exchanges, sustaining or challenging status quos related to, for example, relations between men and women or the treatment of historically disadvantaged groups such as psychiatric patients. This notion of the nature and effects of power is one of the guiding assumptions in my empirical research methodology, especially as it has expressed in interdisciplinary research on health law and policy.

For my empirical research on the discourse in Review Panel hearings, I adopt Janet Thornborrow’s framework for critical discourse analysis, which is particularly effective for identifying the influences of institutional contexts, such as legal systems, but also incorporates elements from a methodology called “conversation analysis” for examining question and answer exchanges in conversations.²⁶ Thornborrow’s methodology is

²⁵ Norman Fairclough & Ruth Wodak, “Critical Discourse Analysis” in T.A. van Dijk, ed, *Discourse as Social Interaction* (London: Sage, 1997) 258 at 258.

²⁶ Janet Thornborrow, *Power Talk: Language and Interaction in Institutional Discourse* (London: Pearson Education, 2002).

especially suitable for my analysis of the transcripts of Review Panel hearings, in which there are multiple levels of institutional contexts, including hospitals and government agencies, as well as extensive question and answer exchanges between participants.

In Chapter 7, I apply the critical discourse analysis methodology I develop in Chapter 6 to transcripts of Review Panel hearings and the written decisions the panel renders at the end of the hearings. The data for this research was collected from my review of more than 2500 Review Panel decisions for the hearings that took place between 2008 and 2012 inclusive. I apply my critical discourse analysis methodology to three transcripts of Review Panel hearings concerning two patients, one of whom had two hearings, as well as two other panel decisions for which transcripts of the hearings were not available. My analysis of question and answer sequences, submissions of the parties, and Review Panel decisions at the end of the hearings disclose how the provisions of the *Mental Health Act* related to civil commitment operate and the effects they have on patients. I conclude that the data reveals that psychiatrists apply these provisions of the *Mental Health Act* in a discriminatory manner that has prejudicial and harmful impacts on the patients.

1.1(E) Concluding Chapter

In Chapter 8, I summarize my findings and restate my conclusion that British Columbia's *Mental Health Act* is not only discriminatory on its face, but also in the way psychiatrists use it and the effect it has on patients. I reflect on the implications of my research for advancing a vision of relational rights that supports changes to mental health laws based on the fundamental importance of patient consent in all health care decisions. Finally, I discuss some of the limitations in my research and offer suggestions for future research.

1.2 Conclusion

In this chapter I have provided summaries of the subsequent seven chapters of this dissertation related to the historical, theoretical, normative and empirical dimensions of this research project. My motivation for conducting this research is to expose the way mental health laws in British Columbia operate in order to clarify problems that must be addressed to create more responsible laws and policies. The laws our society uses to isolate, confine and impose invasive psychiatric treatment on some of its citizens reveal much about how we understand who our neighbours are and ultimately how we understand ourselves. I hope that the evidence I disclose in this research and the normative vision I offer can form the basis for a more open, inclusive, and compassionate society.

Chapter 2 History

2.0 Introduction

In the past fifty years psychiatric medicine has had a profound effect on Western industrial societies, shaping conceptions of normality and deviance, as well as influencing the laws that reinforce these norms. If some voices within the psychiatric community are to be believed, the growing influence of psychiatry has developed from a deepening understanding of the way that mental illnesses are caused by abnormal brain functioning, which has given rise to treatments that change the brain's chemistry.¹ Psychiatry's influence is seen in a number of startling statistics, reflecting a tendency to diagnose people as having serious mental disorders for which the primary treatment is the use of psychotropic medications. These statistics include a fifty-fold increase in the sale of antidepressant and antipsychotic medications for all age groups between 1985 and 2008² and a forty-fold increase in the diagnosis of bipolar disorder among children and adolescents in the United States between 1995 and 2003.³ Some legal scholars argue that laws, including the coercive laws of civil committal, must be fashioned to keep abreast of what they regard as indisputable advances in neurobiological psychiatry, which holds that social environments have no important role in the existence of serious mental illnesses.⁴ Other scholars, however, argue that psychiatry's growing dominance and the "epidemic of

¹ Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997) at 239; Torrey E. Fuller, *Surviving Schizophrenia: A Family Manual*, 6th ed (New York: Harper Collins, 2013) at 120.

² Robert Whitaker, *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* (New York: Crown, 2010) at 230.

³ *Ibid* at 233.

⁴ John Gray, Margaret Shone & Peter Liddle, *Canadian Mental Health Law and Policy* (Toronto: LexisNexis, 2008) at 66.

mental illness”⁵ seen in our society is not the result of the discovery of disease entities in the brain, but rather the product of a number of social factors.⁶ Some of these critics assert that psychiatry’s tendency to diagnose people as having serious mental illnesses and treat them with the long-term use of psychiatric medications is ill conceived and socially harmful.⁷ Moreover, some mental health advocates argue that laws that adopt neurobiological psychiatric assumptions are themselves reinforcing these social harms and at the same time creating forms of discrimination and human rights abuses, particularly when medical treatments are involuntarily imposed.⁸

This conflict between the proponents of neurobiological psychiatry and its opponents is a reflection of a few of many perspectives on contemporary psychiatry. There are a number of scholars who have themselves been diagnosed with schizophrenia or bi-polar disorder and who describe the benefits of psychiatric medication in their lives.⁹ Yet, some scholars who acknowledge the benefits of psychiatric medication are nevertheless critical of biomedical psychiatry’s misuse of these medications and the way that Western industrial countries have created disadvantageous social environments for people diagnosed as

⁵ Marcia Angell, “The Epidemic of Mental Illness: Why?” *The New York Review of Books* (23 June 2011) 1, online: nybooks.com <<http://www.nytimes.com>>.

⁶ Allan V. Horwitz, *Creating Mental Illness* (Chicago: University of Chicago Press, 2005); Liah Greenfeld, *Mind, Modernity, Madness: The Impact of Culture on Human Experience* (Cambridge: Harvard University Press, 2013).

⁷ Whitaker, *Anatomy of an Epidemic*, *supra* note 2 at 3.

⁸ See Carla McKague & Harvey Savage, *Mental Health Law in Canada* (Toronto: Butterworths, 1987) at ix; See also James Gottstein, *The Law Project for Psychiatric Rights*, online: Psychrights <<http://www.psychrights.org>>.

⁹ For example, in her book *The Center Cannot Hold* (New York: Hyperion Books, 2007), American law professor Elyn Saks gives an account of the years she spent struggling with what she describes as schizophrenia and the benefits she experienced from anti-psychotic medications and talk therapy. Also see Kay Redfield Jamieson’s description of her struggles with what she describes as bio-polar disorder and the benefits she received from psychiatric medication such as lithium in her memoir *An Unquiet Mind: A Memoir of Moods and Madness* (New York: Vintage Books, 1997).

having mental illnesses.¹⁰ Indeed within areas of the psychiatric community itself there is ongoing critique of the narrowness of understanding and treating acute psychological distress biomedically and pharmacologically.¹¹

These controversies concerning contemporary psychiatry have implications and importance far beyond academic arenas; for the assumptions we make about persons thought to be mentally ill and the treatment given to them shape how we understand human existence and the nature of our moral and legal communities. And the laws that both express and reinforce these assumptions have far-reaching consequences for many aspects of our lives, including our health care systems, prison policies, police conduct, and educational systems. For example, society must now deal with children who are growing up under the broadening reach of psychiatric diagnostic categorization and the use of medications with serious side effects that may shape their bodies and minds from very young ages.

To what extent is the law implicated in these changes and how can it be designed to meet these challenges in a responsible and compassionate manner? This dissertation is an attempt to address these questions. This chapter establishes a framework for understanding

¹⁰ See, for example, Emily Martin, *Bipolar Expeditions: Mania and Depression in American Culture* (Princeton: Princeton University Press, 2007). In this book, Martin describes the benefits she has experienced from the use of psychiatric medication to control what she describes as bi-polar disorder while at the same time exploring the misuses of this medication within the psychiatric community and the way that “bi-polar personality” is constructed in American society.

¹¹ See, for example, Duncan Double, ed, *Critical Psychiatry* (London: Palgrave MacMillan, 2006). In this collection of essays, a number of psychiatrists argue that psychiatry can be practised without assuming that mental illness is only a manifestation of brain pathology. Proponents of critical psychiatry encourage the limited and cautious use of psychiatric medication and argue for, among other things, an increased use of non-medical treatment, such as psychodynamic therapy. The work of Stanford anthropologist Tanya Luhrman also acknowledges the benefits of advances in psychiatric medications while at the same time raising concerns about the overreliance on pharmaceutical interventions to the exclusion of other forms of social support. See Tanya Luhrman, *Of Two Minds: An Anthropologist Looks at American Psychiatry* (New York: Vintage Book, 2000).

the problems created by the confluence of psychiatric medicine and law in the past fifty years. The chapter is divided into two main sections. Section 1 focuses on developments in psychiatry since the 1950s; Section 2 is an investigation of the way that mental health law has developed since the mid-nineteenth century, focusing particularly on the laws of British Columbia. Section 1 of this chapter begins by describing the emergence of neurobiological psychiatry, which is rooted in a reductionist view of human behaviour organized around diagnostic categories based on the assumption that mental disorders are discrete disease entities in the brain. The development of medications for the treatment of bipolar disorder, depression and schizophrenia, and the creation of the *Diagnostic and Statistical Manual* (DSM) are discussed. The epidemic of mental illness in contemporary Western industrial society is examined in detail, including an exploration of the alarming increase in the diagnosis of many different forms of mental illnesses in the past fifty years, the pervasive way that they are being treated with medications, and the social consequence of these developments. Section 1 concludes by describing the debate between those who regard mental illness as a purely biological brain disease and those who argue that the ascription of mental illness is, at least in part, created by a complex combination of social forces that requires a cautious approach for the use of psychiatric medications.

Section 2 of this chapter begins by providing a history of mental health law in British Columbia. Emphasis is placed on how mental health statutes and regulations in this province have incorporated assumptions from neurobiological psychiatry and have influenced social practices related to police activity, the functioning of administrative tribunals, and even the practice of psychiatry itself. The laws of civil commitment, which permit involuntary psychiatric treatment for people thought to be unable to make treatment

decisions for themselves, highlight this issue most dramatically. It is for this reason that the nature and effect of these laws are among the core issues in this dissertation. This chapter concludes by arguing that the particular combination of the discourses of law and psychiatry into a medico-legal discourse of mental disorder may create and perpetuate forms of discrimination and other human rights violations, which are seen on the face of the laws and, more importantly, in their pervasive social effects.

2.1 The Medicalization of Life and the Growth of Neurobiological Psychiatry

2.1(A) The Modern Epidemic of Mental Illness

It seems that we live in a society in which it is almost unquestionably assumed that refinements in diagnostic psychiatry and developments in psychopharmacology have permitted significant strides in both the identification and treatment of mental illnesses. These types of assumptions are set out in Edward Shorter's 1997 book *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* in which he proclaimed that: "If there is one central intellectual reality at the end of the twentieth century, it is that the biological approach to psychiatry – treating mental illness as a genetically influenced disorder of brain chemistry – has been a smashing success."¹² Yet, as some critics have recently noted, these developments have not been associated with a reduction in the incidence of serious mental illnesses, but rather an explosion of the number of people diagnosed with them, as well as a rapid proliferation of the number of diagnostic categories.¹³ These alarming trends have been scrutinized in a number of books and journal articles in the past ten years, published by scholars working in fields such as

¹² Shorter, *A History of Psychiatry*, *supra* note 1 at vii.

¹³ Whitaker, *Anatomy of an Epidemic*, *supra* note 2 at 205.

sociology¹⁴, psychology¹⁵ and even within academic psychiatry itself.¹⁶ There has been increasing concern that the alignment of technology with the imperatives of multinational pharmaceutical corporations has contributed to the “medicalization” of behaviours that were hitherto considered non-medical social behaviours.

Ivan Illich was one of the first thinkers to suggest that the medical establishment was turning too many people into medical subjects and thereby medicalizing life itself.¹⁷ While Illich is a scholar frequently associated with this “medicalization thesis,” some of the most comprehensive and penetrating writings on this subject are found throughout the work of Michel Foucault, particularly in his book *The Birth of the Clinic*.¹⁸ In this book Foucault maintains that professional disciplines and historical and institutional forces, exemplified in medical institutions and practices that emerged in the 18th and 19th centuries, have created apparatuses and discourses concerning health that are focused on the normalization of the human body. The networks of power related to this medical normalization, described as “biopower,” are reinforced in law, educational systems, welfare policy and psychiatry, and then shape pervasive and dominant ways of understanding and speaking about individuals as well as populations of human beings.¹⁹

¹⁴ Horwitz, *Creating Mental Illness*, *supra* note 5.

¹⁵ Richard Bentall, *Doctoring the Mind: Why Psychiatric Treatments Fail* (London: Penguin Books, 2009).

¹⁶ David Healy, *Pharmageddon* (Berkeley: University of California Press, 2012).

¹⁷ Ivan Illich, *Limits to Medicine* (London: Penguin, 1976).

¹⁸ Michel Foucault, *The Birth of the Clinic*, translated by A.M. Sheridan Smith (New York: Vintage Books, 1994).

¹⁹ Deborah Lupton, “Foucault and the medicalization critique” in Alan Petersen and Robin Bunton, eds, *Foucault, Health and Medicine* (New York: Routledge, 1997) 94–110.

As I demonstrate in the next chapter on Foucault's conception of power and human agency, the way that biopower is expressed and the effects it has on persons and populations depends on many factors that intersect in unique ways in different local communities depending on discursive and institutional forces and on the activities of human agents who embody them and resist them.²⁰ In addition to these local factors there are nevertheless a number of overarching forces in Western industrial societies that contributed to the hegemony of a neurobiological way of understanding of human beings, as well as a proliferation of pharmaceutical interventions in the population. As Ray Moynihan and Alan Cassels argue, "the ups and downs of daily life have become mental disorders, common complaints are transformed into frightening conditions, and more and more ordinary people are turned into patients. With promotional campaigns that exploit our deepest fears of death, decay and disease, the \$500 billion dollar pharmaceutical industry is literally changing what it means to be human."²¹ This is most apparent in the United States where the largest pharmaceutical companies are located and where their products are aggressively marketed.²²

Some of the most comprehensive investigations of the reasons for increases in the diagnosis and treatment of mental illness in American society are seen in the writing of

²⁰ For an examination of the multiple intersecting forces that create understandings and practices related to the present medical treatment of human beings see Nicolas Rose, "Medicine, History and the Present," in Colin Jones & Roy Porter, eds, *Reassessing Foucault: Power, Medicine and the Body* (London: Routledge, 1994) 48-72.

²¹ Ray Moynihan & Alan Cassels, *Selling Sickness: How the World's Biggest Pharmaceutical Companies are Turning Us All into Patients* (Vancouver: Graystone Books, 2005) at xii. See also Shirley Lee & Avis Mysyk, "The Medicalization of Compulsive Buying" (2004) 58 *Sciences and Medicine* 1709. In this study, the authors focus on the way compulsive buying is now regarded as a medical disorder for which pharmaceutical intervention is prescribed, rather than an expression of social behaviour that must be understood in the context of a society driven by voracious consumerism.

²² In 2009, seven of the twelve largest pharmaceutical companies were American. See "Fortune Global 500 2009 Pharmaceutical Industry" (2009) *Fortune* 160:2 12.

medical journalist Robert Whitaker.²³ One of Whitaker's central contentions is that psychiatric medications have not had the effect of reducing the incidence of mental illness and that they are not an effective long-term treatment. Whitaker bases his conclusions on his review of a number of historical records in the twentieth century and observes that whereas in 1955 "one in every 586 Americans were hospitalized due to mental illness",²⁴ by 1987 one in 184 American were thought to be disabled due to mental illness to the extent that they received government benefits for this disability.²⁵ He also notes that between 1987 and 2007 the number of American citizens receiving long-term disability benefits rose from one in 184 to one in every 76, an increase of more than 100%.²⁶

The increase in the diagnosis of bipolar disorder is particularly significant. As Whitaker notes, "a rare disorder in 1955 has become common-place today. SSRIs²⁷ took the country by storm in the 1990s and from 1996 to 2004 the number of adults diagnosed with bipolar illness rose 56 percent."²⁸ One of the most notable trends is the number of children thought disabled by mental illness in the United States. This is reflected in children's receipt of disability benefits for mental illness, which increased thirty-five fold between 1996 and 2004 while all other forms of disability, such as cancer, decreased.²⁹

²³ Whitaker, *Anatomy of an Epidemic*, *supra* note 2.

²⁴ *Ibid* at 6.

²⁵ *Ibid*.

²⁶ *Ibid* at 7.

²⁷ SSRI is an abbreviation for "selective serotonin reuptake inhibitor", a type of antidepressant medication, of which the best known example is Prozac.

²⁸ Whitaker, *Anatomy of an Epidemic*, *supra* note 2 at 172.

²⁹ *Ibid* at 8.

As noted above, one of the most alarming trends is the forty-fold increase in the diagnosis of bipolar disorder in children and adolescents from 1995 to 2003. It should not be surprising that some of the most pernicious effects of the medicalization of society and, in particular, the increasing use of psychiatric medication, are visited upon the most vulnerable members of society. This is supported by research consistently showing that people with lower socioeconomic status are disproportionately diagnosed as having serious mental illnesses, such as schizophrenia.³⁰ Moreover, research confirms that both the medical and the legal profession are more likely to label women as mentally incompetent and to impose involuntary medical treatment on them.³¹ The implications of these findings are explored at greater length in the concluding chapter of this dissertation.

Whitaker is a journalist and one might wonder whether academic researchers agree with his description of the dramatic increases in the incidence of mental illness in terms of an “epidemic”. In fact some researchers at prominent universities have begun to describe the increase in mental illness in similar terms. Consider, for example, the following comments by Richard McNally, professor of psychology at Harvard University:

Only about 2-3 percent of people born before 1915 developed the disorder [of clinical depression], despite having lived through WW II and the Great Depression. In contrast, about 20 percent of those born between the late 1950s and the early 1970s have had depression. During the past century, depression has been striking people at increasingly younger ages.³²...

³⁰ John Fox, “Social Class, Mental Illness, and Social Mobility: The Social Selection-drift Hypothesis for Serious Mental Illness” (1990) 31 *Journal of Health and Social Behaviour* at 344; Carl Cohen, “Poverty and the Course of Schizophrenia: Implications for Research and Policy” (1993) 44:10 *Hospital and Community Psychiatry* 951 at 951.

³¹ Barbara Secker, “Labeling Patient (In)Competence: A Feminist Analysis of Medico-Legal Discourse” (1999) 30:2 *Journal of Social Philosophy* 295 at 302.

³² Richard J. McNally, *What is Mental Illness?* (Cambridge: Harvard University Press, 2011) at 5.

Nearly 50 percent of Americans have been mentally ill at some point in their lives, and more than a quarter have suffered from mental illness in the past twelve months. *Madness, it seems, is rampant in America.*³³

Other scholars have also voiced concerns about the rampant increases in the diagnosis of mental illness. Some of the strongest critiques are advanced by David Healy, who is particularly critical of the dramatic increase in the diagnosis of bipolar disorder. As he put it: “When it comes to bipolar disorder, American medicine is in the grip of an enthusiasm reminiscent of the seventeenth century Dutch Tulip mania. Children as young as one year of age are being put on anti-psychotics, and some clinicians even contemplate the possibility of making in-utero diagnoses.”³⁴

The increase in the number of people diagnosed as having serious mental illness is seen not only in the United States, but in many other Western industrial communities as well. In Australia, for example, the use of antidepressant medications tripled between 1990 and 2000 and during the same period there was a ten-fold increase in the use of these medications for persons under the age of twenty-four.³⁵ Similar trends have been found across Canada, such as the dramatic increase in prescriptions of anti-psychotic medication for children in Manitoba³⁶ as well as for the prescription of all psychiatric medication to the general population in Saskatchewan.³⁷ In British Columbia there was an eighteen-fold increase between 1996 and 2011 in the use of new forms of anti-psychotic medications for children age eighteen and under for a wide range of problems not approved by Health

³³ *Ibid* at 1 [emphasis added].

³⁴ Healy, *supra* note 13 at 152.

³⁵ Ray Moynihan & Alan Cassels, *supra* note 15 at 32.

³⁶ Silvia Alessi-Severini et al, “Ten Years of Antipsychotic Prescribing to Children: A Canadian-Based Study” (2013) 57:1 Canadian Journal of Psychiatry 52.

³⁷ Xiangfei Meng et al, “Trends in Psychotropic Use in Saskatchewan from 1983 to 2007 (2013) 58:7 Canadian Journal of Psychiatry 426.

Canada, including anxiety, depression and hyperactivity.³⁸ These medications are increasingly prescribed by family doctors and pediatricians.³⁹ Family doctors and pediatricians do not have the authority that psychiatrists have to certify patients for civil commitment, and their observations concerning a patient's alleged mental illness do not have the same impact on the patient's identity as a psychiatrist's diagnostic label. Nevertheless, the practices of family doctors and non-psychiatric medical specialists demonstrate the wide-ranging effects of certain forms of psychiatric thinking that lead to a heavy reliance on pharmaceutical interventions and may lead to referrals to psychiatrists.

Just as significant is the evidence that importing neurobiological psychiatry into non-Western societies results in the sudden and rapid increase in the appearance of western-style mental disorders.⁴⁰ In his 2010 book *Crazy Like Us: The Globalization of the American Psyche*, Ethan Watters demonstrates how American culture and psychiatric thinking are supplanting local beliefs about the nature of mental disorder and are shaping both the nature and incidence of psychiatric illnesses in those countries, seen, for example, the rapid increase in post-traumatic stress disorder in nations in the global South.⁴¹ In addition, changes in the description, experience and incidence of depression in Japan have added to the "mega-marketing" of psychiatric medications in that country since 2000.⁴²

³⁸ Rebecca Ronsley et al, "A Population-Based Study of Antipsychotic Prescription Trends in Children and Adolescents in British Columbia from 1996 to 2011" (2013) 56:6 Canadian Journal of Psychiatry 361.

³⁹ *Ibid* at 361.

⁴⁰ M.J. Miller & A.J. Pumariega, "Culture and Eating Disorders: A Historical and Cross-Cultural Review" (2001) 64:2 Psychiatry: Interpersonal and Biological Processes 93.

⁴¹ Ethan Watters, *Crazy Like Us: The Globalization of the American Psyche* (New York: Free Press, 2010) at 65.

⁴² *Ibid* at 187; Laurence Kirmayer, "Psychopharmacology in the Globalizing World: The Use of Antidepressants in Japan" (2006) 39(3) Transcultural Psychiatry at 295.

Medical sociologist Allan Horwitz has described all of these recent changes as follows:

A huge cultural transformation in the construction of mental illness has occurred in a relatively short time. The broad array of mental illness at the beginning of the twenty-first century has little resemblance to older stereotypes of madness that persisted throughout human history. Categorical classifications of distinct mental illnesses are far more extensive and more diverse than those found in asylum psychiatry. Neither do the discrete categorical diseases that are firmly embedded in discourse about mental illness share many similarities with the broad neurotic conditions based on unconscious mechanisms that dynamic psychiatry emphasized for most of the twentieth century. The extensive use of disease categories for a wide variety of human behaviors is unique in human history; most of the many mental illnesses that are now taken for granted as objective natural entities are recent creations.⁴³

Although Horwitz's comments were intended to apply to Western industrial societies, they have become relevant for other nations affected by the global marketing of biomedical psychiatry. This suggests that cultural forces, such as the international reach of industrialization, may play a significant role in the labelling and alleged identification of "mental illnesses" that are increasingly described in terms of discrete biological disease entities.

2.1(B) The Reasons for the Epidemic

2.1(B)(i) The Neurobiological Model of Psychiatry

The reasons for this significant increase in the diagnosis of mental illness since the middle of the last century are many and complex.⁴⁴ Those who support the neurobiological model of psychiatry argue that this increase is due to advances in the scientific understanding of the brain, made possible by the same types of technologies that have given rise to beneficial developments in other areas of medicine, such as the treatment of cancers and heart

⁴³ Horwitz, *supra* note 5 at 4.

⁴⁴ See Rose, *supra* note 21, 48-72.

disease.⁴⁵ They refer to studies that appear to indicate that serious mental illnesses, such as schizophrenia and bipolar disorder, have strong hereditary components⁴⁶ and that CAT scans of persons with these disorders show that they tend to have structural abnormalities in their brains.⁴⁷ In addition, these researchers draw inferences from the observation that psychiatric medication alters the balance of neurochemicals in the brain, such as dopamine and serotonin, with the result that many people who are thought to suffer from delusions, hallucinations or extreme moods can have their symptoms alleviated after taking the medication. These researchers argue that observations about the *consequences* of patients taking this medication in changing their behaviours justifies the researchers' inference that the original *cause* of the disorder is neurobiological and not the result of social factors, such as poverty or traumatic childhood.⁴⁸

2.1(B)(ii) The Influence of the DSM

In response to these various assertions concerning the biological basis of mental illness, some scholars have questioned the validity of the studies allegedly showing a strong hereditary component underlying severe mental illness.⁴⁹ They have also argued that some of the unusual structural features of the brains of some people who are diagnosed as having schizophrenia or bipolar are the *consequence* of prolonged use of anti-psychotic medication, and not the cause of the disorders themselves.⁵⁰ The argument that the effects of anti-psychotic medication proves that the underlying disorder is purely physiological is

⁴⁵ Shorter, *supra* note 1 at 239; Gray et al, *supra* note 4 at 11.

⁴⁶ Shorter, *supra* note 1 at 240; Fuller, *supra* note 1 at 118.

⁴⁷ Shorter, *supra* note 1 at 269; Fuller, *supra* note 1 at 122.

⁴⁸ Gray et al, *supra* note 4 at 66.

⁴⁹ Bentall, *supra* note 11 at 113.

⁵⁰ *Ibid* at 153.

based on a fallacy concerning the nature of causation. To use an analogy, certain powerful medications that change neurochemistry might seriously affect a musician's ability to perform or compose music, but this is not proof that musical talent is only the result of brain physiology. Rather, training, education, social environment and culture all play a role in determining whether musical talent is ever developed.

Others argue that, even if there are genetic and physiological factors related to bipolar disorder and schizophrenia, social environments play an important role in determining whether, and to what extent, the genetic tendencies are ever manifested in a particular individual. As Allan Horwitz explains in his book *Creating Mental Illness*:

Genes have attained cultural status as icons....Both scientific and popular reports associate the presumed demonstration of a genetic influence with the primary causes of human behavior. They fail to note the nonspecific, limited, and contextual effects of genes...the explanation for why a given individual develops a mental disorder is distinct from why the rate of a disorder in one population is different from the rate of that disorder in another population. Genetic factors can only explain the variation that arises within a given population, while environmental factors are largely responsible for variation that occurs between groups over historical time and across social space...The social context can have a profound influence not only on the form that expresses a possible genetic tendency to disorder, but also on whether a disorder arises at all.⁵¹

The question that must be addressed, therefore, is: what is it about contemporary society that has caused the dizzying increase in the tendency to diagnose people as having mental illnesses and to use pharmaceutical treatments for these alleged disorders? Horwitz contends that this is the result of a number of historical and cultural forces starting in the mid-twentieth century, one of the most important of which was a transformation in the nature of psychiatric thinking when diagnostic psychiatry gained ascendancy over

⁵¹ Horwitz, *Creating Mental Illness*, *supra* note 5 at 149.

psychoanalytic psychiatry. In the psychoanalytic theory that Sigmund Freud introduced in works such as *The Psychopathology of Everyday Life*,⁵² mental pathologies such as neuroses and compulsive disorders were seen as existing along a spectrum and exhibited in varying degrees in many, if not most, people in society. The psychodynamic view of the mind involved the notion that ways of understanding the mind were necessarily broad and vague; disorders, including depression and mania, were thought to exist along a continuum and therefore psychoanalytic treatment required sensitive awareness of an individual's personal history and social milieu. According to Horwitz, a revolution in psychiatry occurred with the publication of the *Diagnostic and Statistical Manual (DSM-III)* in 1980, which provided checklist criteria for classifying mental disorders into diagnostic categories associated with constellations of observed behaviours. Despite the DSM-III's avowed commitment to neutrality about the causes of these disorders, North American psychiatry's adoption of a medical model of human behaviour led to the view that these diagnostic categories are associated with neurochemical pathologies.⁵³ The standardization of psychiatric categories and diagnostic criteria in the DSM-III and later in the DSM-IV has resulted in the creation of a canonical discourse that is "transferable between the domains of industry, government and biomedicine."⁵⁴ Hence the use of psychopharmacological medications for changing the neurochemistry of the brain soon became the dominant and widely used way of understanding and treating mental disorders.

⁵² Sigmund Freud, *Psychopathology of Everyday Life* (London: Penguin Books, 1941).

⁵³ See Horwitz, *Creating Mental Illness*, *supra* note 5 at 4. See also Rachel Cooper, *Classifying Madness: A Philosophical Examination of the Diagnostic and Statistical Manual of Mental Disorders* (New York, Springer Dordrecht, 2005) at 125.

⁵⁴ Andrew Lakoff, *Pharmaceutical Reason: Knowledge and Value in Global Psychiatry* (Cambridge: Cambridge University Press, 2005) at 35.

Psychiatrist Allen Frances has described the trend to increase the number of diagnostic categories by describing social behaviours as pathologies as “diagnostic inflation.”⁵⁵ He contends that the newest version of the DSM, the DSM-5, published in 2013, has resulted in diagnostic hyperinflation, in which, for example, gluttony is described as “binge eating disorder”, the forgetfulness experienced by some older adults as “mild neurocognitive disorder”, and temper tantrums as “disruptive mood dysregulation disorder.”⁵⁶ As he says, the DSM-5 adds new diagnoses “that turn everyday anxiety, eccentricity, forgetting and bad eating habits into mental disorders” that are treated with psychiatric medication.⁵⁷ Joel Paris expresses similar reservations about the DSM-5, particularly because it is more deliberately and closely aligned with a neuroscientific and pharmaceutical ideology than earlier versions of the DSM.⁵⁸ He is concerned about the way that it broadens the definition of bipolar disorders to include “bipolar spectrum disorder” which refers to wide range of mood instabilities in the general population, and how a liberal interpretation of the new category of “autism spectrum disorder” might include “all eccentrics on the planet.”⁵⁹

2.1(B)(iii) The Influence of Pharmaceutical Companies

The influence of pharmaceutical companies in the way that mental disorders are described and treated cannot be overemphasized.⁶⁰ Some scholars contend that multinational

⁵⁵ Allen Frances, *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (New York: Harper Collins, 2013) at xiv.

⁵⁶ *Ibid* at xvii.

⁵⁷ *Ibid* at xv.

⁵⁸ Joel Paris, “The Ideology Behind DSM-5” in Joel Paris & James Philips, eds, *Making the DSM-5: Concepts and Controversies* (New York: Springer Business; Science Media, 2013) at 39.

⁵⁹ *Ibid* at 42.

⁶⁰ As Whitaker notes, in 1985 the combined sale of anti-psychotic medication and antidepressants in the United States was \$503 million, but this number had grown to \$24.2 billion by 2008. The sale of anti-psychotic medication now exceeds the sale of all other forms of medication, including statins for high blood pressure. *Supra* note 2 at 320.

pharmaceutical companies have played a major role in the creation and perpetuation of this epidemic. For instance, in his book *Pharmageddon*, David Healy provides a compelling account of the alarming frequency with which large pharmaceutical companies aggressively market new medications through questionable research, which has been funded by the companies and ghost-written by their employees.⁶¹ They then pay academic researchers to have their names put on the research papers to give the misleading impression that they have the imprimatur of an objective expert.⁶² The research is then published in journals and professional medical publications that are disseminated to physicians and psychiatrists who prescribe the medications, all the while assuming that their views are supported by sound scientific evidence. Similar arguments are advanced by Ray Moynihan and Alan Cassels in their 2006 book *Selling Sickness: How the World's Largest Pharmaceutical Companies are Turning Us All into Patients*, in which they claim that these companies create medical problems out of behaviours, such as shyness, which are re-described as pathologies, such as “social anxiety disorder,” for which psychiatric medication is prescribed.⁶³ The publication of the DSM-5 will only increase the power and influence of pharmaceutical companies. As Joel Paris states, “In the DSM-5 the overall definition of mental disorder in the manual is weak, failing to distinguish psychopathology

⁶¹ Healy, *Pharmageddon*, *supra* note 12 at 96.

⁶² See especially Margaret Angell, “Is academic medicine for sale?” (2000) 342 *New England Journal of Medicine* at 2. In this paper, the former editor-in-chief of the *New England Journal of Medicine* describes the difficulties in finding independent reviewers for papers on anti-depressant medication because so many academic psychiatrists have financial ties to pharmaceutical companies.

⁶³ Moynihan & Cassels, *supra* note 24 at 119.

from normality. Moreover, there are powerful interests, both corporate and public, that could profit from a highly inclusive diagnostic system.”⁶⁴

2.1(B)(iv) The Importance of Cultural Factors

In response to these assertions concerning the important role that social and cultural factors play in the description and understanding of mental disorders, some scholars have argued that while there may be transient trends in the historical appearance of certain mental disorders, such as anorexia among women in North American society oppressively obsessed with female appearance, other disorders are more clearly caused by physiological disorders. Such scholars often use the example of schizophrenia, which they claim “probably has neurochemical causes”⁶⁵ and which cannot be explained away as the by-product of pharmaceutical companies’ overzealous marketing or any other social factor. Nevertheless, there are compelling reasons to conclude that our society’s understanding of the nature of schizophrenia is also strongly influenced by social factors. Even in our current cultural environment, using one category to label patients as “schizophrenic” tends to mask very important differences between people. In a study entitled *Empirical Correction of Seven Myths about Schizophrenia with Implications for Treatment* the authors maintain that one of the myths about schizophrenia is that it is a single disorder, whereas in fact there is wide heterogeneity even within this diagnostic category.⁶⁶ As such,

⁶⁴ Joel Paris, “Preface” in Joel Paris and James Philips, eds, *Making the DSM-5: Concepts and Controversies* (New York: Springer Business; Science Media, 2013) at vi. See also Lisa Cosgrove & Sheldon Krimsky, “A Comparison of DSM-IV and DSM-5 Panel Members’ Financial Association with Industry: A Pernicious Problem Persists” (2012) 9:3 PLOS Medicine 1. In this paper the authors note that whereas 57% of the task force members for the DSM-IV had financial ties to the pharmaceutical industry, 69% of the task force members of the DSM-5 have such ties.

⁶⁵ Ian Hacking, *Mad Travelers: Reflections on the Reality of Transient Mental Illness* (Cambridge: Harvard University Press, 1998) at 101.

⁶⁶ Harding Courteney & James Zahniser, “Empirical Corrections of Seven Myths About Schizophrenia with Implications for Treatment” (1994) 90 Acta Psychiatrica Scandinavica 140.

treatment strategies must take account of differences arising from many individual factors, including gender, age, cultural background, and level of education.⁶⁷

Some of the most convincing evidence of cultural variability in understanding and treating people labelled as having schizophrenia is from World Health Organization (WHO) studies on the differences in outcome for people with this diagnosis in Western industrial countries as compared to countries in the global South.⁶⁸ This research indicates that persons diagnosed with schizophrenia in these latter countries, such as India, Nigeria and Colombia, tend to have better long-term outcome than those in countries such as the United States. In these countries, 64% of the patients were asymptomatic after five years, whereas in Western industrial countries only 18% were doing this well. One of the most important differences between the nations was that in the global South only 16% of patients were kept on anti-psychotic medication for prolonged periods of time, whereas in Western industrial countries 61% were maintained on these drugs. Very similar observations were made in a five-year follow-up study sponsored by the WHO, which used standardized criteria for diagnosis and assessment of outcome based on levels of remission in observable symptoms, as well as “occupational adjustment, relationships with friends and degree of social interaction.”⁶⁹ Although the authors of this study did not identify precisely the reasons for the differences in outcome, they strongly suggest that social and cultural factors were responsible for better outcomes in developing countries, not only for schizophrenia,

⁶⁷ *Ibid* at 141.

⁶⁸ A. Jablensky et al, “Schizophrenia: Manifestations, Incidence and Course in Different Cultures, A World Health Organization Ten-Country Study” (1992) 20 *Psychological Medicine* 1.

⁶⁹ J. Leff et al, “The International Pilot Study of Schizophrenia: Five-Year Follow-Up Findings” (1992) 22 *Psychological Medicine* at 137.

but also for other forms of mental illness.⁷⁰ Medical anthropologist Kim Hopper confirms in her research on schizophrenia that the beneficial outcomes found in WHO short-term studies spanning five years persisted beyond fifteen years.⁷¹ Hopper suggests that stronger social support and less critical attitudes toward unusual psychological problems in the cultures of countries in the global South may account for better outcomes in those societies.⁷²

In their book *Schizophrenia, Culture, and Subjectivity: The Edge of Experience*, cultural anthropologists Janis Jenkins and Robert Barrett review the WHO studies and other academic literature on the social and cultural variables related to the presence and treatment of schizophrenia in numerous societies around the globe. Although they themselves assume that there is some genetic contribution to schizophrenia they conclude that:

What we know about culture and schizophrenia at the outset of the twenty-first century is the following: culture is critical in nearly *every* aspect of schizophrenic illness experience: the identification, definition and meaning of the illness during the prodromal, acute, and residual phases; the timing and type of onset; symptom formation in terms of content, form, and constellation; clinical diagnosis; gender and ethnic difference; the personal experience of schizophrenic illness; social response, support and stigma; and, perhaps most important, the course and outcome of the disorders with respect to symptomatology, work, and social functioning.⁷³

Their conclusion, supported by the WHO research, is that one of the best predictors of a poor outcome for a person diagnosed as having schizophrenia is to reside in a Western

⁷⁰ *Ibid* at 145.

⁷¹ Kim Hopper, "Interrogating the Meaning of "Culture" in the WHO International Studies of Schizophrenia" in Janis Jenkins and Robert Barrett, eds, *Schizophrenia, Culture, and Subjectivity: The Edge of Experience* (Cambridge: Cambridge University Press, 2004) at 72.

⁷² *Ibid* at 76.

⁷³ Janis Jenkins & Robert Barrett, "Introduction" in Janis Jenkins & Robert Barrett, eds, *Schizophrenia, Culture, and Subjectivity: The Edge of Experience* (Cambridge: Cambridge University Press, 2004) at 62.

industrial nation.⁷⁴ Ironically, this occurs despite the fact that we live in a society obsessed with the identification and medical treatment of mental disorders by legions of mental health professionals, whose ranks have grown rapidly in the late twentieth and early twenty-first centuries.⁷⁵

2.1(C) Psychiatric Treatment Programs

2.1(C)(i) Misconceptions about the Efficacy of Neuroleptic Medications

The reasons why treatment outcomes for people diagnosed as having mental illnesses in Western industrial countries are so poor are as complex as the reasons for the epidemic of mental illness itself. Some of the most troubling research indicates that the overuse of psychopharmacological medication may be contributing to illness and creating or prolonging disability. In his essay “The Case Against Anti-psychotic Drugs: A 50-year Record of Doing More Harm than Good”, Robert Whitaker reviewed the medical literature concerning the treatment of schizophrenia with anti-psychotic drugs (also called “neuroleptics”) that were developed in the 1950s.⁷⁶ On the basis of this review, he reached a number of surprising conclusions, the most controversial of which is that at least 40% of people diagnosed with schizophrenia would be better off if they had never been treated with neuroleptics. Another remarkable conclusion is that, for most patients, prolonged use of these drugs increases the likelihood of psychotic relapse and re-hospitalization.⁷⁷

⁷⁴ *Ibid* at 12.

⁷⁵ According to Allan Horwitz, between 1970 and 1995 the number of mental health professionals in the United States increased by 400%. *Horwitz, supra* note 5 at 4.

⁷⁶ Robert Whitaker, “The Case Against Anti-Psychotic Drugs: A 50-Year Record of Doing More Harm Than Good” (2004) 64 *Medical Hypotheses* at 5.

⁷⁷ *Ibid* at 7.

Whitaker observes that the current psychiatric standard of care for the treatment of schizophrenia is to keep people with this diagnosis on neuroleptic medication indefinitely. This standard of care and its underlying assumptions are at the centre of Whitaker's critical review of medical research on the efficacy of neuroleptic drugs that, among other things, have the effect of altering how the brain processes a neurotransmitter called dopamine. According to Whitaker, much of the enthusiasm for the use of neuroleptics is based on research sponsored by the National Institute of Mental Health (NIMH) in 1964.⁷⁸ The research involved 344 patients diagnosed with schizophrenia from nine hospitals who were randomly assigned to either a group that was treated with neuroleptics or a control group that was given a placebo. According to this study, after six weeks of treatment 75% of the patients given neuroleptics were either improved or very much improved, but only 23% of the placebo patients had these types of positive outcomes. On the basis of these findings, neuroleptics were promoted as anti-schizophrenic "magic bullets."⁷⁹ However, three years later the same researchers reported on the one-year outcome of all the patients and found that those who were on the neuroleptics were much more likely to experience relapse (i.e., recurrence of acute psychotic symptoms) and re-hospitalization than those who had received the placebo.⁸⁰

According to Whitaker, further research sponsored by the NIMH in 1971 found that relapse rates rose with the dose of the medication given.⁸¹ Subsequent NIMH studies also confirm

⁷⁸ J. Cole, G. Klerman & S. Goldberg, "The National Institute of Mental Health Psychopharmacology Service Centre Collaborative Study Group. Pheno-thiazine Treatment in Acute Schizophrenia" (1964) 10 Archives of General Psychiatry at 246.

⁷⁹ Whitaker, "The Case Against Anti-psychotic Drugs", *supra* note 69 at 6.

⁸⁰ N. Schooler et al, "One Year After Discharge: Community Adjustment of Schizophrenic Patients" (1967) 123 American Journal of Psychiatry at 986.

⁸¹ Whitaker, "The Case Against Anti-psychotic Drugs", *supra* note 69 at 6.

that newly admitted patients diagnosed with schizophrenia had better long-term outcomes if they were treated without medication.⁸² One of these studies suggests that people diagnosed with schizophrenia who are given neuroleptics have a higher relapse rate after two years than those who are treated without these drugs in experimental homes staffed by non-professionals.⁸³ This study also maintains that patients given the experimental treatment were “better functioning” than the patients on neuroleptics who had not experienced relapse.⁸⁴

Whitaker also examines an article published in 1995 that reported on a review of 66 earlier relapse studies involving approximately 4,400 patients.⁸⁵ The authors of that review conclude that 53% of patients who withdraw from neuroleptic drugs relapse within ten months, while only 16% of those who remained on these drugs relapse within the same period of time. However, Whitaker notes that up to 30% of persons diagnosed with schizophrenia do not respond at all to neuroleptics and, of those who are on the medication, more than one-third relapse within a year, even if they continue taking the medication. In order to be considered for participation in the research all of the 4,400 patients in the 1995 study had been “good responders” who had positive responses to the neuroleptics from the start. Without pointing this out, the authors of the 1995 article provide a misleading account of the efficacy of neuroleptic medication. Moreover, as Whitaker notes, the 1995 study involved only people who had been on neuroleptics and then discontinued this use.

⁸² *Ibid* at 7.

⁸³ Lorne Mosher, “Soteria and other alternatives to acute psychiatric hospitalization” (1999) 187 *Journal of Nervous and Mental Disease* at 142.

⁸⁴ Whitaker, “The Case Against Anti-psychotic Drugs”, *supra* note 69 at 7.

⁸⁵ P. Gilbert et al, “Neuroleptic withdrawal in schizophrenic patients” (1995) 52 *Archives of General Psychiatry* at 173.

In contrast, all of the earlier studies cited above compared people who were on neuroleptics with people who were not so medicated but rather received other forms of treatment. Thus, the 1995 study examined *withdrawal* from medication whereas the earlier studies examined the efficacy of medical treatment with neuroleptics as compared to non-medical treatment.⁸⁶

On the basis of his research review, Whitaker concludes that prolonged use of neuroleptic medication probably causes the high percentage of relapse among those who take these types of drugs. In further support of that assertion, he describes the results of neurophysiological research studies indicating that neuroleptics cause changes in the structure of the brain, resulting in patients having a greater susceptibility to relapse.⁸⁷ Whitaker notes that, although new types of neuroleptic drugs such as risperidone may have fewer side effects than the original neuroleptics, they cause some of the same neurophysiological changes and therefore likely will cause similar rates of relapse in the patients who take these new forms of medication.⁸⁸

The prolonged or life-long use of neuroleptic medication also has been questioned recently by some scholars within the psychiatric community itself. For example, Emmanuel Stip, professor of psychiatry at the University of Montreal, states that “After fifty years of neuroleptics, we are able to answer the following simple question: Are neuroleptics effective in treating schizophrenia?”⁸⁹ The answer he gives is that there is “no compelling

⁸⁶ Whitaker, “The Case Against Anti-psychotic Drugs”, *supra* note 69 at 7.

⁸⁷ *Ibid* at 8.

⁸⁸ *Ibid* at 10.

⁸⁹ *Ibid*.

evidence on the matter, when “long-term” is considered.”⁹⁰ Skepticism about the efficacy of psychiatric medications is also expressed by Joel Paris, professor and former chair of the department of psychiatry at McGill University who has stated: “Today, too many psychiatrists believe that mental disorders reflect disordered chemistry that can be made right by the proper combination of drugs. Although the future should bring more valid diagnoses and better therapeutic methods, the idea that current diagnoses can guide treatment is illusory.”⁹¹ He is especially concerned about the widespread use of psychopharmacological medication for children diagnosed with bipolar disorder and he claims that such patients “who receive these agents can expect to be on them for many years – if not for life. This could turn out to be one of the worst scandals in the history of psychiatry – and we have had quite a few.”⁹² It is worth noting that the rate of diagnosis and treatment of bipolar disorder in children is far higher in the United States than in European countries such as Germany and the Netherlands.⁹³ Again, this demonstrates the cultural variability in the perception, description, and treatment of mental disorders that are thought to have purely physiological causes.

2.1(C)(ii) Side-effects and Limited Use of Neuroleptics

Research confirms that the psychiatric medications that are used so widely today have many serious side effects. For example, anti-psychotic medication used to treat people diagnosed with serious mental illnesses, such as bipolar disorder and schizophrenia,

⁹⁰ Emmanuel Stip, “Happy Birthday Neuroleptics! 50 Years Later; la folie du doute” (2002) 17:3 *European Psychiatry* 115. Quoted in Whitaker, *Anatomy of an Epidemic*, *supra* note 2 at 98.

⁹¹ Joel Paris, *Prescriptions for the Mind: A Critical View of Contemporary Psychiatry* (New York: Oxford University Press, 2008) at 53.

⁹² *Ibid* at 82.

⁹³ J.M. Zito, D.J. Safer & L.T.W. De-Jong, “A Three-Country Comparison of Psychotropic Medication Prevalence in Youth” (2008) 2 *Child and Adolescent Psychiatry and Mental Health* 2.

“increase rates of heart attack, strokes, diabetes, and suicides. Studies that have examined longer term outcomes for patients on these drugs universally show a reduction in life expectancy measured in decades, not just years.”⁹⁴ Society has yet to see the long-term consequences of these drugs on the vast number of children who are being subjected to these treatment regimes at ever-earlier ages.

2.1(C)(iii) The Value of Psychiatric Treatment

This is not to say, however, that psychiatric medications should be eliminated or that they are useless for assisting people in distress. This is acknowledged by some of the most vociferous critics of the current drug-based treatment paradigms. In his book *Doctoring the Mind: Why Psychiatric Treatment Fails*, Richard Bentall criticizes the long-term use of anti-psychotic medication but concedes that:

This does not mean that anti-psychotics have no place in the treatment of adult patients suffering from psychosis. For many who experience terrifying voices and delusional fears, or who are dangerously lost in the excitement of acute mania, they are undoubtedly a useful therapy, at least in the short term. But they are flawed tools and certainly not the panacea for madness they have often been assumed to be. Some patients are more harmed than helped by them and they should therefore be used cautiously. Despite these serious limitations their use has become almost synonymous with psychiatric treatment. Weaning services from this dangerous addiction will necessitate completely rethinking the values and goals of psychiatric care.⁹⁵

Indeed, even Whitaker’s research indicates that some people are assisted by these medications and that while a number of people would better off if they had never been on anti-psychotic medication, some benefit from its use.⁹⁶ Moreover, as Nikolas Rose has

⁹⁴ Healy, *supra* note 12 at 89.

⁹⁵ Bentall, *supra* note 11 at 240.

⁹⁶ Whitaker, “The Case Against Anti-psychotic Drugs”, *supra* note 69 at 11.

pointed out, the lengthy training that psychiatrists receive may make some of them particularly qualified in the clinical perception and treatment of persons in acute psychological distress.⁹⁷ This psychiatric training can include the discernment of when the use of psychiatric medication is appropriate, the suitable doses of the medication, the use of psychotherapy in conjunction with medication, and the way that the medication may be discontinued for certain patients. Thus, the growth of medical understanding of human life may have both deleterious and beneficial consequences, repressive and emancipatory potential.

This dissertation is not an attempt to discount all forms of psychiatric treatments, but rather to demonstrate the harms that can arise from the adoption of certain forms of neurobiological psychiatric discourse in coercive legal systems. Indeed similar concerns have been raised by some psychiatrists themselves, who, like Richard Bentall, recommend rethinking the “values and goals of psychiatry.”⁹⁸ Assessing and changing these values and goals requires an investigation of the historical and social processes that create and reinforce them.

2.1(D) Summary of Section 2.1

In the twentieth century, the emergence of neurobiological psychiatry, reinforced by the use of the DSM-III, has dramatically changed how Western industrial societies, and more recently countries in the global South, understand and treat people labelled as mentally ill. This model of psychiatric understanding has had far-reaching consequences in the way that

⁹⁷ Nikolas Rose, “Law, Rights and Psychiatry” in Peter Miller and Nikolas Rose, *The Power of Psychiatry* (Cambridge: Polity Press, 1986) at 195.

⁹⁸ Double, *Critical Psychiatry: The Limits of Madness*, *supra* note 11 at 3.

the medical system over-diagnoses and treats patients from young ages and for long – often lifelong – periods of time. The use of psychiatric medications and diagnostic categories has pervasive effects on many aspects of society.

2.2 Medico-legal Discourse and the History of Mental Health Law in British Columbia

In this section, I first show how forms of biomedical thinking, including neurobiological psychiatry, cannot be seen as separate from norms, including legal norms, with which they are inextricably connected. This is followed by a history of mental health law in British Columbia, which shows how a unique form of medico-legal discourse has been created in this province, discourse that shapes legal and medical institutions, including discursive practices related to involuntary psychiatric treatment. The section concludes with an examination of policy statements from the British Columbia government for its future plans for mental health care in this province, showing a further entrenchment of current biomedical ways of understanding and treating mental illness.

2.2(A) The Medico-legal Discourse of Mental Illness

Rethinking treatment values and standards of care for people in mental distress not only requires an assessment of practices within medical communities, but also must be based on a detailed articulation of the nature and effects of laws that define the legal criteria for standards of care for determining the adequacy of health policies. These policies have far-reaching implications for the conduct of medical practitioners, hospital administrators, prison officials, and police officers. Indeed, understanding the law can clarify the extent to which powerful forms of legal discourse have had a role in shaping our understanding of the nature of mental illness. This highlights the importance of avoiding the assumption

underlying the biomedical model, of which the neuropsychiatric model is a subspecies, that “medical facts” can exist without being fundamentally shaped by ethical and legal norms.

As Elliot Mishler states in his book *Social Contexts of Health, Illness and Patient Care*:

health and illness are social facts as well as biological facts...[the] biomedical model strips away social contexts of meaning. Illness is then viewed as an autonomous entity, defined by standard universal criteria, isolated from the lives and experience of patients and physicians. However, sociocultural variables are equally relevant to the narrow conception of disease. Briefly put, there is no way to define a biological “norm” or “deviation” without specific reference to populations and their sociocultural characteristics. “Normal for what”, “Normal for whom” that is, assertions about the normality of levels of biological functioning or about the normal structure of an organ, must be based on relationships between observed instances and the distribution in a specific populations of these structures and functions. Further, implicit to any specified norm is a set of presupposed standard conditions with regard to whom, and on whom measurements are taken. All types of disease raise social and personal questions about the individual and his immediate group. Thus, disease and medical care are directly woven into the social fabric. In our culture science has provided us with disease forms which, on logical grounds, are not connected to the social fabric.⁹⁹

Mishler’s comments concerning medical norms are particularly relevant when scrutinizing psychiatric conclusions about capacity and competency, because conceptions about capacity and competency are unavoidably shaped by legal norms.¹⁰⁰ These norms determine, among other things, whether people diagnosed as having mental illnesses are regarded as autonomous agents and whether they should be detained and have treatment imposed on them involuntarily.¹⁰¹ As Clive Unsworth puts it, “Law actually constitutes the

⁹⁹ Eliot Mischler, “The definition of disease” in Eliot Mischler, ed, *Social Contexts of Health, Illness and Patient Care* (Cambridge: Cambridge University Press, 1981) at 4.

¹⁰⁰ David Weisstub, *Enquiry on Mental Competency: Final Report* (Toronto: Queen’s Printer for Ontario, 1990) at 32.

¹⁰¹ *Ibid* at 292.

mental health system, in the sense that it authoritatively constructs, empowers and regulates the relationships between the agents who perform mental health functions.”¹⁰²

The way that a fusion of psychiatric thinking and legal norms occurs – creating a medico-legal discourse – will constantly shift depending on changing social, cultural and historical circumstances. It is therefore necessary to scrutinize the historical development of medical and legal practices in local contexts in order to elucidate how mental illness is understood and treated at those locations. This type of investigation assists us in understanding how the norms associated with these conditions engender stigma and discriminatory assumptions concerning disability. A historical exploration of the development of mental health law system in British Columbia provides numerous insights into the nature of our society’s treatment of those regarded as mentally ill and assists in the development of appropriate recommendations to change this system.

2.2(B) A History of British Columbia’s Mental Health Law Regime

The history of mental health law in British Columbia reflects changes in these types of laws throughout the world since the beginning of the nineteenth century. The historical trends have been described as “a pendulous movement between two extremes of either unduly restrictive legalism or broad and potentially unchecked medical discretion.”¹⁰³ The focus of the discussion is on the laws in British Columbia, as well as on the laws of England, which, until recently, formed the foundation for the legal system in this province.

¹⁰² Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford: Clarendon Press, 1987) at 5. As quoted in Archibald Kaiser “Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State” (2009) 17 Health LJ 139 at 140.

¹⁰³ Phillip Fennell, “Law and Psychiatry: The Legal Constitution of the Psychiatric System”(1986) 13 Journal of Law and Society 35 at 35.

2.2(B)(i) Nineteenth and Early Twentieth-Century Legalism

As an outpost of the British Empire for much of the nineteenth century, the colony of British Columbia adopted English law and policies for the treatment of people who were labelled as “lunatics.” Although the social consequences of enacting these laws in British Columbia were similar to the consequences in England, they were seen much earlier in that country. Beginning in the late eighteenth century, English statutes such as the *Act for the Regulation of Madhouses*¹⁰⁴ governed the confinement and segregation of those regarded as lunatics in privately operated homes. In the mid-nineteenth century the *Lunatic Asylum Act*¹⁰⁵ was enacted for the operation of highly regulated large asylums.¹⁰⁶ These English statutes mandated the institutional segregation of the people labelled as lunatics and contributed to an increase in the asylum population in England from approximately 5,000 in 1794 to 100,000 by the end of the nineteenth century.¹⁰⁷ Between 1845, when the *Lunatic Asylum Act* was enacted, and 1890, the population of people detained in asylums in England increased by over 400%, while the general population increased by only 78%.¹⁰⁸

In 1872, British Columbia enacted the *Insane Asylum Act*,¹⁰⁹ which adopted most of the substantive provisions from England’s *Lunatic Asylum Act*. The *Insane Asylum Act* was created in response to public concern that people regarded as lunatics were simply incarcerated and neglected in prisons in the cities of Victoria and New Westminster, British

¹⁰⁴ *Act for the Regulation of Madhouses*, 14 Geo. 3 c.49.

¹⁰⁵ *Lunatic Asylum Act*, 8 & 9 Vict., c 100.

¹⁰⁶ Roy Porter, “Foucault’s Great Confinement” in Arthur Still and Irving Velody, eds, *Rewriting the History of Madness: Studies in Foucault’s Histoire de al folie* (London: Routledge, 1992) at 119.

¹⁰⁷ *Ibid* at 120.

¹⁰⁸ Unsworth, *supra* note 93 at 62.

¹⁰⁹ *Insane Asylum Act*, RSBC 1872-73, c 28.

Columbia.¹¹⁰ When British Columbia's *Insane Asylum Act* came into force, judges of the Supreme Court of British Columbia, like their counterparts in England, were given broad jurisdiction and discretion over the treatment of people labelled as lunatics. Pursuant to section 6 of the *Insane Asylum Act*, physicians' recommendations for civil committal always had to be reviewed by a judge who would issue the final committal order. The *Lunacy Jurisdiction Act*,¹¹¹ also enacted in 1872, gave judges of the Supreme Court of British Columbia power to appoint guardians and committees over the person and estate of "natural-born fools, lunatics and persons deprived of understanding and reason by acts of God."¹¹² Rights to marry, own property, commence lawsuits, vote, and many other rights were often stripped from people who had been committed.¹¹³ There were no statutory mechanisms for patients to challenge or appeal committal orders after detention occurred.

¹¹⁰ Gerry Ferguson, "Control of the Insane in British Columbia, 1849-78: Care, Cure, or Confinement" in John McLaren, Robert Menzies & Dorothy Chunn, *Regulation Lives: Historical Essays on the State, Society, the Individual and the Law* (Vancouver: UBC Press, 1987) at 63. In 1872 British Columbia's first asylum called Royal Hospital was established in Victoria. It was closed in 1878 and its 36 residents were moved to the Provincial Asylum for the Insane in New Westminster where the patient population grew to 300 by 1899. B.C. Mental Health & Addiction Services, *Riverview Hospital: A Legacy of Care and Compassion* (Vancouver: B.C. Mental Health & Addiction Service, 2010) at 15.

¹¹¹ *Lunacy Jurisdiction Act*, 1872, 35 Vict. Ch. 112. This *Act* adopted England's *Lunacy Act, 1845*, 8 & 9 Vict., c 100.

¹¹² The statutes of England and British Columbia at this time did not, in themselves, define the term lunatic. Both adopted a definition from the common law, which made a distinction between idiots and lunatics, according to which "An idiot or natural fool is one that hath no understanding from his nativity, and therefore is by law presumed never to attach any. On the other hand a lunatic or *non compos mentis*, is one who hath understanding, but by disease, grief or other accident, hath lost the use of his reason. A lunatic is one that has lucid intervals, sometimes enjoying his senses and sometimes not and that frequently depends on a change of the moon." Danby P. Fry, "Introduction" in *The Lunacy Acts: Statutes Related to Private Lunatics, Pauper Lunatics, Criminal Lunatics, Commissioners of Lunacy and Public and Private Asylums* (London: Knight and Company, 1864) at 3. The first definition of "lunatic" in a British Columbia statute appeared in section 2 of the 1888 amendment to the *Insane Asylums Act*, which provided that, "the word "lunatic" shall mean any insane person, whether found so by inquisition or not." No statute in British Columbia at that time defined the meaning of "insane."

¹¹³ Gray, Shone & Liddle, *supra* note 4 at 35.

In 1897 two pieces of legislation, the *Hospitals for the Insane Act*¹¹⁴ and the *Lunacy Act, 1897*¹¹⁵ were enacted in British Columbia for the treatment of people labelled as lunatics. The *Hospitals for the Insane Act* was concerned with the civil committal and involuntary treatment of people labelled as lunatics. The term “asylum” was replaced with “hospital” and a “patient” was defined in section 2 as “every person received or detained as a lunatic or taken charge of as a lunatic.” A lunatic was also defined in section 2 as, “any insane person, whether found so by inquisition or not, or any idiot, or imbecile, or person of unsound mind.” The meaning of insanity or unsound mind remained undefined in British Columbia legislation at that time. The *Hospitals for the Insane Act* required two physicians to complete statutory medical certificates confirming in writing that the potential patient “is a proper person for care and treatment in some hospital for the insane.”¹¹⁶ Before civil committal was effected, judges, magistrates, or registrars of the court had to complete a statutory form showing that they had read the medical certificates, personally examined the person in court, and confirmed that the person “is a Lunatic and a proper person to be taken charge of and detained under care and treatment...” There were no provisions in that *Act* that permitted patients to have the committal orders reviewed or reversed.

The purpose of the *Lunacy Act, 1897* was to confer special jurisdiction on British Columbia Supreme Court judges, defined in section 3 as “Judges in lunacy,” to conduct independent inquisitions to determine whether a person is a lunatic¹¹⁷ and to make orders for the

¹¹⁴ *Hospitals for the Insane Act*, RSBC1897 c 18.

¹¹⁵ *Lunacy Act, 1897*, 61 Vict. Ch. 126. The full title of that *Act* is *An Act respecting the Care and Commitment of the Person and Estates of Lunatics*. Section 1 of that *Act* states that it may be cited as the “Lunacy Act.” This *Act* adopted key features of England’s *Lunacy Act, 1890*, 53 Vict. ch. 5.

¹¹⁶ *Ibid* at 2048.

¹¹⁷ Section 2 of the *Lunacy Act* states that:

appointment of committees to manage the property and estates of persons found to be lunatics. Judges granted full power to the committee to manage the person and his or her estate, subject only to directions from the Court. The independent inquisitions could, pursuant to section 2(d) of the *Act*, concern persons who were already detained under the *Hospitals for the Insane Act* or consider applications for the appointment of committees for persons who were alleged to be lunatics, but who had not been committed under the latter *Act*. The *Lunacy Act* was amended in 1911 to appoint the province's Attorney General, under section 49, to be the *ex officio*¹¹⁸ committee for persons civilly committed to hospitals who did not have committees. Together, British Columbia's *Hospitals for the Insane Act* and *Lunacy Act* endorsed judicial oversight of all aspects of the lives of people who were labelled as lunatics. Scholars regard these pieces of legislation, and their English counterparts, as the high-water mark of nineteenth-century legalism¹¹⁹ and observe that members of the medical profession at the time expressed indignation at the incursion of the law into a domain they believed should be based only on physicians' discretion.¹²⁰

“the expression “lunatic” shall have or include the meanings following, that is to say:

Lunatics so found by inquisition;

Lunatics so found by inquisition, for the protection or administration of whose property any order has been made before the commencement of this Act;

Every person lawfully detained as a lunatic, though not so found by inquisition;

Every person not so detained and not found a lunatic by inquisition, with regard to whom it is proved, to the satisfaction of the Judge in lunacy, by affidavit or otherwise, that such person is, through mental infirmity arising from disease or age or otherwise, incapable of managing his affairs; and

Every person with regard to whom the Judge in lunacy is satisfied, by affidavit or otherwise, that such person is or has been a criminal lunatic, and continues to be insane and in confinement.

¹¹⁸ *Ex officio* is from the Latin, meaning “by virtue of one’s office.” *The Dictionary of Canadian Law* 2d ed, sub verbo “*ex officio*”.

¹¹⁹ Robert Gordon and Simon Verdun-Jones, “Mental Health Law and Law Reform in the Commonwealth: The Rise of a New Legalism?” in David Weiss, ed, *Mental Health and Law: International Perspectives: Vol. 2* (Toronto: Pergamon Press, 1986) at 4.

¹²⁰ *Ibid* at 4.

2.2(B)(ii) Legislative Changes in the 1940s

Other than changing the title of the *Hospitals for the Insane Act* to the *Mental Hospitals Act* in 1912, there were no significant changes to British Columbia's mental health law system until the 1940s. With the amendment to the *Mental Hospitals Act*¹²¹ in 1940, patients were, for the first time in British Columbia, given the right, under section 21 of that *Act*, to have their committal orders reviewed by a review panel consisting of two physicians who were not the two who originally committed the patient. The patient was permitted to apply for this review only after three months following the date of detention. There were no provisions permitting further review. All civil committal orders under the *Mental Hospitals Act* were subject to judicial approval under section 9 of that *Act*. Revised versions of the *Lunacy Act* remained in effect in British Columbia and maintained judicial scrutiny over the "care and commitment of the person and estates of the lunatic." The definition of lunatic found in section 2 of the 1940 *Lunacy Act* was exactly the same as that in the 1897 *Lunacy Act*. Significantly, however, the definition "patient" in the *Mental Hospitals Act* of 1940 revealed a new psychiatric orientation. A patient was no longer described as "insane" and instead was defined in section 2 as "a "mentally ill person" who is suffering from such a disorder of the mind as to require care, supervision, and control for his own protection or welfare or for the protection of others, and includes any idiot, imbecile or person of unsound mind; and also any person who is a lunatic within the meaning of the *Lunacy Act*" (emphasis added).¹²² The difference in the legislative definitions between newly described mentally ill persons and lunatics, narrowly defined in

¹²¹ *Mental Hospitals Act*, RSBC 1940, c 27.

¹²² In the 1897 *Hospitals for the Insane Act*, "patient" was defined in section 2 simply as "every person received or detained as a lunatic or taken charge of as a lunatic" [emphasis added].

earlier legislation, show how medical thinking in the 1940s was beginning to diverge from Victorian legalism.¹²³

2.2(B)(iii) Institutional Changes in the 1940s and 1950s

The changes in British Columbia's mental health law system starting in the 1940s were incipient reflections of the growth of psychiatric influence and the empowerment of medical authorities in Western industrial countries in the early to mid-twentieth century. Large mental hospitals first seen in the nineteenth century in jurisdictions such as England and the eastern United States arose in British Columbia in 1913. The provincial government purchased 1,000 acres in Coquitlam for the creation of an asylum called "The Hospital for the Mind" (later renamed Riverview Hospital in 1964) taking 340 patients considered the most seriously ill from New Westminster's Provincial Asylum for the Insane.¹²⁴ The treatment at the time consisted of work therapy, rest in quiet surroundings, hydrotherapy,¹²⁵ and massage.¹²⁶ By 1916 the patient population had more than doubled to 687 patients and a second building was constructed.¹²⁷ By 1925 there were 1,884 patients in residence at Riverview.¹²⁸

¹²³ In 1948, the *Clinics of Psychological Medicine Act* was enacted, which authorized the establishment of clinics, separate from hospitals, where people could be assessed for the purpose of determining whether they were candidates for certification under the *Mental Hospitals Act*. The definition of "mentally ill person" was the same in both *Acts*. The *Clinics of Psychological Medicine Act* expanded the definition of patient, pursuant to section 2, to include "all persons who are treated in or by a clinic of psychological medicine or in or by a mental hospital."

¹²⁴ B.C. Mental Health & Addiction Services, *Riverview Hospital: A Legacy of Care and Compassion*, supra note 101 at 24.

¹²⁵ *Ibid* at 17. Hydrotherapy treatment involved immersing patients in baths at 90 to 112 degrees Fahrenheit and then putting them in dry hotpack to cause perspiration. Some physicians at the time thought that this treatment induced relaxation and sleep for the most disturbed patients.

¹²⁶ *Ibid*.

¹²⁷ *Ibid* at 24.

¹²⁸ *Ibid* at 27.

In the 1930s and 1940s psychiatry was increasingly treating broader segments of the public and using new technologies for changing patients' brains.¹²⁹ By 1942, Riverview Hospital had expanded to include a 675-bed Female Chronic Unit, the Veterans Unit (later called Crease Clinic), and a home for the elderly called Valleyview.¹³⁰ Psychiatric technology had also changed and in that same year Riverview introduced electro-convulsive therapy (ECT), sulfa drugs and psychosurgery, including lobotomies.¹³¹

By 1951, Riverview's population reached its highest point with 4,630 patients in full-time residence.¹³² This dramatic increase in mental hospital population was seen throughout the Western industrial world. For instance, in the 50 years prior to 1955, the public mental health population in England and America increased 400%, while the general population during the same time period had only doubled.¹³³

2.2(B)(iv) Changes to Mental Health Legislation in the 1960s

2.2(B)(iv)(a) Patients Estates Legislation

In 1962 the *Lunacy Act* was repealed by the *Patients Estates Act*,¹³⁴ which maintained judicial authority over the determination of whether persons were capable of managing themselves and their estates, as well as over the appointment of committees. All reference

¹²⁹ *Ibid* at 102.

¹³⁰ *Supra* note 87 at 32.

¹³¹ *Ibid* at 42. In 1950, 413 patients received ECT treatment and 50 patients received lobotomies in 1951.

¹³² *History: B.C. Mental Health Timeline*, online: B.C. Mental Health & Addiction Services <www.bcmhas.ca>, retrieved September 10, 2013.

¹³³ Andrew Scull, *Decarceration: Community Treatment and the Deviant* (Cambridge: Polity Press, 1984) at 7.

¹³⁴ *Patients' Estates Act*, SBC 1962, c 44

to lunatics was expunged from the *Patients Estates Act*, and the persons who were the subject of that *Act* were patients, defined in section 2 in the following terms:

2. “patient” means

(a) a person who is described as one who is, because of mental infirmity arising from disease, age, or otherwise, incapable of managing his affairs, in a certificate signed by the medical officer in charge of a mental hospital as defined in section 2 of the *Mental Hospitals Act* or by the medical officer in charge of a Provincial clinic of psychological medicine as defined in section 2 of the *Clinics of Psychological Medicine Act*; or

(b) a person who is declared under this Act by a Judge to be

- (i) incapable of managing his affairs;
- (ii) incapable of managing himself; or
- (iii) incapable of managing himself or his affairs.

The *Patient’s Estate Act*¹³⁵ confirmed that the office of the Official Committee¹³⁶ rather than the Attorney General was the ex officio committee for patients who did not have private citizens, such as family members, to act as the committee.

2.2(B)(iv)(b) Civil Commitment Laws

The changes in British Columbia’s mental health law system that started in the 1940s showed an increased emphasis on medical discourse and authority. These changes were also seen in other jurisdictions. For example, England’s *Mental Treatment Act* of 1930 shifted emphasis from legal protections of patients to increased authorization for physicians to exercise discretion in issuing committal and treatment orders, without judicial review, in situations they deemed to be emergencies.¹³⁷ In Ontario, the *Mental Hospitals Act* of

¹³⁵ The *Patients’ Estate Act* was later renamed the *Patients’ Property Act*, RSBC 1996 c 349, which is still in effect today. Other than the change in name, the two Acts are substantially the same.

¹³⁶ The replacement of the Attorney General with the Official Committee as the ex officio committee was first instituted under the 1955 amendment to the *Lunacy Act*. The office of the Official Committee has since been replaced with office of the Public Guardian and Trustee of British Columbia.

¹³⁷ *Fennell*, *supra* note 94 at 4. However, complete abolition of judicial oversight of committal orders at the time of admission did not occur until the enactment in 1959 of *Mental Health Act*, 1959 (UK) 7 & 8 Eliz. II, c 72.

1935¹³⁸ allowed physicians for the first time in that province's history to commit patients on the basis of the opinions of two physicians, without any judicial oversight or endorsement.¹³⁹ A further amendment to that *Act* allowed committal based on only one physician's opinion.¹⁴⁰ The changes to mental health law in jurisdictions such as England and Ontario, whereby physicians could make civil commitment orders without any juridical supervision, were finally adopted in dramatic revisions to mental health laws in British Columbia in the 1960s.

Although the *Patient's Estate Act* maintained judicial supervision over the appointment of committees, in British Columbia's *Mental Health Act*¹⁴¹ enacted in 1964,¹⁴² discretion for making final committal orders was transferred entirely from judges to physicians who treated the patients. In addition, when patients applied for release from detention in hospitals, Review Panel members consisted entirely of physicians, though not the same physicians who had treated them. The *Mental Health Act* also eliminated reference to lunacy, insanity, idiocy and imbecility and instead referred to a patient as a "mentally disordered person"¹⁴³ or a "mentally ill person."¹⁴⁴ Under section 24 of that *Act*, civil

¹³⁸ *Mental Hospitals Act*, SO 1935, c 39.

¹³⁹ Amy James, "Psychiatric Power and Informed Consent in Post-World War II Canada" (2002) 22:4 Health Law in Canada at 105.

¹⁴⁰ *Ibid.*

¹⁴¹ *Mental Health Act*, RSBC 1964, c 29. This *Act*, under section 43, repealed the *Mental Hospitals Act* and the *Clinics of Psychological Medicine Act*.

¹⁴² This may have been inspired by similar legislations removing judicial involvement in committal orders at initial admission found in England's 1959 *Mental Health Act*, 1959 (UK) 7 & 8 Eliz. II, c 72.

¹⁴³ The *Mental Health Act*, s 2 defines "Mentally disordered person" as a "mentally retarded or mentally ill person".

¹⁴⁴ The *Mental Health Act*, s 2 defines "Mentally ill person as "a person who is suffering from a disorder of the mind (a) that seriously impairs his ability to react appropriately to his environment or to associate with others; and (b) that requires medical treatment or makes care, supervision, and control of the person necessary for his protection or welfare or for the protection of others".

commitment could take place if two physicians certified that the patient required medical treatment or “care, supervision, and control in a Provincial mental health facility for his own protection or welfare or for the protection of others.” This broad discretion allowing physicians to detain patients for their welfare was similar to provisions found in other jurisdictions at that time and reflected a social commitment to medical paternalism.¹⁴⁵ It has been described as the “beneficence” model of mental health care.¹⁴⁶

The enactment of British Columbia’s *Mental Health Act* in 1964 is the culmination of a trend, seen since the 1940s, of a medical discourse of mental illness supplanting a Victorian legal definition of lunacy oriented toward a person’s capacity to control his or her affairs. While the new mental health legislation removed judicial involvement from initial civil committal decisions, it would be mistaken to conclude that the law’s influence had waned. Instead, the legislation tilted civil committal decisions toward psychiatric discretion while regulating the relationship between physicians and patients. The medico-legal discourse that emerges at this time is shaped by considerations of biomedical rationality. This same form of medico-legal discourse is found in many jurisdictions in the 1960s.¹⁴⁷

2.2(B)(v) Deinstitutionalization and the New Legalism

Since the 1960s there have been two major social trends that together have significantly influenced mental health law and policy in many countries. The first is a process termed “deinstitutionalization,” which describes how large psychiatric hospitals have gradually been emptied in the past fifty years and how this has changed community medicine and

¹⁴⁵ Jessica Berg et al, *Informed Consent: Legal Theory and Clinical Practice* (Oxford: Oxford University Press, 2000) at 22.

¹⁴⁶ *Ibid* at 22.

¹⁴⁷ *Gray, Shone & Liddle, supra* note 4 at 37.

constructed the identities of patients.¹⁴⁸ The second trend is the role of human rights legalism rooted in liberal political philosophy in shaping mental health law and policy. The influence that human rights philosophies have had on mental health laws has been called the “new legalism,” which some scholars maintain harkens back to the “old legalism” seen in nineteenth-century England’s *Lunacy Act*, insofar as it represents an attempt to put legally regulated restrictions on psychiatric decision-making.¹⁴⁹ Although these two broad trends have had ramifications in every jurisdiction in the common law world, each community’s response to these trends is different. Therefore, the forms of discourse shaped by these trends in local contexts are unique and it is imperative to examine closely the medico-legal discourse that emerges in each location. The following subsection first gives an account of deinstitutionalization in British Columbia and then examines the nature and consequences of the new legalism in this province.

2.2(B)(v)(a) Deinstitutionalization

In Canada, beginning in the mid-1960s, psychiatric hospitals started to close and provinces allocated responsibility for the care of psychiatric patients to centres in the community, such as clinics attached to general hospitals. Some scholars explain that this trend is the result of the introduction of new forms of neuroleptic medication that allowed patients’ symptoms to be controlled with less supervision.¹⁵⁰ According to other scholars, new economic policies arose in Western industrial nations in which governments attempted to shift responsibility for the treatment of people labelled as having mental illness from centrally funded facilities to the less expensive short-term treatment centres in the

¹⁴⁸ *Ibid* at 69.

¹⁴⁹ Gordon & Verdun-Jones, *supra* note 110 at 6.

¹⁵⁰ Gray, Shone & Liddle, *supra* note 4 at 12.

community.¹⁵¹ Still other scholars refer to the increased public awareness, heightened by the civil rights movement, of the miserable living conditions and restraints on liberty for patients in many hospitals. In Canada these sentiments were expressed in publications such as the Canadian Mental Health Association's 1964 report entitled *More for the Mind* advocating the closure of segregated psychiatric hospitals, such as Riverview, so that patients could be integrated into society where they would live and receive treatment close to family and supportive members of the community.¹⁵²

Regardless of the causes of deinstitutionalization, it is now widespread in the Western industrial world and has had profound effects on all aspects of society. A few statistics illustrate the nature and effects of deinstitutionalization. Between 1960, when institutionalization reached its peak in Canada, and 1976, the number of patients in psychiatric hospitals had decreased by 75%.¹⁵³ During the same period one third of the asylums in Canada permanently closed.¹⁵⁴ In British Columbia, Riverview Hospital remained open, but downsizing reduced the population from approximately 4600 in the 1950s to 1000 in the early 1990s.¹⁵⁵ By the time the British Columbia Liberal government

¹⁵¹ Whitaker, "The Case Against Anti-psychotic Drugs" *supra* note 69 at 5.

¹⁵² Charlene Ronquillo, *Deinstitutionalization of Mental Health Care in British Columbia: A Critical Examination of the Role of Riverview Hospital from 1950 to 2000: Proceedings from the 18th Annual History of Medicine, Cambridge, 2012* (Cambridge: Cambridge Scholars, 2012) at 24.

¹⁵³ Nancy Herman & Candace Smith, "Mental Hospital Depopulation in Canada: Patient Perspectives" (1989) 34 *Canadian Journal of Psychiatry* 386.

¹⁵⁴ *Ibid* at 386.

¹⁵⁵ Donald MacFarlane et al, "Clinical and Human Resource Planning for the Downsizing of Psychiatric Hospitals: The British Columbia Experience" (1997) 68 *Psychiatric Quarterly*, abstract.

came into power in 2001 this number had been reduced to 663 and Riverview was finally closed in 2012.¹⁵⁶

The length of time that people who are diagnosed as being seriously mentally ill spend in hospitals has also decreased dramatically. In 1960, 50% of such patients were hospitalized for an average of seven years; today 90% of the same types of people are hospitalized for less than a month.¹⁵⁷ Nevertheless, since 1966 the admissions to general hospitals for short terms psychiatric care has increased over 500%.¹⁵⁸ What these trends demonstrate is that patients now receive much more frequent short-term treatment in localized community settings and de-centralized agencies.

With deinstitutionalization, the new project for psychiatry in British Columbia and other Western industrial societies has become the non-custodial management of risk and protection of the public. This process includes the maintenance of persons through the use of medications on extended leave orders that keep people civilly committed while ostensibly free in the community. It also involves the administrative process of directing persons to various other professionals and agencies in the community for further management.¹⁵⁹ The management of persons thought to be mentally ill is now distributed through many remotely operating networks, such as short-term medical clinics, police activities, and custodians of detention centres. It appears, however, that the primary focus

¹⁵⁶ Riverview, *supra* note 115 at 85.

¹⁵⁷ Berg et al, *supra* note 145 at 388.

¹⁵⁸ *Ibid.*

¹⁵⁹ Nikolas Rose, "Psychiatry as a Political Science: Advanced Liberalism and the Administration of Risk" in *History of the Human Sciences, Vol 9(2)* (London: Sage, 1996) 1 at 17.

is on the use of psychiatric medication for all segments of the population diagnosed as having a mental illness.¹⁶⁰

2.2(B)(v)(b) The New Legalism based on Human Rights Discourse

Mental health law regimes began to diverge in very significant ways in the late 1960s when numerous court decisions in the United States held that patients' constitutional rights to liberty and privacy were violated if involuntary treatment orders were made when the patient had the mental capacity to withhold consent to treatment.¹⁶¹ When it was found that patients had this mental capacity, courts held that involuntary committal orders could be upheld only if it was also found that the patients were a danger to themselves or others. With these court decisions, the doctrine of informed consent began to have a central place in American health law and was strongly supported by many academic authorities.¹⁶² Consequently, a general shift from the beneficence model to the autonomy model of mental health care occurred in the 1970s and 1980s in many jurisdictions.¹⁶³

The American law of informed consent was soon adopted by the Supreme Court of Canada. Until the late 1970s in Canada, physicians were permitted to make decisions regarding patients' welfare, not only for psychiatric purposes but also for any type of

¹⁶⁰ As Sheila Wildeman argues in her article "Access to Treatment of Serious Mental Illness: Enabling Choice or Enabling Treatment" in Colleen Flood, ed, *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) at 231, much Canadian mental health policy (including widespread community treatment orders enforced by treatment teams) in the past twenty years has focused on compliance with schemes for enforcing the use of psychiatric medication rather than fostering the goals of autonomy and independent living. She notes that several empirical studies have confirmed that many people diagnosed with serious mental illness, including many who are involuntarily committed to hospitals, are sufficiently competent to make decisions regarding their own treatment.

¹⁶¹ Berg et al, *supra* note 145 at 20. For a critical examination of the history of American civil commitment laws in the 1960s and 1970s see Christopher R. Williams and Bruce A. Arrigo, *Law Psychology and Justice* (Albany: State University of New York Press, 2002) 127-152.

¹⁶² *Ibid.* See also: Stephen Morse, "Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law" (1977) *Southern California Law Review* 527.

¹⁶³ *Ibid* at 21.

medical treatment. These decisions were based on the physician's view of what would be in the patient's best interest. Often the patients were not consulted regarding their wishes and they rarely questioned the physicians' decisions.¹⁶⁴ In the landmark case of *Reibl v. Hughes* the Supreme Court of Canada cited a number of American authorities and confirmed the importance of principles of informed consent to health care in relation to assessing a physician's liability for negligent surgical treatment.¹⁶⁵ Courts in Ontario then applied these principles to cases of consent to psychiatric treatment,¹⁶⁶ but courts and legislatures in some other provinces, most notably British Columbia, have refrained from following or codifying these Ontario decisions.¹⁶⁷

Today there is a wide spectrum of types of mental health legislation across Canadian provinces and other jurisdictions around the world, particularly in relation to criteria for assessment of capacity to consent to treatment.¹⁶⁸ The general trend has been to enact legislation that ostensibly imposes legal restrictions on physician discretion in committal and psychiatric treatment. Whereas Ontario is the province in Canada that ostensibly expresses in its laws the greatest concern for patient autonomy and informed consent to treatment, British Columbia's mental health law system is least concerned with these considerations.¹⁶⁹ British Columbia's mental health legislation since 1964 shows superficial enhancement of patients' rights, while at the same time reserving broad discretion for physicians to impose involuntary psychiatric treatment.

¹⁶⁴ Brian Hoffman, *The Law of Consent to Treatment in Ontario* (Toronto: Butterworths, 1997) at 61.

¹⁶⁵ *Reibl v. Hughes*, [1980] 2 SCR 880, 114 D.L.R. (2d) 1.

¹⁶⁶ *Fleming v. Reid*, [1991] OJ 1083, 4 O.R. (3d) 74.

¹⁶⁷ *McCorkell v. Riverview Hospital (Director)*, [1993] BCJ 1518, 81 B.C.L.R. (2d) 273.

¹⁶⁸ Gray, Shone & Liddle, *supra* note 4 at 19.

¹⁶⁹ *Ibid* at 465.

2.2(B)(vi) The Modern Evolution of British Columbia's Mental Health Law System

2.2(B)(vi)(a) Changes to the *Mental Health Act* between 1979 and 1998

British Columbia's response to the new legalism is first seen in the *Mental Health Act* of 1979.¹⁷⁰ The broad committal criteria found in the 1964 legislation remained unchanged in section 20 of the 1979 legislation and the Review Panels were bound by these criteria. The 1979 *Act* is substantially the same as the 1964 *Mental Health Act* except that the new legislation allowed patients, pursuant to section 21, to apply for review of the committal order one month following the initial detention (rather than three months under the predecessor *Act*) and the Review Panel no longer consists of two physicians, but rather has three members: a lawyer who acts as chair, a physician and a community member.

Later amendments in 1996 to British Columbia's *Mental Health Act*¹⁷¹ have included provisions for extended leave of patients who remain under civil commitment orders but are permitted to live in the community. This reflects how mental health law has been fashioned to address the situations of patients who are living outside of hospitals following deinstitutionalization. In addition, the new legislation requires Review Panel hearings no later than 14 days following the patient's application for a hearing and then, if the panel upholds the detention order, the patient has a right to apply for further review after one month, three months, six months and one year.¹⁷² This schedule for periodic review is

¹⁷⁰ *Mental Health Act*, RSBC 1979 c 256.

¹⁷¹ *Mental Health Act*, RSBC 1996 c 288.

¹⁷² Gerard Clements, *Guide to the Mental Health Act* (British Columbia: Ministry of Health, 2005) at 10.

similar to schedules found in other provinces in Canada.¹⁷³ However, the feature that distinguishes British Columbia's mental health laws from those in all other provinces is that British Columbia permits physicians and hospital directors to impose involuntary treatment on patients even when the patient has the mental capacity to refuse to consent to treatment, and under section 31 "treatment authorized by the director is deemed to be given with the consent of the patient" regardless of the patient's actual wishes. This confers extraordinary powers on physicians and hospital directors to detain and treat patients. These powers were reinforced when a deterioration criterion for involuntary committal was introduced into the legislation in an amendment to the *Act* in 1998.¹⁷⁴ This amendment allows psychiatrists to impose involuntary medical treatment on patients whom they believe are at risk of deteriorating without medication, even though the patients are currently mentally capable of making treatment decisions for themselves and are not at risk of harming themselves or others.¹⁷⁵ This legislative change occurred at the same time as

¹⁷³ For example, in Alberta, after the initial Review Panel hearing, the patients have rights, pursuant to section 39, for further hearings every six months; *Mental Health Act*, R.S.A. 2000 c M-13. Under section 37 of Nova Scotia's *Involuntary Treatment Act*, RSNS 2005 c 42, after the initial Review Panel hearing, patients have the right to further hearings after 60 days, six months, one year, 18 months, and 24 months.

¹⁷⁴ The *Mental Health Amendment Act*, 1998 Bill 22, RSBC, c 35 was proclaimed on July 30, 1998. The amendment widened the previous criteria under section 24, by permitting civil commitment of a patient to prevent mental or physical deterioration, regardless of whether the patient was a risk to him or herself or to others.

¹⁷⁵ Section 1 of the *Mental Health Act* states that:

1... "person with a mental disorder" means a person who has a disorder of the mind that requires treatment and seriously impairs the person's ability:

to react appropriately to the person's environment, or
associate with others.

After a physician concludes that a patient's condition meets the first criterion set out in section 1, Section 22 allows the physician to detain a patient for 48 hours at a hospital if the physician who completes Form 4 of the *Mental Health Act* confirms that three further criteria are satisfied. These three criteria are set out in section 22(3)(c), and require confirmation that the patient:

22(3)(c)

requires treatment in or through a designated facility;

the remarkable growth in psychiatric power and the sharp increase in the use of psychiatric medication, described in Section 1 of this chapter. Neurobiological forms of thinking shaped the law, which then in turn codified that thinking and reinforced it through regulations, directives and documentary forms used by psychiatrists, hospitals and law enforcement agencies.¹⁷⁶ A form of medico-legal discourse strongly oriented toward neurobiological psychiatry was thereby consolidated in the 1998 amendments to British Columbia's *Mental Health Act*.

The detailed operation of British Columbia's mental health law system is analyzed in much greater detail in subsequent chapters, particularly chapter 5, which examines whether the *Mental Health Act* contravenes the *Canadian Charter of Rights and Freedoms*¹⁷⁷ and the *United Nations Convention on the Rights of Persons with Disabilities*.¹⁷⁸ Suffice it to note in this chapter that the health law regime in this province is closely aligned with neurobiological psychiatry and therefore focused on imposing and enforcing drug-based treatment programs in hospitals and on patients who are on extended leave in the community. This model of psychiatric intervention is similar to that in other jurisdictions when mental hospitals were closed, but it is less constrained in British Columbia by legal regulations based on the discourse of human rights. As subsequent chapters demonstrate, since greater deference is accorded to psychiatrists in this province, there is less inclination

requires care, supervision and control through a designated facility to prevent the person's substantial mental or physical deterioration or for the protection of the person or patient or the protection of others; and cannot suitably be admitted as a voluntary patient [emphasis added].

¹⁷⁶ *Supra* note 4 at 66.

¹⁷⁷ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act, 1982* (UK), 1982, c 11 [*Charter*].

¹⁷⁸ *United Nations Convention on the Rights of Persons with Disabilities*, adopted 13 December 2006, GA Res 61/106, UN Doc A/Res/61/106 (entered into force 3 May 2008).

to question their judgment, for example, to monitor extended leave orders and determine whether a patient's ongoing psychiatric treatment is necessary or appropriate. This deference to psychiatric discretion has consequences for the construction of many social practices and therefore the formation of patients' identities, including the ease with which psychiatrists can certify patients for involuntary treatment with medications that have serious side effects that alter moods, cognition, and general metabolism.¹⁷⁹

2.2(B)(vi)(b) Neo-liberal Health Policies

Another important factor that influences the management of mental health issues in British Columbia is the government's movement toward more neo-liberal economic and social policies,¹⁸⁰ reflected in severe cutbacks in welfare, lack of funding for housing and treatment centres in the community, and reduction of financial support for patients' advocates to assist patients when they have been civilly committed.¹⁸¹ As in many other countries, the aspirations expressed in policy documents, such as *More for the Mind*, that promoted deinstitutionalization in the 1960s and promised care in community were never

¹⁷⁹ People who are the subject of civil commitment orders under British Columbia's *Mental Health Act* are by definition presumed to be patients who are incapable of managing their affairs by definition under s 1 of the *Patient Property Act* RSBC 1996 c 351 without regard to any assessment of mental capability. Similarly, by operation of s 11 of the *Representation Agreement Act*, RSBC 1996, c 405, people subject to civil commitment orders under the *Mental Health Act* are not given the right, accorded to all other capable adults in British Columbia, to have their wishes concerning health care legally respected under representation agreements that they signed. Again, these people lose this right by joint operation of the *Mental Health Act* and *Representation Agreement Act*, even if they in fact have the capacity to make treatment decisions for themselves according to the criteria set out in the *HCCA*. This negation of rights continues indefinitely for patients who are released from hospitals under extended leave certification orders; they are still civilly committed, even though they may live in the community for the rest of their lives.

¹⁸⁰ Marina Morrow, "Recovery: Progressive Paradigm or Neo-liberal Smokescreen" in Brenda LeFrancois, Robert Menzies & Geoffrey Reaume, eds, *Mad Matters: A Critical Reader in Canadian Mad Studies* (Toronto: Canadian Scholars' Press, 2013) at 223.

¹⁸¹ *Ibid* at 328. I am using the term "neo-liberal" to refer to "forms of political-economic governance premised on the extension of market relationships" in many areas of society. Wendy Larner, "Neo-liberalism, Policy, Ideology, Governmentality" (2000) 63 *Studies in Political Economy* at 5.

supported by adequate social resources for people released from hospitals.¹⁸² The lack of social support reflects many governments' commitment to neo-liberal policies reducing public funding for community resources while at the same time advancing policies that place increased responsibility on individuals for their own care.¹⁸³

The promotion of individual "responsibilization"¹⁸⁴ might appear to be in conflict with the assumption that psychiatric patients should remain on medication indefinitely under the supervision of physicians. However, this assumption is rooted in the notion that mental illness is a pathology that inheres in the individual alone, that it is not, at least in part, a product of an unsupportive social environment. It appears that the blanket assumption that medication should be the primary, and often exclusive, treatment for mental illness involves an implicit, related view that support in the social environment is not important.

This impoverished view of community creates numerous social problems. For example, in the past twenty years in British Columbia, the management of public perception of the risk associated with community presence of people thought to have mental illness has been increasingly delegated to the police, who are now the front-line mental health workers in our community.¹⁸⁵ In 2008, the Vancouver Police Department published a report on the

¹⁸² See, for example, Real Isaac & Virginia Armat, *Madness in the Street: How Psychiatry and Law Abandoned the Mentally Ill* (New York: Free Press, 1990).

¹⁸³ Morrow, *supra* note 170 at 329. See also Katherine Teghtsoonian, "Managing Workplace Depression: Contesting the Contours of Emerging Policy in the Workplace" in Pamela Moss & Katherine Teghtsoonian, *Contesting Illness: Processes and Practices* (Toronto: University of Toronto Press, 2008) 69-89.

¹⁸⁴ "Responsibilization" is a term coined by Nikolas Rose in his analysis of Foucault's concept of governmentality to describe the way that neo-liberal regimes govern at a distance by instilling a sense of individual responsibility on citizens to care for themselves. See Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton, Princeton University Press, 2007) at 4. I examine the concepts of responsibilization and governmentality in the next chapter.

¹⁸⁵ Fiona Wilson-Bates, *Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources* (Vancouver: Vancouver Police Department, 2008) at 29.

way that inadequate social support and resources for people regarded as being mentally ill leads to situations that involve expensive and time-consuming police intervention.¹⁸⁶ In British Columbia, the police are empowered under section 28 of the *Mental Health Act* to detain people suspected of having serious mental illnesses, not only when they engage in violent activity, but also when they are disturbing the peace by, for example, shouting obscenities in department stores.¹⁸⁷ Between 1999 and 2008, these types of “mental health arrests” increased 500% in Vancouver¹⁸⁸; between 2010 and 2012 they increased by 16%; and so far in 2013 there has been a 23% increase over 2012.¹⁸⁹ With limited housing and mental health resources, the police are increasingly inclined to incarcerate such people in jails or short-term detention facilities,¹⁹⁰ resulting in a criminalization of persons labelled as mentally ill.¹⁹¹

¹⁸⁶ *Ibid* at 1.

¹⁸⁷ Section 28 of the *Mental Health Act* provides as follows:

Emergency procedures

28(1) A police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person

- (a) is acting in a manner likely to endanger that person’s own safety or the safety of others, and
- (b) is apparently a person with a mental disorder.

(2) A person apprehended under subsection (1) must be released if a physician does not complete a medical certificate in accordance with section 22(3) and (4).

¹⁸⁸ *Ibid* at 29.

¹⁸⁹ Vancouver Police Department, *Vancouver’s Mental Health Crisis: An Update Report* (Vancouver: Vancouver Police Department, 2013) at 1.

¹⁹⁰ Wilson-Bates, *supra* note 175 at 31.

¹⁹¹ A Corrections Service Canada 2005 study reported that the percentage of the newly incarcerated Canadian prison population thought to suffer from mental illness almost doubled between 1998 and 2004. Online: CBC News <http://www.cbc.ca/Canada/story/205/11/04/mentalprisoners_051104.html>. Retrieved May 30, 2007.

2.2(B)(vi)(c) The British Columbia Government's 10-year Plan

In the Liberal government's 2010 report entitled *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia* (the "Report")¹⁹² the unnamed authors from the Ministry of Health Services note that in 2008/09 the province spent over \$1.3 billion in "services that directly addressed mental health and substance use."¹⁹³ The Report is a policy statement document that expresses a general vision of how the government will reduce costs of care while at the same time enhancing people's mental health. In order to achieve this vision the plan is to:

1. Improve the mental health and well-being of the population;
2. Improve the quality and accessibility of services for people with mental health and substance use problems; and
3. Reduce the economic costs to the public and private sectors resulting from mental health and substance use problems.¹⁹⁴

The report does not give specific details on how much money will be spent on mental health programs, such as early medical invention programs for young people who are thought to be mentally ill¹⁹⁵ or screening women "in the prenatal period for mental health and substance-use related risk factors and provide appropriate follow-up,"¹⁹⁶ and therefore it is unclear whether such programs will receive adequate funding. Although the Report confirms that housing is necessary for people thought to suffer from mental illness, there is no commitment in the Report for any increase in housing.¹⁹⁷ While the Report does

¹⁹² Ministry of Health Services/Ministry of Children and Family Development, *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia* (Victoria: Ministry of Health, 2010).

¹⁹³ *Ibid* at 1.

¹⁹⁴ *Ibid* at 40.

¹⁹⁵ *Ibid* at 6.

¹⁹⁶ *Ibid* at 14.

¹⁹⁷ *Ibid* at 34.

express laudable goals, such as to promote policies against the stigmatization of people labelled as mentally ill, its focus is on medical intervention to prevent people from burdening society when they enter into mental crisis. This is most clearly revealed in the Report as follows:

As the cornerstone of our health care system, family practitioners play a key role in the management of mental health and substance use problems in all communities, particularly those that are rural or remote. Family doctors are typically sought first as a source of help. Evidence demonstrates that having a family doctor reduces the unnecessary use of emergency services, including inpatient care.¹⁹⁸

Yet as studies cited in Section 1 of this chapter have shown, family doctors have increasingly prescribed anti-psychotic medication for children as the norm for early intervention into their lives.¹⁹⁹ To be sure, family doctors play an important role by frequently being the first professional that the family consults for health care issues. The problem is that the assistance that family doctors can provide is limited, particularly when patients are in financial crisis or do not have adequate housing. A treatment regime focused primarily on pharmaceutical intervention may divert attention from patient problems that arise from inadequate social support. Unfortunately, the cornerstone of the Report is an affirmation of the use of the biomedical model for the amelioration of social problems. Nowhere in the Report is there any reference to a commitment to increase funding for housing, to mental health law reform, or to policies that would provide more financial resources for patient advocates. In many ways the Report is an example of the

¹⁹⁸ *Ibid* at 26.

¹⁹⁹ Ronsley et al, *supra* note 32.

neo-liberal economic social policy with a strong focus on medical intervention that is historically characteristic of British Columbia's medico-legal culture.²⁰⁰

2.2(C) Summary of Section 2.2

The metaphor of the history of mental health law in past 200 years as a pendulum swinging between unfettered physician discretion and the stern guidance of the law may give the misleading impression that law and medicine are discrete institutional discourses, that they may overlap or that one dominates at times, but that they always can be analyzed separately. The argument I make in this dissertation, however, is that within the area of mental health law these discourses are inseparable, and that at any point in time it is best to regard the field as being shaped by a hybrid medico-legal discourse. British Columbia's history shows how a form of medico-legal discourse that emerged in this province since 1964 accords a particularly high level of authority to neurobiological psychiatry. The result is that the exercise of psychiatric discretion has taken priority over human rights related to patient autonomy and the right to consensual medical treatment. The medico-legal culture in this province has far-reaching consequences in influencing social policies and practices, with many serious implications for people subjected to psychiatric treatment.

²⁰⁰ Recent proposals to British Columbia's guardianship legislation also maintain deference to psychiatric labelling. In particular, the comprehensive proposals for amending guardianship legislation found in *Bill 29, The Adult Guardianship and Planning Statutes Amendment Act, 2007*, revokes the *Patient's Property Act*, as well as a number of sections of the *HCCA*, *Power of Attorney Act* and *Representation Agreement Act*. *Bill 29* also clarifies appointment procedures for guardians and substitute decision makers. However, *Bill 29* makes no reference to the *Mental Health Act* or any sections in any of the aforementioned legislation that negate the rights of people subject to civil commitment orders. *Bill 29* has not been proclaimed into law. Earlier proposals for comprehensive revisions to British Columbia's guardianship legislation were also abandoned. See Robert Gordon, "Out to Pasture: A Case for the Retirement of Canadian Mental Health Legislation" in Jill Peay, ed, *Seminal Issues in Mental Health Law* (Aldershot: Ashgate, 2005) at 37. In this paper Gordon discusses a working paper he co-authored with the Joint Working Committee on Adult Guardianship in 1992 commissioned by the Office of the Public Guardian and Trustee. The working paper, which recommended enhancing the rights of psychiatric patients in guardianship legislation, was shelved when British Columbia's *Mental Health Act* was amended to strengthen psychiatric discretion in the late 1990s.

2.3 Conclusion

This chapter has explored some of the consequences of the emergence of neurobiological psychiatry as an aspect of the medicalization of life based on what Foucault described as the proliferation of biopower. In particular this chapter has shown how a medication-centred treatment model based on neurobiological psychiatry has become aligned with, and reinforced by, mental health policies and legislative regimes. The history of medico-legal discourse in British Columbia shows that there is a strong tendency in this province to grant a high level of deference to psychiatric authority, mostly at the expense of patients' rights. The way in which people diagnosed as having mental illnesses are put on long-term extended leave medication treatment programs is an indication of the way that individual differences are ignored and presumptions are made concerning their levels of mental capacity and disability. As subsequent chapters in this dissertation demonstrate, the consequence of these practices is that people's identities are shaped in ways that are discriminatory and create both personal and social disadvantages. An examination of the networks of power that underlie these practices requires a theoretical perspective that is both empirically driven and involves a critical view of historical and political processes. This theoretical perspective is exemplified in Michel Foucault's philosophy, which is explored in the next two chapters and which provides the basis for critical discourse analysis of British Columbia's medico-legal discourse and recommendations to change the way our society treats people regarded as mentally ill.

Chapter 3 Foucault and Relational Agency

3.0 Introduction

Foucault's philosophy offers important insights into the operation of mental health law systems, particularly in the way they shape the identities of patients. Yet his view on how social forces construct human identity has been perceived as anti-humanist, as having erased the human subject from historical and social analysis.¹ Nevertheless, in the final ten years of his life, he developed a view of human agency that, at first sight, appears radically at odds with this perception. In exploring Foucault's views on human agency in this chapter, I first provide a brief outline of some of Foucault's early writings, much of which focused on the history of psychiatry and the social construction of madness and deviance. I then examine his theory of governmentality, particularly as it has been used to understand community psychiatry and deinstitutionalization. This is followed by an account of some of the most important features of Foucault's writing on human agency seen in his writing on governmentality, but more fully articulated in his work on the ethics of care of the self. Together these arguments demonstrate that Foucault developed a highly innovative vision of human agency, which provides productive ways of understanding a range of human experiences and social problems in modern society, especially those related to mental health laws as found in British Columbia.

¹ Richard Bernstein, "Foucault: Critique as a Philosophical Ethos" in Michael Kelly, ed, *Critique and Power: Recasting the Foucault/Habermas Debate* (Cambridge: MIT Press, 1998) at 211.

3.1 Power/knowledge and the Social Construction of Madness

3.1(A) Histories of Disciplinary and Normalizing Institutions

One of the central premises in Foucault's work is the inextricable relationship between knowledge and power.² According to Foucault: "Every point in the exercise of power is at the same time a site where knowledge is formed. And conversely, every piece of knowledge permits and assures the exercise of power. There is no opposition."³ In books such as *A History of Madness*,⁴ *Discipline and Punish*⁵ and *The History of Sexuality, Vol. I*⁶ Foucault provides historical accounts of the workings of regimes of power/knowledge in the social construction of madness, criminality and sexual identity, and the way that all of these constructions have a role in constituting, and in turn being reciprocally reconstituted by, normality and social order. On this account, normalization can be seen as having a pervasive effect of the operation of power/knowledge (referred to hereafter simply as "power") in social formations. Foucault maintains that the normalizing effects of power are seen even in the smallest details of the most private spheres of our lives. This has been found, for example, in European Christian societies in the way that people policed themselves and their sexual urges through confessional practices. According to Foucault, this self-scrutiny was extended from religious institutions and practices to our secular social world, resulting in, among other things, Western industrial society's obsession with

² Joseph Rouse, "Power/Knowledge" in Gary Gutting, ed, *The Cambridge Companion to Foucault* (Cambridge: Cambridge University Press, 2003) at 95.

³ Michel Foucault, "Power and Norm: Notes" in Michael Morris and Paul Patton, eds, *Power, Truth, Strategy* (Sydney: Fenal Publications, 1979) at 310.

⁴ Michel Foucault, *History of Madness*, translated by Jean Khalifa (Oxford: Routledge, 2006).

⁵ Michel Foucault, *Discipline and Punish: The Birth of the Prison*, translated by Alan Sheridan (New York: Vintage Books, 1979).

⁶ Michel Foucault, *The History of Sexuality*, translated by Robert Hurley (New York: Vintage Books, 1990).

sexuality as well as the experience of sexual pleasure.⁷ Foucault's work can be distinguished from other types of historical studies in which the authors suggest that certain historical developments are based on necessary and universal features of human nature, or arise from inevitable teleological processes. Instead, Foucault's historical studies show the contingency of current practices and beliefs. His genealogies of prisons,⁸ medical clinics and practices,⁹ and psychiatric hospitals¹⁰ are particularly useful for understanding the current state of mental health laws in the Western industrial world, including British Columbia.

One of Foucault's most controversial suggestions in his book *History of Madness* is that the nature of madness is not the same across all historical periods and cultures. He argues that the segregation of those regarded as deviant provided the opportunity for the development of myriad types of specialists whose practices actually contributed to the social processes that created both the identification and experience of madness within these historical and cultural contexts. Foucault provides an account of some of the most important historical events leading to the widespread institutionalization of the mad in Europe commencing in the seventeenth century.¹¹ According to Foucault, prior to the seventeenth century, those regarded as mad were included within medieval and renaissance societies' very conception of themselves; the mad were often considered a source of inspiration, pointing to a type of wisdom in unreason. Although there were many reasons for the

⁷ *Ibid* at 58.

⁸ *Supra* note 5.

⁹ Michel Foucault, *The Birth of the Clinic*, translated by A.M. Sheridan Smith (New York: Vintage Books, 1994) at 38.

¹⁰ Foucault, "Discipline and Punish", *supra* note 5.

¹¹ Gary Gutting, "Foucault and the History of Madness" in Gary Gutting, ed, *The Cambridge Companion to Foucault* (Cambridge: Cambridge University Press, 2003) at 49.

changing attitudes toward those labelled mad, new forms of social organization of work and the stigmatization of idleness were among the most important influences on policies designed to segregate and isolate these people.¹²

3.1(B) Panopticism

In *Discipline and Punish* and *The Birth of the Clinic*,¹³ Foucault showed that, as a result of the apparatuses of disciplinary organizations found in Enlightenment educational systems and the increasing specialization of the medical profession, those who were labelled mad were separated from those regarded as criminal. Both groups of people were collected into immense penitentiaries characterized by highly regimented organization. Within the institutions the inmates were subjected to total forms of technical, “panoptic” social control, simultaneously permitting complete visibility of the subjects of discipline, while at the same time ensuring invisibility for the authorities doing the surveillance. As a form of social control, surveillance emerged after a medical discourse of normalization gained dominance over a juridical discourse related to a hierarchical ordering of society.¹⁴ This juridical discourse relied heavily on retributive forms of maintaining social order, illustrated in public displays of execution or torture.¹⁵

The disciplines associated with panopticism not only aimed for strict control of bodies, but also, more importantly, for disciplined minds resulting from the internalization of social norms. The technical apparatuses in prison settings involved strict strategies of spatial

¹² Foucault, “Discipline and Punish”, *supra* note 5 at 55; see also Roy Porter, *The Social History of Madness: Stories of the Insane* (London: Weidenfeld & Nicolson, 1987) at 17.

¹³ Foucault, “Birth of the Clinic”, *supra* note 9.

¹⁴ Foucault, “Discipline and Punish”, *supra* note 9 at 145.

¹⁵ *Ibid* at 73.

control in forms of segregation, as well as temporal ordering which, among other things, measured punishment in terms of sentences. It is important to stress, however, that Foucault never conceived of this internalization as a deterministic construction of the individual. Psychological resistance is always possible, but, as discussed later in this chapter, Foucault does not elaborate on this aspect of human agency until the final phases of his career.

3.1(C) Normalization

In the asylums that appeared in the nineteenth century, there was almost total control of every aspect of the subjects' lives. Yet by depriving people of agency and membership in a community, the asylums seemed to create, or at least reinforce, the very behaviours they were supposed to eliminate.¹⁶ Although processes of internalizing norms had, of course, occurred in other historical periods, beginning in the eighteenth century scholars' explanations of these psychological processes reflected the influence of medical and social scientific discourses.¹⁷ According to Foucault, the professional expertise and micro-powers created by spatial control through segregation caused a widespread expansion of a similar form of normalizing discipline into the community. As such, panopticism became a pervasive form of social control, creating the possibility for new forms of "normal" identities as well as "deviant" identities outside asylums.¹⁸ Other Foucauldian scholars who have studied the late nineteenth-century and early twentieth-century eugenics movements have noted that the technologies and expertise that created and identified new

¹⁶ Andrew Scull, *Decarceration: Community Treatment and the Deviant* (Cambridge: Polity Press, 1984) at 7.

¹⁷ Roy Porter, *The Social History of Madness: Stories of the Insane* (London: Weidenfeld & Nicolson, 1987) at 19.

¹⁸ Michel Foucault, *Discipline and Punish*, *supra* note 5 at 195.

forms of abnormality also created obsessions with cleanliness, tidiness and the desire to attain perfect bodies among members of the so-called normal population.¹⁹ This resulted in an increase in social segregation between populations that were regarded as deviant and those that were regarded as non-deviant.²⁰

As Foucault's historical description of the asylum illustrates, the asylum was simultaneously a site of institutional power and a site for the creation of expert knowledge, contributing to the enhanced exercise of biopower and the normalization of human bodies and minds. Indeed, much of the taxonomy and diagnostic criteria for understanding mental illness arose from psychiatric research conducted in asylums.²¹ As a result, "a whole army of wardens, doctors, specialists and criminologists appeared to appropriate functional-analytic spaces and allocate treatment of subjects within that space."²² Despite the recognized limitations of asylums and penitentiaries,²³ these institutions were increasingly used to segregate the growing number of persons who were labelled deviant, as illustrated by the statistical data from England and British Columbia set out earlier in the historical account in Chapter 2 of this dissertation.

3.2 The Problem of Agency and the Nature of Governmentality

3.2(A) The Problem of Agency

This brief account of Foucault's early work shows that he provides a compelling way to understand disciplinary practices and normalization resulting from the operation of power

¹⁹ Sharon Snyder & David Mitchell, *Cultural Locations of Disability* (Chicago: University of Chicago Press, 2006) at 100.

²⁰ *Ibid.*

²¹ Michel Foucault, "Power and Norm: Notes", *supra* note 3 at 233.

²² Scull, *supra* note 17 at 213.

²³ Porter, *supra* note 16 at 20.

in highly coercive institutional settings. Yet, particularly in works such as *Discipline and Punish*, it is difficult to see any clear distinction between power and coercive physical force, which leaves the impression that power is primarily repressive. As such, Foucault's early works appear to leave little room for any cogent or useful conception of human agency. Indeed, at the end of his career he acknowledged that in his early writing he had "conceived the relationship between the subject and games of truth in terms either of coercive practices – such as those of psychiatry and the prison system – or of theoretical or scientific games – such as the analysis of wealth, of language and of living beings."²⁴

In addressing concerns regarding the relationship between power and freedom in a later phase of his career, Foucault revised his thinking about the working of power and showed how power can both create subjects and also facilitate freedom through human agency.²⁵ His thinking during this phase of his career involved two modifications: the first was his concept of governmentality and the second was a theory of ethics, which he initially described in his essays entitled "Governmentality"²⁶ and "The Subject and Power."²⁷ Both of these works mark a shift away from thinking of power in terms of force, violence, domination, and coercion. Instead, power was conceptualized in terms of "relations of governance," in which focus is placed on governance of self by others and governance of self by oneself. This provided the framework for Foucault's interconnected conceptions of

²⁴ Michel Foucault, "The Ethics of the Concern for Self as a Practice of Freedom" in Robert Hurley, ed, *Ethics, Subjectivity and Truth* (New York: New Press, 1997) at 281.

²⁵ James Tully, Coursepack: *The Question of the Subject in the Later Foucault* (Faculty of Law, University of Victoria, 2008) at 7.

²⁶ Michel Foucault, "Governmentality" in *Ideology & Consciousness*, 6 (1979), translated by Rosi Braidotti. Reprinted in Graham Burchell, Colin Gordon & Peter Miller, eds, *The Foucault Effect* (Chicago: University of Chicago, 1991) at 88.

²⁷ Michel Foucault, "The Subject and Power", translated by Robert Hurley and others, in James D. Faubion, ed, *The Essential Works of Michel Foucault 1954-1984: Volume 3: Power* (New York: New York Press, 1994) at 326.

governmentality and care of the self. Together they provide the foundation for a complex conception of relational agency, as well as a way of understanding the relationship between questions of politics and questions of ethics. Each of the interconnected poles of the governance by others, described as “governmentality”, and the ethical governance of oneself is examined in turn.

3.2(B) The Nature of Governmentality

3.2(B)(i) The Conduct of Conduct

Beginning in the late 1970s Foucault directed an increasing amount of his attention to the networks of power/knowledge found in advanced liberal societies, which use a model of market deregulation to shape economic and social policies.²⁸ This context framed Foucault’s development of his theory of governmentality, which he defines as follows:

The ensemble formed by institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, its principal form of knowledge political economy and its essential technical means apparatuses of security.²⁹

In broad terms, the theory of governmentality shifts the focus from the state, conceived as a central locus of control, and instead examines networks of power in micro-settings in communities.³⁰ Governmentality is concerned primarily with government as a de-centred process of governance and focuses on the “conduct of conduct.”³¹ Governments, therefore, are analyzed not in terms of political philosophies, but rather on the basis of their

²⁸ Foucault, “Governmentality”, *supra* note 26.

²⁹ *Ibid* at 88.

³⁰ Nikolas Rose, “Psychiatry as a Political Science: Advanced Liberalism and the Administration of Risk” in *History of the Human Sciences, Vol 9(2)* (London: Sage, 1996) at 1.

³¹ Charles Gordon, “Government Rationality: An Introduction” in Graham Burchell, Colin Gordon & Peter Miller, eds, *The Foucault Effect* (Chicago: University of Chicago, 1991) at 48.

programmatic form that structures relations of power. Applying this to an examination of advanced liberal societies, a governmentality analysis examines how this form of government rationality crystallizes into tactics, technologies, programs, and strategies for enforcing regulatory programs.³²

3.2(B)(ii) Governmentality and Resistance

When thinking about Foucault's theories of governmentality, it is important to note that the implementation of this rationality through programs and technologies,³³ such as legal forms, institutions, and agencies, has the consequence of shaping subjectivities that the political rationalities can then work through to enforce regulations.³⁴ Normalization continues to occur, but less from panoptic forms of social control and more through dispersed systems of monitoring, conducted at a distance. This type of analysis allows a view of the extent to which advanced liberal societies extend acts of normalization that produce normal subjects by acting through subjects who conceive of themselves as free, responsible and autonomous agents. It would be a mistake, however, to conclude that these governing technologies and programs wholly determine personal identity. While much of Foucault's attention was focused on processes of power involved in the social construction of personal identity, he believed that resistance to discourses of power is always possible and is, in fact, an inescapable aspect of these processes. He emphasized that:

³² *Ibid* at 3.

³³ "Technology, here, refers to any assembly structured by a practical rationality governed by a more or less conscious goal...hybrid assemblages of knowledges, instruments, persons, systems of judgment, buildings and spaces underpinned at the programmatic level by certain presuppositions and assumptions about human beings." Nikolas Rose, *The Politics of Life Itself* (Princeton: Princeton University Press, 2007) at 16-17.

³⁴ This is seen in the way that health regulations, programs and institutions affect people's lives and identities or even in the way that tax policies and consumer laws create or curtail opportunities and shape the lives of people, who may conceive of themselves as free agents in a market economy. Nikolas Rose, *Inventing Our Selves: Psychology, Power and Personhood* (Cambridge: Cambridge University Press, 1998) at 150.

these relations of power are then changeable, reversible and unstable. One must observe also that there cannot be relations of power unless the subjects are free. If one or the other were completely at the disposal of the other and became his thing, an object on which he can exercise an infinite and unlimited violence, there would not be relations of power. In order to exercise a relation of power, there must be on both sides at least a certain amount of liberty...That means that in the relations of power, there is necessarily the possibility of resistance, for if there were no possibility of resistance – of violent resistance, of escape, of ruse, of strategies that reverse the situation – there would be no relations of power.³⁵

Foucault therefore distinguished power, which presumes free subjects capable of resistance, from domination, which occurs when the relations of power become frozen and invariable through extremely coercive practices, found in institutions such as the military, the prison or the asylum. In these types of static situations, the dynamic process of power/knowledge and its liberating potential is suspended.³⁶

3.3 Governmentality and Psychiatric Deinstitutionalization

3.3(A) Governance at a Distance

Foucault's theories of governmentality can, of course, be applied retroactively to his earlier work on asylums and prisons; it was not intended to apply only to advanced liberal societies. But it is particularly effective in revealing the workings of power in less centrally regulated societies associated with a free-market rationality. Governmentality analysis, for example, has been applied effectively to a number of areas, including welfare, unemployment, law, and the institutions associated with and shaped by medicine.³⁷

Advanced liberal government strategies for governing subjects include at least three

³⁵ Michel Foucault, *Politics, Philosophy, Culture: Interviews and Other Writings, 1977-84*, ed by Lorne Kritzman (New York: Routledge, 1989) at 332.

³⁶ Michel Foucault, "The Ethics of the Concern for Self as a Practice of Freedom", translated by Robert Hurley, *Ethics, Subjectivity and Truth* (New York: New Press, 1997) at 285.

³⁷ Thomas Lemke, "'The Birth of Bio-politics': Michel Foucault's Lecture at the College de France on Neo-liberal Governmentality" (2001) 2 *Economy and Society* at 190.

important elements.³⁸ The first is an extension of market rationalities, conceived in terms of contracts, consumers, and competition, to areas hitherto dominated by other forms of rationality such as bureaucratic or professional logic. The second is a process of governing at a distance by setting up agencies such as welfare professionals or educational institutions that do not constantly receive directives from a central government authority, but rather are shaped at a distance because they are constrained by programs that involve budget targets, audits, professional codes, and the logic of consumer demand. The third strategy involves generating a sense of responsibility within communities and individuals for their own welfare.³⁹ As these forms of government rationality are deployed, many new types of professionals and experts arise who assist in the functioning of individuals and communities who are being governed at a distance.

In Foucault's definition of governmentality, quoted above, he stresses that security and the minimization of risk that arises from social behaviour that is not under constant surveillance is the primary purpose of government regulation. Thus, risk management becomes one of the central concerns related to security, around which these programs are developed.⁴⁰ This is reflected in the proliferation of technologies of insurance as well as the development of complex systems of laws related to liabilities for failure to control risk. In this social environment, people increasingly think of themselves and others in terms of personal responsibility and autonomy, a process that Nikolas Rose calls "autonomization"

³⁸ Rose, *supra* note 30 at 23.

³⁹ *Ibid.*

⁴⁰ *Ibid* at 12.

and “responsibilization”.⁴¹ These ways of managing risk and security have had a significant role in shaping the forms of deinstitutionalization and the community treatment of those diagnosed as having mental illnesses.

3.3(B) Deinstitutionalization

It is important to stress, however, that while governmentality research allows certain generalizations about global social trends in advanced liberal societies, focus must be placed on local settings, such as British Columbia, to see the actual workings of power and resistance. As I described in Chapter 2, rates and patterns of deinstitutionalization in Western industrial countries are different depending on configurations of power and knowledge in specific communities. What these trends demonstrate in countries such as Canada is that patients are receiving much more frequent short-term treatment in localized community settings and de-centralized agencies.

The dismantling of the asylum and the de-centring of the institutional management of psychiatric subjects has had a number of consequences for psychiatry itself. Whereas psychiatry as practised in the asylum was primarily concerned with confinement, the new project for psychiatry in the community after asylums closed became the non-custodial management of risk and protection of the public, a process that includes the maintenance of patient competency through the use of medications and the administrative process of directing persons to various other professionals and agencies in the community for further management.⁴² Nevertheless, there are important implications for the social construction of

⁴¹ Nikolas Rose, *Governing the Soul: The Shaping of the Private Self* (London: Free Association Press, 1999) at xxii.

⁴² Nikolas Rose, “Psychiatry as Political Science: Advanced Liberalism and the Administration of Risk”, *supra* note 30 at 29.

identity for persons who are released from conditions of near total domination of asylums and exposed to other types of conditions in the community. As Nikolas Rose has observed:

The asylum conferred a certain unity upon the subjects of psychiatry and upon the project to underpin that institutional and moral unity with a unified system of knowledge...However, the very uncertainty and contestability of knowledge which community psychiatry embodies and intensifies is not wholly without progressive possibilities. For if all others can claim their portion of expertise, so, perhaps, can those who have for so long been denied the voice of the system which governs them: the subjects of psychiatry itself.⁴³

Rose suggests that subjects constructed by power/knowledge networks and the processes of governmentality in advanced liberal societies have new opportunities to exercise resistance, which were much less accessible in the total institution of the asylum. The very existence of new forms of resistance will in turn shape the institutions, professional identities and laws that emerge to deal with new types of persons, assumptions about new forms of pathology, and assertions of new types of rights.

Laws, of course, change and adapt to new social trends. In particular, mental health legislation, which empowers the police, physicians and hospital administrators to detain and involuntarily treat people thought to be mentally ill, has become an increasingly potent instrument in the assertion of power in advanced liberal societies. This legislation, with its numerous documentary forms, regulations and protocols, is an integral part of community mental health care. Since mental health legislation differs so markedly between jurisdictions, even within the common law world, it is important to examine the nature of the laws in each jurisdiction and, just as important, how these laws have been implemented and institutionalized. These laws also provide opportunities for patients to resist and

⁴³ *Ibid.*

challenge treatment orders and have them reviewed by specialized administrative tribunals constituted under mental health statutes, such as section 25 of British Columbia's *Mental Health Act*.

But even if we assume that there are these new opportunities for resistance, it may be difficult to see *how* this resistance operates, whether there is a place for free reflection and thought, or indeed for any meaningful sense of freedom at all. It might still appear that subjects are largely constructed by pervasive social forces and that normalization is so effective because it operates through subjects who erroneously imagine that they are free. Foucault addresses these concerns in his writings on ethics and relational agency, which occupied his attention in the final five years of his life.

3.4 Relational Agency, Ethics and Politics

3.4(A) Agency and Resistance

In *The Subject and Power*, Foucault more clearly articulates a theory of agency within the context of governmentality and explored it further in works such as *The Hermeneutics of the Subject*, in which he states:

If we understand by governmentality a strategic field of power relationships in their mobility, transformability and reversibility, then I do not think that reflection on this notion of governmentality can avoid passing through, theoretically and practically, the element of a subject defined by the relationship of the self to the self. Although the theory of the political power as an institution usually refers to a juridical conception of the subject of rights, it seems to me that the analysis of governmentality – that is to say, of power as a set of reversible relationships – must refer to an ethics of the subject defined by a relationship of the self to the self. Quite simply, this means that in the type of analysis I have been trying to advance for some time you can see that power relations, governmentality, the government of the self and of others, and the relationship of the self to the self, constitute a chain, a thread and I think it is around these notions

that we should be able to connect together the question of politics and the question of ethics.⁴⁴

It was within his examinations of the relationship of the self to the self that Foucault more fully articulates the conception of the human agent as a subject capable of resistance and freedom. Of course, in adopting a view that human agents have a capacity for freedom, Foucault was not abandoning his theory that social practices have normalizing force and are enormously influential in constructing the subject. Rather Foucault sees freedom arising from the capacity for resistance, which is more than simply brute opposition to normalizing forces. Resistance is related to two features of an agent's existence in the world. The first is the indeterminacy of the power relations that bear on each person, the gaps and uncertainties in the nexus of power/knowledge, which provide opportunities for novel forms of opposition.⁴⁵ These observations about the opportunities for resistance in the spaces afforded in the governance by others are not new or particularly novel. This type of resistance has been one of the most intensely studied subjects in sociology, political theory, and cultural anthropology for many years.⁴⁶

3.4(B) Agency and Reflective Thinking

The second, more innovative step that Foucault took to develop his account of resistance was to articulate a theory of agency in which the opportunity for freedom arises from the capacity for reflective thought within contexts of power and resistance. This is not a

⁴⁴ Michel Foucault, *The Hermeneutics of the Subject*, translated by Graham Burchell (New York: Palgrave MacMillan, 2005) at 252.

⁴⁵ Judith Butler, "For a Careful Reading" in Judith Butler & Nancy Fraser, eds, *Feminist Contentions* (New York: Routledge, 1995) 127 at 135.

⁴⁶ See e.g., James Scott, *Domination and the Arts of Resistance: Hidden Transcripts* (London: Yale University Press, 1990); Susan Seymour, "Resistance" (2006) 6 *Anthropological Theory* 303; Maureen Mahoney and Barbara Yngvesson, "The Construction of Subjectivity and the Paradox of Resistance: Reintegrating Feminist Anthropology and Psychology" 18 *Journal of Women in Culture and Society* at 44.

representational theory of mental activity in which the mind is viewed as an internal theatre for the depiction of private pictures of the world. Instead, thought is conceived in terms of “games of truth,” in which truth claims are justified through negotiated manoeuvres mediated through contested social practices.⁴⁷ As a number of philosophers have noted, Foucault’s theory of human activity is consistent with the philosophy of the later Wittgenstein, who repudiated his earlier “picture” theory of language and asserted that knowledge claims are grounded in social linguistic practices he called “language games.”⁴⁸ According to Wittgenstein the very idea of a private language is incoherent because any intelligible reference to inner thoughts and experiences requires criteria rooted in social and cultural practices.

Similarly, Foucault avoided metaphors suggesting inward gazing when describing thought and instead referred to it as an activity of care for the self. The self is not a substance or an interior space, but rather a form of relationship of self to self and self to other. Subject positions and speech acts are negotiated along three axes by agents who are embodied and socially situated:

In this sense, thought is understood as the very form of action - as action insofar as it implies the play of true and false, the acceptance or refusal of rules, the relation to oneself and others. The study of forms of experience

⁴⁷ This is similar to the pragmatic theory of truth as warranted assertability. On this view the truth of a proposition is established, not by its reference to an external object, but by the *justifications* we give for the belief in the proposition. These justifications are negotiated linguistic social exchanges or language games. For example, although we might assume that the truth of the theory of gravity is conclusively established by observations of objects falling to the ground, these beliefs are part of a network of countless other beliefs and assumptions that we assume are justified. As Richard Rorty states, “We do not have any way to establish the truth of a belief or the rightness of an action except by reference to the justifications we offer for thinking what we think or doing what we do. The philosophical distinction between justification and truth seems not to have practical consequences.” Richard Rorty & Pascal Engel, *What’s the Use of Truth* (New York: Columbia University Press, 2007) at 44.

⁴⁸ Cressida Heyes, *Self Transformations: Foucault, Ethics and Normalized Bodies* (New York: Oxford University Press, 2007) at 14.

can thus proceed from an analysis of “practices” – discursive or not – as long as one qualifies that word to mean the different systems of action insofar as they are inhabited by thought as I have characterized it here...⁴⁹

Even when it might appear that our thoughts are completely private, or radically novel, this thinking is always relational and arises from recognizing possibilities within shared social practices that are, in turn, always situated within particular historical and cultural contexts. Foucault insisted that “one has to get rid of the constituent subject, to get rid of the subject itself, to arrive at an analysis which can account for the constitution of the subject within a historical framework.”⁵⁰

3.4(C) Agency and Care of the Self

Foucault believed that he found a historical precedent for this conception of care of the self in certain pre-Christian ethical practices within Stoic philosophy.⁵¹ He contrasted these ethical practices with the confessional practices that emerged out of early Christianity, which involved the idea of bringing oneself into harmony with an inner truth, an essential self. Early Christian philosophers held that this internal alignment was effected by a hermeneutics of the subject, which involved following rules to introspectively monitor one’s relationship to a true self.⁵² This picture of the human agent has been reiterated throughout Western thought since that time and is seen, for example, in Cartesian

⁴⁹ Michel Foucault, “Preface to the History of Sexuality” translated by Robert Hurley in Paul Rabinow, ed, *Ethics: Subjectivity and Truth* (New York: Routledge, 1994) at 201.

⁵⁰ Michel Foucault, *The Foucault Reader*, ed by Paul Rabinow (Harmondsworth: Penguin, 1989) at 59.

⁵¹ Michel Foucault, *Ethics, Truth and Subjectivity*, *supra* note 24.

⁵² In Chapter 8 I show how a hermeneutics of the subject is found in modern psychiatric thinking and lurks beneath most contemporary mental health law in its search for natural kinds of mental disease entities, as well as in assumptions about whether patients have “insight” into their condition.

philosophy and Freudian psychoanalysis.⁵³ Confessional technologies for internal transformation, in conjunction with the disciplinary technologies of normalization, have created a view of human nature in which freedom is thought to result from aligning oneself with one's "authentic" inner nature, often with the assistance of professionals specializing in psychological growth. Foucault, however, rejected the notion that there is a "truth" about oneself that can be discovered, a notion seen in what he described as the "California cult of the self":

In the California cult of the self, one is supposed to discover one's true self, to separate it from that which might obscure or alienate it, to decipher its truth thanks to the psychological or psychoanalytic science, which is supposed to be able to tell you what your true self is. Therefore, not only do I not identify this ancient culture of the self with what you might call the California culture of the self, I think they are diametrically opposed.⁵⁴

A criticism that may be levelled at Foucault is that his theory of care of the self, which is also described as an "aesthetics of the self", is elitist, a type of dandyism,⁵⁵ relevant for aristocratic Roman philosophers or Parisian intellectuals but hardly helpful for understanding the daily lives and struggles of common people. Moreover, the type of reflective thinking that Foucault called "problematization", that is the questioning of received norms and disclosing that they are not universal necessities, might appear to

⁵³ Carl Elliot, "Does Your Patient Have a Beetle in His Box? Language Games and Psychopathology" in Cressida Heyes, ed, *The Grammar of Politics: Wittgenstein and Political Philosophy* (Ithaca: Cornell University Press, 2003) at 189.

⁵⁴ Michel Foucault, "On the Genealogy of Ethics: An Overview of Work in Progress" in Hubert Dreyfus & Paul Rabinow, eds, *Michel Foucault: Beyond Structuralism and Hermeneutics* (Chicago: University of Chicago Press, 1983) at 245.

⁵⁵ Pierre Hadot, "Reflections on the Notion of the 'Cultivation of the Self'" in Timothy J. Armstrong, ed, *Michel Foucault: Philosopher: Essays Translated from the French and German* (New York: Routledge, 1992) at 230.

require a level of critical thinking that is beyond many people's capabilities.⁵⁶ Bear in mind, however, that reflective thinking, problematization and resistance are not activities that only trained philosophers or intellectuals are capable of engaging in. All human agents engage in these forms of thinking all the time, but with greater or lesser degrees of sophistication.

3.4(D) Relational Agency and Autonomy

Other critics have argued that Foucault's theory of the human agent, capable of freedom arising from reflective thinking, is evidence that he lapsed into liberal political thinking before he died and that his view of the agent harbours a conception of a type of Kantian transcendental subject.⁵⁷ This is certainly not anything like Foucault's conception of human agents who can never stand outside of social contexts or be capable of exercising their wills in isolation from all public norms. Power, conceived as the "conduct of conduct," pervades even our most private moments, always shaping possible actions. Moreover, Foucault's conception of freedom does not involve the creation of a "free zone" in which one has escaped from the power of others. Rather this is a relational conception of human autonomy.

While some scholars have suggested that the language of autonomy, with its historical roots in liberalism, has no place in Foucauldian theory,⁵⁸ others have argued that, provided

⁵⁶ Michel Foucault, *The Use of Pleasure: The History of Sexuality, Volume 2*, translated by Robert Hurley (New York: Vintage Books, 1985) at 11.

⁵⁷ Eric Para, *Foucault 2.0: Beyond Power and Knowledge* (New York: Other Press, 2006) at 146.

⁵⁸ Mark Bevir, "Foucault and Critique: Deploying Agency against Autonomy" (1999) 27 *Political Theory* at 65.

our concept of agency is understood relationally, then so too can references to autonomy.⁵⁹ In this view, the right to make decisions for oneself, to have others respect the choices one makes about one's body and the course of one's life, and to criticize existing regimes of truth is, in our culture, tied very closely to how we conceive of human agency and autonomy. According to those who promote the latter view, these rights and values need not be abandoned when we adopt a relational view of agency, provided we recognize that choices related to individual self-determination are made by embodied agents engaged, in the deepest levels of their thinking, in relational social practices.⁶⁰

3.4(E) Relational Agency, Ethics and Politics

For Foucault, freedom is an ontological condition for ethics, but it is not an ethics grounded in a conception of a universal, essential, or transcendental subject. Ethical self-reflection involves exercising power over oneself, while always remaining in a field of social power and resistance. As Paul Patton has observed, “the ‘work of freedom’ may be regarded as a process of cultural self-creation, one which seeks to expand the space of possibilities for personal identity”.⁶¹ This work of freedom is simultaneously a personal and cultural endeavour and therefore necessarily is a political project, a view developed in the work of David Owen, who argues that:

⁵⁹ See David Owen, “Genealogy as Exemplary Critique: Reflections on Foucault and the Imagination of the Political” (1995) 24 *Economy and Society* at 497. See also Paul Patton, “Foucault, Critique and Rights” (2005) 6 *Critical Horizons* at 284.

⁶⁰ One of the most fully developed articulations of this view in relation to law is found in the work of Jennifer Nedelsky. See Jennifer Nedelsky, *Laws Relations: A Relational Theory of Self, Autonomy, and Law* (Oxford: Oxford University Press, 2011). For an account of recent developments in relational theory in sociology see Pierpaolo Donati, *Relational Sociology: A New Paradigm for the Social Sciences* (London: Routledge, 2011).

⁶¹ Paul Patton, “Taylor and Foucault on Power and Freedom” 37 *Political Studies* (1989) at 266.

by locating our activity of self-overcoming within historically contingent relations of intersubjectivity, Foucault may be read as claiming that our becoming-in-the-world is always already a becoming-with-others. The significance of the intersubjective situatedness of our ascetic/aesthetic labour is just that this activity aims beyond itself to the production of a certain kind of being – the self as a work of art – so too it aims beyond itself to the production of relations of intersubjectivity which foster this mode of being. *Ethics is always already politics.*⁶²

As this quotation highlights, reflection on the self in ethical self-scrutiny is always a critical reflection on social and political norms that, in part, produced that self. Foucault does speak about the *truth* of that self and the world it inhabits, but, again, not as an eternal or transcendental truth. Instead, Foucault analyzes the notion of truth in terms of truthful speech activities.⁶³ He states, for example, that “one of the main moral obligations for any subject is to know oneself, to tell the truth about oneself, and to constitute oneself as an object of knowledge both for other people and oneself.”⁶⁴ The central importance of truthful speech in the care of the self was the subject of the final phase of Foucault’s career when he devoted a number of lectures on the topic of a form of truthful speech that the ancient Greeks called *parrhesia*, which is explored in detail in the next chapter.

3.5 Conclusion

Foucault’s writings on governmentality, relational agency and ethics provide productive ways of understanding social institutions, normalization, and social conflict in modern Western industrial society. His writings offer insight into the normalizing operation of medical, legal, and psychiatric discourses by showing how power is channelled through

⁶² David Owen, “Genealogy as Exemplary Critique: Reflections on Foucault and the Imagination of the Political” (1995) 24 *Economy and Society* at 497 [emphasis added].

⁶³ Michel Foucault, *The Courage of Truth: The Government of Self and Others II, Lectures at the College De France 1983-1984*, translated by Graham Burchell (New York: Palgrave Macmillan, 2011) at 3.

⁶⁴ Michel Foucault, “Subjectivity and Truth” in *The Politics of Truth*, translated by Lysa Hochroth & Catherine Porter (Los Angeles: Semiotexte, 2007) at 151.

institutions shaped by technologies of governmentality. As such, Foucault's writing offers opportunities for critical perspectives on deinstitutionalization and the emergence of medico-legal institutions for the psychiatric treatment of patients living in the community in advanced liberal Western industrial societies. Although these institutions have a powerful effect on shaping personality, they do not deterministically construct human beings. Rather, people are capable of resisting the influences of these institutions, thereby transforming them. Resistance and autonomy, conceived relationally, are always self-reflective, as well as a form of participation in collective political and cultural endeavours. In the next chapter I examine Foucault's thoughts on human rights and the question of whether his conception of relational agency, genealogical critique and *parrhesia* provide a consistent normative framework for understanding those rights, particularly the rights of patients who resist psychiatric treatment.

Chapter 4 Human Rights, Genealogical Critique and *Parrhesia*

4.0 Introduction

Although Foucault was critical of traditional rights discourse that arose from historical legal formations,¹ in the last phase of his career he wrote a number of papers that appear to strongly promote the advancement of human rights.² This chapter is an examination of Foucault's ideas on rights and whether these ideas are consistent with his work on governmentality, relational agency, genealogical critique, and *parrhesia*. This chapter demonstrates that Foucault's philosophy not only provides ideas for understanding the operation of mental health law systems, but also offers a basis for normative critiques of these systems arising from a conception of relational rights, as well as a way to make recommendations for changing them.

In exploring these issues, I first outline Foucault's thoughts on the purpose of genealogical critique and the way he used it to disclose the historical contingency and arbitrary forms of thought we commonly assume are necessary and universal. I then describe Foucault's use of genealogical critique to explore notions of juridical authority that were historically rooted in the assumption that power emanated from forms of social organization associated with sovereign royalty. This is followed by my examination of how, despite the

¹ See, for example, Michel Foucault, "Society Must be Defended" in Paul Rabinow, ed, *Essential Works of Foucault 1954-1984, Vol. 1, Ethics* (New York: The New York Press, 1997) at 59.

² See, for example, Michel Foucault, "The Risks of Security" translated by Robert Hurley and others in James D. Faubion, ed, *The Essential Works of Foucault, 1954-1984, Volume 3, Power* (New York: The New Press, 1994) at 365; Michel Foucault, "Confronting Governments: Human Rights" translated by Robert Hurley and others in James D. Faubion, ed, *The Essential Works of Michel Foucault 1954-1984, Volume 3* (New York: New York Press, 1994) at 474. Also see Ben Golder, "Foucault's Critical (Yet Ambivalent) Affirmation: Three Figures of Rights" 20 (2011) *Social and Legal Studies* 283-312.

persistence of juridical conceptions of authority, normalizing disciplines have changed the way that the law and governments have operated in the past two hundred years. Next, I provide an account of Foucault's vision of human rights, which rejects theories of rights associated with juridical conceptions of authority and agency and instead is based on a conception of human freedom consistent with the view that our thinking and forms of conduct arise from historical and cultural forces. In the final section of this chapter I describe Foucault's concept of *parrhesia*, the origins of which he found in ancient Greek texts, but which he modified as a way of understanding forms of self-formation arising from ways people put themselves at risk through confrontational truth-telling. This chapter demonstrates that genealogical critique and *parrhesia* are consistent with, and in fact exemplary of, the type of freedom that is the basis of Foucault's normative vision and his advocacy of human rights.

4.1 The Nature of Genealogical Critique: Foucault contra Kant

Although I explored some of Foucault's studies that employed genealogical critique in the last chapter, it is worth taking a closer look at his thoughts on the nature of this form of critique. Doing so will assist in setting the stage for Foucault's ideas concerning human rights and the normative dimension of his vision of human freedom. Some of Foucault's most important comments on genealogical critique are found in his essay "What is Enlightenment?" in which he discussed Kant's essay of the same title, published in 1784.³ Kant states that the purpose of critical examination of current forms of thinking was to determine the universal forms of all possible human thought and moral action. In contrast,

³ Michel Foucault, "What is Enlightenment?" translated by Robert Hurley and others in Paul Rabinow, ed, *Essential Works of Foucault 1954-1984, Vol. 1, Ethics* (New York: New York Press, 1997) at 303.

Foucault advances a form of critique that problematizes what we take to be necessary and universal by showing that they are historically contingent and “the product of arbitrary constraints”⁴ arising from linguistic and social conventions. According to Foucault:

Criticism is no longer going to be practiced in the search for formal structures with universal value, but rather as a historical investigation into events that have led us to constitute ourselves and to recognize ourselves as subjects of what we are doing, thinking, and saying. In that sense criticism is not transcendental, and its goal is not that of making metaphysics possible; it is genealogical in design and archaeological in its method. Archaeological – and not transcendental – in the sense that it will not seek to identify the universal structures of all knowledge and of all possible moral action, but will seek to treat the instances of discourse that articulate what we think, say, and do as so many historical events. And this critique will be genealogical in the sense that it will not deduce from the form of what we are what is impossible for us to do and to know; but it will separate out, from the contingency that has made us what we are, the possibility of no longer being, doing, thinking, what we are, do, or think. It is not seeking to make possible a metaphysics that has finally become a science; it is seeking to give new impetus, as far and wide as possible, to the undefined work of freedom.⁵

As Foucault stresses, genealogical critique is not an attempt to step outside of history; instead it involves an acknowledgment that the person doing the genealogical critique is herself historically situated and is focused on local struggles. Foucault emphasizes that genealogy is concerned with “the claims of local, discontinuous, disqualified, illegitimate knowledges against the claims of a unitary body of theory which would filter, hierarchize and order them in the name of some true knowledge and some arbitrary idea of what constitutes science and its objects.”⁶ This type of critique is not merely an interesting academic exercise, but what Foucault described as a “limit attitude,” a project of

⁴ *Ibid* at 315.

⁵ *Ibid* at 315-316.

⁶ Michel Foucault, “Two Lectures”, translated by Colin Gordon et al in Colin Gordon, ed, *Power/Knowledge: Selected Interviews and Other Writings 1972-77* (New York: Vintage Books, 1980) at 83.

identifying what we assume to be the limits on our ways of thinking, thereby opening potential for personal and social transformation by pointing to new possibilities for thinking and acting. In order to show how Foucault's thoughts on human rights are based on this notion of the "undefined work of freedom," it is necessary to first describe the juridical conceptions of human rights against which he developed his own ideas about rights. This requires giving an outline of Foucault's thoughts on the historical origins of juridical authority and sovereignty, which underlie both historical and contemporary understandings of legal, political, and moral rights.

4.2 The Development of Sovereign Power and Juridical Authority

4.2(A) The Emergence of Monarchical Authority

In writings such as *Truth and Juridical Forms*,⁷ and *Society Must be Defended*,⁸ Foucault describes early forms of tribal power in Europe rooted in ongoing territorial wars. In these societies, investigation into breaches of tribal rules involved trial by ordeal, in which the guilt of those alleged to have transgressed tribal rules was determined by whether they could survive various forms of physical ordeals such as being exposed to fire or submersed in ice water.⁹ These tribal rules were superseded following the emergence of the authority of royalty in the Middle Ages, which led to a coordination of pre-existing power alliances and a monopoly on the use of violence to enforce the dictates of authority. The recovery of Roman law in the twelfth century resulted in a codification and consolidation of this

⁷ Michel Foucault, "Truth and Juridical Forms", translated by Robert Hurley and others in James D. Faubion, ed, *The Essential Works of Foucault, 1954-1984, Volume 3, Power* (New York: New York Press, 1994) at 1.

⁸ Michel Foucault, "Society Must Be Defended", translated by Robert Hurley and others in Paul Rabinow, ed, *Essential Works of Foucault 1954-1984, Vol. 1, Ethics* (New York: New York Press, 1997) at 60.

⁹ *Ibid* at 65.

authority that then was administratively enforced, resulting in shared social assumptions about “the absolute power of monarchy.”¹⁰ The power of the monarchy was claimed to emanate from God and was symbolically expressed in multiple rituals to display the divine rights of kings.

In contrast to earlier trials by ordeal, legal inquiry and the “authoritarian search for truth” in these monarchical systems took the form of extracting confession following inquisition to determine whether the accused had transgressed limits established by the power of the sovereign. Thus, the legal system arising from the authority of the sovereign king took the form of establishing clear thresholds to determine which acts breached these limits and punishment could be inflicted accordingly.¹¹ Other than scrutinizing carefully described acts that transgressed these thresholds law was not directly concerned with the lives of subjects who were defined primarily in terms of their status within feudal hierarchies. Provided these thresholds were not breached, the law would not directly concern itself with the lives of the subjects.¹² Although law in the Middle Ages and the classical period in Europe was not exclusively concerned with punishment, the symbolic expression of the sovereign’s legal authority was found in spectacular punishment, torture, and executions staged in full public display, described in gruesome detail in *Discipline and Punish*.¹³ The purpose of these displays and less extravagant spectacles, such as public floggings and

¹⁰ Foucault, “Two Lectures”, *supra* note 7 at 94.

¹¹ Victor Tadros, “Between Governance and Discipline: The Law and Michel Foucault” (1999) 18 *Oxford J Legal Stud* at 87.

¹² Foucault, “Society Must be Defended”, *supra* note 1 at 30.

¹³ Michel Foucault, *Discipline and Punish: The Birth of the Prison*, translated by Alan Sheridan (New York: Vintage Books, 1979) at 32.

confinement in manacles, was to show the sovereign's monopoly on power, as well as to demonstrate to the populace the acts that transgressed this authority.

4.2(B) Juridical Monarchy

This constellation of inquisitorial practices and symbolic displays of sovereign authority represent what Foucault described as the “juridical monarchy” which was the basis for juridical legal practices and laws.¹⁴ In order to understand Foucault's thoughts on law and the nature of rights, it is important to note that his reference to “sovereignty” refers to the notion that power emanates from a central source external to human agents. While sovereignty was initially seen as inhering in royalty, assumptions about the power of central authorities remained even after the power of royalty was curtailed, including assumptions about the scope of the authority for exercising this power and the thresholds for determining whether citizens transgressed sovereign authority. Indeed, even after the authority of royalty was extinguished, the form of the assumptions concerning power as concentrated in central authorities persisted. In other words, “sovereignty,” as a way of understanding power and the relationship between central authorities and free citizens, remained in currency and persists to this day. As Foucault states:

At bottom, despite the differences in epochs and objectives, the representation of power has remained under the spell of monarchy. In political thought and analysis we still have not cut off the head of the kings. Hence the importance that the theory of power gives to the problem of right and violence, law and illegality, freedom and will and especially the state and sovereignty...To conceive of power on the basis of these problems is to conceive it in terms of a historical form that is characteristic of our societies: the juridical monarchy.¹⁵

¹⁴ Michel Foucault, “Truth and Juridical Forms”, *supra* note 8 at 53.

¹⁵ Michel Foucault, *The History of Sexuality: An Introduction: Volume 1*, translated by Robert Hurley (New York: Vintage Books, 1978) at 88-89.

Similarly, the “juridical” as a form of understanding how sovereign power functions and is codified in law continues to be a prevalent and highly influential form of discourse to the present day. Since the juridical notion of power assumes that power can be possessed by a central authority, it also assumes that this power can be delegated and owned by others, that one has a “right” to this power.¹⁶ In addition, the concept of the “juridical subject” is a notion that human beings are free in areas of their lives that are not restricted by the power of central authorities, i.e., the sovereign power. Myriad laws in the Western industrial world are iterations of descriptions of the thresholds for exercising these rights to own power and the freedoms of juridical subjects.¹⁷ Nevertheless, although assumptions about sovereignty and the juridical understandings about power continue to shape the way law describes itself, including most human rights discourse, this does not necessarily describe how the law *operates* in disciplinary societies. The manner in which the law operates can be demonstrated by revealing the effects of the disciplines and the processes of normalization in modern societies.

4.3 The Social and Legal Effects of the Disciplines

4.3(A) The Spread of Normalizing Disciplines

As described in Chapter 3, in the late eighteenth and early nineteenth century, disciplinary medical and carceral practices related to panopticism in penitentiaries became dislodged

¹⁶ Foucault, “Two Lectures”, *supra* note 7 at 88.

¹⁷ This is seen in both public and private law. For example, in criminal law boundaries are established that permit people to engage in private activities provided that threshold conditions are not breached, at which point the Queen or the Crown, representing the sovereign will of the people, intervenes to protect the public interest. In the private sphere, the law of torts sets out threshold conditions of duties of care and legal criteria to assess the causation of injury to people and property. These conditions and criteria are regarded as bright lines between the acts of individuals and thresholds of conduct for determining when these acts engage the public interest. If thresholds are crossed, legal redress can be obtained through public institutions such as the courts. Finally, the law of agency is an example of the way that powers and rights can be voluntarily delegated or even sold.

from the institutions in which they were born and were adopted within educational institutions and eventually throughout society. Consequently, these disciplinary practices were psychologically internalized as self-discipline and reinforced at all levels of socialization. According to Foucault, the spread of normalizing discipline had important consequences for the operation of law, which continued to describe itself in terms of juridical forms of power. The first is that, whereas juridical forms describe thresholds and the discrete acts of individuals that violate these boundaries, discipline is concerned with whole persons and takes as its project the normalization of entire lives of persons within a normalized population.¹⁸ Deviations from norms are observed and described in terms of comparisons with other persons in the population through the use of examinations, statistical tables and measures to correct deviance and enforce normalization.¹⁹ Thus, disciplinary regimes achieve social control by providing multiple, continuous invasive pressure on all aspects of individuals' lives, in contrast to earlier forms of social control focused on individuals' discrete acts which were subjected to orders from sovereign authority. Disciplinary technologies therefore not only deter and prohibit actions, but also serve to create normal subjects and label persons as abnormal whose behaviour deviates too far from the norms. Through a disciplinary regime's proliferating micro-observation of the minutiae of conduct, disciplinary society is constantly extending beyond existing laws, which are in turn persistently attempting to regulate these practices through legal forms.²⁰

¹⁸ Tadros, *Between Governance and Discipline: The Law and Michel Foucault*, *supra* note 12 at 89.

¹⁹ Foucault, *The History of Sexuality: An Introduction: Volume I*, *supra* note 16 at 27.

²⁰ Foucault, "Two Lectures" *supra* note 7 at 108.

4.3(B) Juridical Forms Merged with the Disciplines

According to Foucault, the emergence of disciplinary society did not result in the collapse of expressions of juridical forms of authority. On the contrary, juridical legal forms were merged with the operation of disciplinary practice. As he explains:

I do not mean to say that law fades into the background or that institutions of justice tend to disappear, but rather that the law operates more and more as a norm, and the judicial institution is increasingly incorporated into a continuum of apparatuses (medical, administrative, and so on) whose functions are for the most part regulatory.²¹

The law then monitors the new disciplines by “recoding them into the form of law.”²² The new disciplines related to, for example, observing and governing those regarded as mentally abnormal resulted in the remarkable proliferation of legislation described as “lunatics” and “insane asylum” statutes and regulations for the management of hospitals and patients.²³ Along with the growth of normalizing regulations there has been a corresponding proliferation of experts, including adjudicators in administrative law activity. As Foucault observes:

The activity of judging has increased precisely to the extent that the normalizing power has spread...The judges of normality are present everywhere. We are in a society of the teacher-judge, the doctor-judge, the educator-judge, the “social worker”-judge.²⁴

Foucault’s thoughts on governmentality, described in the previous chapter, provide a detailed description of the way networks of government policies, procedures and tactics,

²¹ Foucault, *The History of Sexuality: An Introduction: Volume I*, *supra* note 16 at 144.

²² *Ibid* at 109.

²³ Michel Foucault, *Psychiatric Power: Lectures at the College de France 1973-1974*, ed by Jacque Legrange, translated by Graham Burchell (New York: Picador, 2006) at 95.

²⁴ Foucault, *Discipline and Punish: The Birth of the Prison*, *supra* note 14 at 304.

spread with increasing efficacy. The operation of the law has become increasingly governmentalized.²⁵

4.4 The Persistence of Sovereignty and Juridical Forms

4.4(A) Juridical Forms in Law

In order to understand Foucault's ideas about human rights and law it is important to be clear on his thoughts concerning the continuing role of the concept of sovereignty and juridical legal forms in contemporary society. Foucault stresses that:

we should not see things as the replacement of a society of sovereignty by a society of discipline and then of a society of discipline by a society of, say, government. In fact, we have a triangle: sovereignty, discipline, and government management, which has the population as its main target and apparatuses of security as its essential mechanism.²⁶

On this account, the juridical legal complex, conceived in terms of sets of coded practices, is increasingly incorporated into government strategies but continues to have an important discursive role in the management of populations; "law remains very much a part of the social game in a society like ours."²⁷ Juridical conceptions of power and free agency continue to be found throughout areas of the law ranging from criminal and constitutional law to contract and tort law. Juridical notions of power also persist within both legal and political philosophy, and continue to inform legislation and judicial decisions. In this juridical view of power, the population is conceived as a collective body of human agents whose free consent to the presence of central government legitimizes the authority of the

²⁵ Nikolas Rose & Mariana Valverde, "Governed by Law?" (1998) 7 Soc & Leg Stud at 543.

²⁶ Michel Foucault, "Governmentality" in James D. Faubion, ed, *The Essential Works of Foucault, 1954-1984, Volume 3, Power*, translated by Robert Hurley and others (New York: The New Press, 1994) at 219.

²⁷ Michel Foucault, "What is Called 'Punishing?'" in James D. Faubion, ed, *The Essential Works of Foucault, 1954-1984, Volume 3, Power*, translated by Robert Hurley and others (New York: The New Press, 1994) at 392.

government, as well as the areas of their lives in which citizens can be free from government power. State power therefore expresses “a single will – or rather, the constitution of a unitary, singular body animated by the spirit of sovereignty – from the particular wills of a multiplicity of individuals.”²⁸

That juridical notions of power continue to inform our thinking about human rights is seen most clearly in the way that judicial decisions refer to the philosophies of John Stuart Mill and Immanuel Kant.²⁹ In Mill’s political philosophy, human agents are free to act as they choose, provided that these actions are compatible with the free actions of others.³⁰ In other words, human agents are free to act provided that they do not harm others and in so doing restrict their freedom. The capacity for this type of free choice and the areas of life created by these choices define a person’s autonomy. The law describes the conditions for exercising this expression of autonomy in society by allowing citizens freedom to pursue private goods in a manner consistent with avoiding harm to others. Similarly, in Kant’s legal philosophy, the form of the law as a set of abstract rules is legitimized by the consent of the free human agents exercising rational will.³¹ The law both expresses and protects rational free choice, which for Kant is the essence of what it means to be a human agent.

²⁸ Foucault, “Two Lectures” *supra* note 7 at 97.

²⁹ Duncan Ivisen, *Rights* (Montreal: McGill-Queens’s University Press, 2008) at 94 and 158. Kant is often cited in reference to articulating principles for determining the intention to commit a crime. See for example the decision of Madame Justice Wilson in *R. v. Perka*, [1984] SCJ No. 40, [1984] 2 SCR 232. Extracts from Mill’s philosophy, particularly his harm principle, have been cited in 47 Supreme Court of Canada cases since 1984, and Mill is often used when the Court is attempting to circumscribe the sphere of private activities in which individuals can freely act, provided that they do not harm others. See for example, the court’s decision upholding federal statutes to prohibit non-medical marijuana use in *R. v. Malmo-Levine* [2003] S.C.R. 571, [2003] SCJ No. 79.

³⁰ John Stuart Mill, “On Liberty” in *On Liberty and Other Essays* (Oxford: Oxford University Press, 1991).

³¹ Arthur Ripstein, “Kant’s Legal Philosophy”, online: *IVR Encyclopedia of Jurisprudence, Legal Theory and Philosophy of Law* <<http://ivr.enc.into>> at 1; Duncan Ivisen, *Rights* (Montreal: McGill-Queens’s University Press, 2008) at 94.

Assumptions about sovereignty and juridical forms of power continue to define current iterations of these liberal philosophies, as well as the jurisprudence that refers to them so often, because they persist in assuming that power is exerted by authorities external to human agents whose capacity for rational choice is not constructed or imperilled by power relations through the process of normalization. Just as historical juridical forms based on the royal sovereignty imagined that there was a threshold boundary between authority and the free activity of private life where power does not reach, so too does liberal political philosophy and jurisprudence assume that there is a sharp boundary between the coercive power of the state and the freedom of citizens in their private lives.³² The juridical forms found both in sovereignty and in liberal political and legal theory continue to assume that the law's target is the acts of individuals and not the entire person.³³ Yet in continuing to conceive of human agents as abstract subjects, these theories and practices fail to account for the way that subjects are shaped, in both repressive and productive ways, by normalization, cultural conditioning, and governance activity itself. Since power relations

³² The assumptions concerning the nature of liberty and rational choice found in Mills and Kant's political philosophies are also reflected in their moral philosophies. Mills utilitarianism and Kant's deontological moral theory both harbour the same assumptions about juridical power and assume that the essential core of human agency, which defines our moral being, is untouched by the powers of normalization. To paraphrase Foucault, we still have not cut off the head of the king in moral theory.

³³ Tradros, *Between Governance and Discipline: The Law and Michel Foucault*, *supra* note 14 at 88. See also Madame Justice Wilson's comments in *R. v. Perka*, *supra* note 30 at 270-271: "The underlying principle here is the universality of rights, that all individuals whose actions are subjected to legal evaluation must be considered equal in standing. Indeed, it may be said that this concept of equal assessment of every actor, regardless of particular motives or the particular pressures operating on his will is so fundamental to the criminal law as rarely to receive explicit articulation. However, the entire premise expressed by thinkers such as Kant and Hegel that man is by nature a rational being, and that this rationality finds expression both in the human capacity to overcome the impulses of one's own will and the universal right to be free from the imposition of the impulses and will of others, supports the view that an individualized assessment of offensive conduct is simply not possible. *If the obligation to refrain from criminal behavior is perceived as a reflection of the fundamental duty to be rationally cognizant of the equal freedom of all individuals, then the focus of an analysis of culpability must be on the act itself (including its physical and mental elements) and not on the actor*" [emphasis added].

pervade all social interactions, we are always, even in our most private moments, subject to the normalizing effects of society and culture.

4.5 Critical Reflection on Juridical Forms in Law

Clearly, Foucault never attempted to engage in the positivist project of developing a grand theory of the law itself, of describing what law “is”.³⁴ While he expressed strong views about the persistence of juridical legal concepts, he certainly did not see the law as a unified system. Instead he saw it as involving a complex relationship between the concepts and practices of sovereignty, discipline, and government, the examination of which must always be done at local levels because social practices differ between communities.³⁵

Foucault’s purpose in examining the complex relationship between juridical forms of law and the disciplines is to open critical reflections on the effects they have in everyday life. Throughout his writings Foucault criticized the conception of rights that arose from these juridical forms that underpin classical liberal political theory. He stated, for instance, that, “The general juridical form that guaranteed a system of rights that were egalitarian in principle was supported by these tiny, everyday, physical mechanisms, by all those systems of micro-powers that are non-egalitarian and asymmetrical that we call the disciplines.”³⁶

This critique of the discourse of rights as a mask for non-egalitarian practices is found

³⁴ Nikolas Rose & Mariana Valverde, “Governed by Law?” (1998) 7 Soc & Leg Stud 543 at 545.

³⁵ Comparing France’s legal system to one of the creations of the artist Jacques Tinguely, whose modernist machine-like sculptures were constructed from wires, bolts and ill-fitted gears, Foucault said: “you think you are seeing one of these enormous contraptions, full of impossible cog-wheels, conveyor belts that don’t convey anything and of grimacing gears; all these things that don’t “work” end up making “it” work.” Michel Foucault, “Lemon and Milk”, translated by Robert Hurley and others in James D. Faubion, ed, *The Essential Works of Foucault, 1954-1984, Volume 3, Power* (New York: The New Press, 1994) at 436. This image of the legal system as a contraption consisting of parts with their own histories and peculiar ways of operating (including countless legal fictions) is equally apt when describing the Canadian legal system and the English common law from which it descended.

³⁶ Michel Foucault, *Discipline and Punish: The Birth of the Prison*, translated by Alan Sheridan (New York: Vintage Books, 1979) at 222.

throughout Foucault's writing and may give the impression that he was averse to the concept of rights. Nevertheless, particularly in his later writings, Foucault suggested that it would be fallacious to jettison the language of human rights altogether. As he affirmed in an interview toward the end of his life:

Through these different practices – psychological, medical, penitential, educational – a certain ideal or model of humanity was developed and now this idea of man has become normative, self-evident, and is supposed to be universal. Humanism may not be universal but may be quite relative to a certain situation. What we call humanism has been used by Marxists, liberals, Nazis and Catholics. *This does not mean that we have to get rid of what we call human rights or freedom, but that we can't say that freedom or human rights has been limited by certain frontiers.* For instance, if you asked eighty years ago if feminine virtue was part of universal humanism, everyone would have answered yes. What I am afraid of is that it presents a certain form of our ethics as a universal model for any kind of freedom. I think that there are more secrets, more possible freedoms, and more inventions in our future than we can imagine in humanism as it is dogmatically represented on every side of the political rainbow: The Left, the Centre, the Right.³⁷ (emphasis added)

Although the traditional doctrinal language of human rights may be used to promote social change that is often regarded as progressive and beneficial, the underlying assumptions about the juridical forms of power and agency may not be effective in initiating change. The use of juridical language may simply show the efficacy of certain forms of discourse in a particular established nexus of power and resistance.³⁸ Yet Foucault advanced a

³⁷ Robert Martin, "Truth, Power, Self: An Interview with Michel Foucault" in L.H. Martin, H. Gutman & P. Hutton, eds, *Technologies of the Self: A Seminar with Michel Foucault* (Amherst: University of Massachusetts Press) 9.

³⁸ The fact that Foucault did not theorize about law itself on a level of abstraction that would satisfy certain critics is not a shortcoming in Foucault's thinking, and certainly not a strike against his thoughts about human rights. See, for example, Kevin Walby, "Contributions to a Post-Sovereignist Understanding of Law: Foucault, Law as Governance, and Legal Pluralism" (2007) 16 Soc & Leg Stud at 559. Walby suggests that while Foucault may not have expelled law altogether, he failed to theorize law's efficacy with sufficient specificity. Walby argues that in modern times law has not only been repressive and disciplinary but has also been, *in itself*, productive of positive change. On this view, existing laws, even in their juridical

conception of rights that was more deliberately severed from juridical forms and the principle of sovereignty. He stated that:

If one wants to look for a non-disciplinary form of power, or rather, to struggle against disciplines and disciplinary power, it is not toward the ancient right of sovereignty that one should turn, but toward the possibility of a new form of right, one which must indeed be anti-disciplinarian, but at the same time liberated from the principle of sovereignty.³⁹

4.6 Foucault's Conception of Human Rights

A number of scholars have written at length on the normative nature of Foucault's later philosophy and its relevance for understanding law and human rights. Paul Patton⁴⁰ and Duncan Ivison,⁴¹ for example, have argued that Foucault's appeal to human rights need not be grounded in any essentialist or transcendental conceptions of human nature, but can be understood as the product of contingent historical forces. This may be contrasted with more typical attempts to ground rights in inalienable internal features of moral beings, such as reflective reasoning, acts of will, or the capacity for sentience.⁴² Instead, Foucault's project was directed at demonstrating that there were no such essential qualities of moral beings. According to Patton we must:

First...appreciate that Foucault's ontological commitment to the view that all social relations are power relations does not disqualify him from appealing to the concept of right. Second, we must acknowledge that the

forms, have been used for the promotion of social change by organizations such as the civil rights movement. These movements have advanced human rights, resisted and confronted governments, and thereby caused real social change.

³⁹ Foucault, "Two Lectures" *supra* note 7 at 108.

⁴⁰ Paul Patton, "Foucault, Critique and Rights" (2005) 6:1 *Critical Horizons* at 267.

⁴¹ Duncan Ivison, "Rights" *supra* note 30 at 186.

⁴² The question of the essential features of beings that are the foundation of their entitlement to rights is a recurring preoccupation in modern Western philosophy. See Duncan Ivison, *Rights* (Montreal: McGill-Queen's University Press, 2008) at 26. For an argument that sentience alone is sufficient for ascriptions of rights entitlements see Gary Francione, *Introduction to Animal Rights: Your Child or the Dog?* (Philadelphia: Temple University Press, 2000) at xxxiii.

manner in which Foucault historicizes and therefore particularizes discourses of rights is also consistent with appealing to rights in particular contexts. Third...we must understand the normative force of rights claims as derived from historically available discourses of rights.⁴³

The consistency of Foucault's theory of power with concepts of rights can be observed when one recognizes that power relations pervade social interactions. Power and resistance, which make normalization possible, produce new forms of human life and social organization that provide the basis for assertions of new types of rights. Genealogical critique shows that these rights do not exist apart from the contingent forces of historical processes. The promotion of these rights at any given time will, in part, draw upon the discursive resources that are socially available and which make speech concerning these rights intelligible to other speakers in a community. For Patton, there is nothing contradictory about using concepts such as "autonomy" and "freedom" found in liberal rights discourse, provided that we recognize that they are not grounded in anything other than historical processes.⁴⁴ Genealogical critique can therefore advance rights discourse by showing how rights that we thought were necessary, such as the divine rights of kings or the exclusive rights of male landowners to vote in 18th century England, are the products of contingent historical processes.⁴⁵ At the same time, genealogical critique can open us to forms of discourse, allowing us to recognize new, hitherto unseen rights. of new types of rights: In the *History of Sexuality*, Foucault described the emergence

it was life more than the law that became the issue of political struggles, even if the latter were formulated through affirmations concerning rights. The "right" to life, to one's body, to health, to happiness, to the satisfaction of needs, and beyond all oppressions and alienation, the

⁴³ *Ibid* at 270.

⁴⁴ *Ibid* at 267.

⁴⁵ *Ibid* at 294.

“right” to discover what one is and all that one can be, this “right” – which the juridical system was utterly incapable of comprehending – was the political response to all those new procedures of power which did not derive, either, from the traditional right of sovereignty.⁴⁶

Thus, while Foucault criticized laws and policies based on juridical forms, he promoted the recognition of new rights in areas such as rights in health care,⁴⁷ the right to suicide,⁴⁸ the rights of political dissidents,⁴⁹ and relational rights in sexuality.⁵⁰ As he emphasized:

Rather than arguing that rights are fundamental and natural to the individual, we should try to imagine and create a new relational right that permits all possible types of relations to exist and not be prevented, blocked or annulled by impoverished relational institutions.⁵¹

In order to give a sense of the pattern of Foucault’s thinking about rights, Duncan Ivison has provided examples of Foucault’s attempts to articulate new forms of rights.⁵² One example is “the right of the governed” who “no longer want to be governed like that, by that, in the name of those principles...and by means of those procedures.”⁵³ These political rights arise out of a critique of existing political power structures. This critique brings into focus the fissures in the exercise of power that create spaces for those who have been constituted by those forms of power to act as agents in effecting change and in identifying sets of relations that give rise to new forms of rights. Such rights extend to “international

⁴⁶ Michel Foucault, *The History of Sexuality: An Introduction: Volume I*, *supra* note 15 at 145.

⁴⁷ Michel Foucault, “The Risks of Security”, translated by Robert Hurley and others in James D. Faubion, ed, *The Essential Works of Foucault, 1954-1984, Volume 3, Power* (New York: The New Press, 1994) at 365.

⁴⁸ *Ibid.*

⁴⁹ Michel Foucault, “The Moral and Social Experience of the Poles Can No Longer be Obliterated” translated by Robert Hurley and others in James D. Faubion, ed, *The Essential Works of Michel Foucault 1954-1984, Volume 3*, *supra* note 45 at 465.

⁵⁰ Michel Foucault, “The Social Triumph of the Sexual Will” in Paul Rabinow, ed, *Essential Works of Foucault 1954-1984, Vol. 1, Ethics* (New York: New York Press, 1997) at 162.

⁵¹ *Ibid* at 158.

⁵² Ivison, *supra* note 42 at 194.

⁵³ *Ibid* at 195; *supra* note 3 at 24.

citizenship that has its rights and its duties, and that obliges one to speak out against every abuse of power, whoever its author and whoever its victims.”⁵⁴

Another example Ivison offers is Foucault’s conception of rights in dialogic exchange. Ivison maintains that participants have rights that are “immanent in the discussion,” including the right to have claims justified, and a corresponding obligation to “listen in good faith” and to acknowledge reciprocity in the exchange.⁵⁵ These relational rights foster consensus in respectful communication. This notion of dialogic rights is explored in greater detail in section 4.9 of this chapter, in which I examine Foucault’s conception of *parrhesia* and truthful speech in dialogic exchanges.

The reference to these examples and explanations of Foucault’s thinking about rights is not an attempt to show that Foucault was seeking foundational concepts to justify assertions of human rights. Rather, Foucault abjured any attempt to develop a grand theory of human rights. As he stated, “One must guard against reintroducing a hegemonic thought on the pretext of presenting a human rights theory or policy.”⁵⁶ Moreover, as Patton has observed, these thoughts on human rights are not a way of seeking final conclusions about the essential nature of law, but are a critique of legal regimes that contain assumptions about

⁵⁴ Michel Foucault, “Confronting Governments: Human Rights”, translated by Robert Hurley and others in James D. Faubion, ed, *The Essential Works of Michel Foucault 1954-1984, Volume 3* (New York: New York Press, 1994) at 474.

⁵⁵ Ivison, *supra* note 42 at 196.

⁵⁶ Michel Foucault, “The Moral and Social Experience of the Poles Can No Longer be Obliterated”, translated by Robert Hurley and others in James D. Faubion, ed, *The Essential Works of Michel Foucault 1954-1984, Volume 3* (New York: New York Press, 1994) at 472.

rights.⁵⁷ This observation raises the question of whether Foucault's work has the philosophical resources to provide a normative justification for that critique.

4.7 The Normative Dimension of Foucault's Conception of Freedom

The normative dimension of Foucault's ethics is freedom, but not a freedom that steps outside of history, culture normalization, or the workings of power.⁵⁸ Instead, as discussed in the previous chapter on relational agency, freedom is a reflective activity, not of introspectively peering into one's unfettered moral core, but of problematizing what is normally taken to be necessary limits in our lives. This does not require that at each moment in our lives in which we exercise freedom that we conduct a genealogical inquiry into all the historical and cultural forces that have created our present situation. We need only question our situation enough to form the intention to think or do otherwise. The actions that are possible or required will be both a product of the power that has created us as well as a reflective resistance to this power. All of this is an expression of the "undefined work of freedom," undefined because it will change with ongoing historical and social events.⁵⁹

Assumptions about human beings and their capacity for freedom, which Foucault describes in terms of a network of the interaction between power and resistance, involve a conception of the moral lives of individuals and of the nature of a moral and political community which allows this activity. Implicit within this vision of personal freedom is also a

⁵⁷ Patton, "Foucault, Critique and Rights", *supra* note 39 at 275.

⁵⁸ David Owen, "Perfectionism, Parrhesia, and the Care of the Self: Foucault and Cavell on Ethics and Politics" in Andrew Norris, ed, *Essays on Stanley Cavell and Political Philosophy* (Stanford: Stanford University Press, 2006) at 133.

⁵⁹ Foucault, "What is Enlightenment", *supra* note 4 at 315-316.

conception of a political community that does not impede resistance. Just as an individual's work of freedom can never be conclusively defined because it is always unfolding in history, so too is the nature of the broader community unfolding over time.

Foucault refers to the nature of community when he states that:

[Richard] Rorty points out that in these analyses I do not appeal to any "we" – to any of the "we's" whose consensus, whose values, whose traditions constitute the framework for a thought and define the conditions in which it can be validated. But the problem is, precisely, to decide if it is actually suitable to place oneself within the "we" in order to assert the principles one recognizes and the values one accepts; or is it not, rather, necessary to make the future formation of a "we" possible by elaborating the question. Because it seems to me that the "we" must not be previous to the question; it can only be the result – and the necessarily temporary result – of the question as it is posed in the new terms in which one formulates it.⁶⁰

Thus, according to Foucault, both the nature of the community and the individual change as each questions and resists the other. This intersubjective questioning and challenging is the basis for ethical and political communities. The problematization of norms means that the work of freedom never ends for either the individual or the community.

With these assumptions about autonomy and the minimal conditions for a moral and political community, we can better understand Foucault's comments on human rights, which included the right to question government. In his essay "What is Critique?" he aligns the questioning of government with the nature of genealogical critique itself when he states that critique is "the movement through which the subject gives itself the right to question truth concerning its power effects and to question power about its discourses of

⁶⁰ Michel Foucault, "Polemics, Politics, and Problematizations: An Interview with Michel Foucault" in Paul Rabinow, ed, *The Foucault Reader* (Harmondsworth: Penguin, 1984) at 385.

truth.”⁶¹ Foucault expresses these views most emphatically in his essay entitled “Confronting Governments: Human Rights”⁶² in which he addresses moral and political issues related to people leaving oppressive regimes and seeking asylum in European countries. Foucault issued a statement in which he says that:

There exists an international citizenship that has its rights and its duties, and that obliges one to speak out against every abuse of power, whoever its author, whoever its victims. After all, we are all members of the community of the governed, and thereby obliged to show mutual solidarity....The suffering of men must never be a silent residue of policy. It grounds an absolute right to stand up and speak to those who hold power.⁶³

Foucault’s reference to an “absolute right” to speak against those who hold power is not, of course, a reference to timeless rights grounded in universal features of human nature. It does show, however, the degree of importance that Foucault accorded to the right to oppose and to speak against governments and legal regimes.

4.8 Criticism of Foucault’s Normative Vision

There are a number of scholars who are sympathetic to Foucault’s repudiation of universal and ahistorical forms of rationality but who nevertheless assert that Foucault’s commitment to genealogical critique undermines any attempt to articulate normative criteria for valuing freedom or criticizing forms of power. Why, they ask, should one form of resistance be preferred over another? Why, for example, should one support disadvantaged racial minority groups that resist racist political regimes rather than minority fundamentalist

⁶¹ Michel Foucault, “What is Critique?” in James Schmidt, ed, *What is Enlightenment?: Eighteenth-Century Answers and Twentieth-Century Questions* (Los Angeles: University of California Press, 1996) at 386.

⁶² Michel Foucault, “Confronting Governments: Human Rights”, translated by Robert Hurley and others in James D. Faubion, ed, *The Essential Works of Michel Foucault 1954-1984, Volume 3* (New York: New York Press, 1994) at 474.

⁶³ *Ibid* at 474-75.

terrorist groups?⁶⁴ Presumably, both groups would be attempting to promote their own versions of what it would mean to be free and to speak truth to power. As feminist philosopher Nancy Fraser has put it, “Clearly what Foucault needs and needs desperately are normative criteria for distinguishing acceptable from unacceptable forms of power. As it stands now, the unquestionably original and valuable dimensions of his work stand in danger of being misunderstood for lack of an adequate normative perspective.”⁶⁵

Charles Taylor has expressed similar concerns about the alleged lack of normative criteria in Foucault’s work, but goes further and states that Foucault’s notion of genealogical critique “ultimately is incoherent.”⁶⁶ As Taylor sees it, Foucault’s genealogies disclose oppressive forms of disciplinary power, as described in *Discipline and Punish*, and appear to suggest that this oppression imposes illusions on people. According to Taylor the very notion of domination involves some conception of a good which is disguised and which must be disclosed by a search for truth. Yet Foucault repudiates any appeal to some independent conception of truth outside of the workings of power, which Taylor believes is required to make sense of the desirability of being liberated from domination. Taylor states that, “the Foucauldian notion of power not only requires for its sense the correlative notions of truth and liberation, but even the standard link between them, which makes truth the condition of liberation. And yet Foucault not only refuses to acknowledge this, but appears to undermine anything except an ironical appeal to “freedom” and “truth”.”⁶⁷ But, as this

⁶⁴ Richard Bernstein, “Foucault: Critique as a Philosophical Ethos” in Michael Kelly, ed, *Critique and Power: Recasting the Foucault/Habermas Debate* (Cambridge: MIT Press, 1998) at 229.

⁶⁵ Nancy Fraser, “Foucault on Modern Power: Empirical Insights and Normative Confusions” (1981) 3 *Praxis International* at 286.

⁶⁶ Charles Taylor, “Foucault on Freedom and Truth” (1984) 12:2 *Political Theory* 152 at 156.

⁶⁷ *Ibid* at 194.

chapter and the Chapter 3 have shown, Foucault's valuation of freedom and speaking truth are more than ironic. These values are an expression of an admittedly historically conditioned stance found in genealogical critique and therefore are values that Foucault can use to criticize domination, or terrorist movements whose aim is to suppress freedom. The problem with Taylor's criticisms is that he assumes power is something that is imposed only from external sources, an assumption that Foucault rejected consistently throughout his writings. Foucault's view was that power itself produces persons who, by problematizing existing power relations, can question the workings of power, and thereby effect social change. This is an ongoing dynamic process, but one which can yield criteria for speaking the truth that are certainly not "ultimately incoherent."⁶⁸

A critical examination of Foucault's conception of genealogical critique, which has an important bearing on his conception of human rights, was set out in Jurgen Habermas' book *The Philosophical Discourse of Modernity*.⁶⁹ According to Habermas, Foucault's genealogical critique is a methodology that cannot separate itself from the historical processes it subjects to critical scrutiny. It must, by its own premises, concede that it too is contingent and therefore cannot provide independent criteria for concluding that it is preferable to any other knowledge claim. Hence, to make any recommendations on the basis of genealogical critique is a "performative contradiction" because the propositional content of the recommendations, implying that it has non-contingent applicability, is contradicted by the assumption that all truth claims are historically contingent. According

⁶⁸ Jurgen Habermas, *The Philosophical Discourse of Modernity*, translated by Frank Lawrence (Oxford: Polity, 1987).

⁶⁹ For further analysis of the Foucault/Habermas debate see James Tully, "To Think and Act Differently: Foucault's Four Reciprocal Objections to Habermas' Theory" in Samantha Ashenden & David Owen, eds, *Foucault contra Habermas: Recasting the Dialogue between Genealogy and Critical Theory* (London: Sage, 1999) at 100.

to Habermas, genealogy is irremediably context-bound and therefore cannot escape the type of criticism that it directs against other forms of knowledge and inquiry. Consequently, on this account, Foucault cannot provide normative criteria for advocating his own forms of thought or recommendations for ways of acting.

A number of scholars have pointed out that the apparent persuasiveness of Habermas' critique is based on the assumption that the justification of normative criteria requires a type of historical inquiry that nevertheless generates a theory of "context-transcending interests."⁷⁰ Habermas claims to ground these interests in forms of speech acts that he asserts govern all forms of rational communication. According to Habermas, these forms of communication are instantiated in historical events and are therefore "context-dependent", but the criteria for determining whether they are rational can be used to assess the communication at any historical moment and are therefore not "context-bound", but rather "context-transcending." But as Michael Kelly has pointed out, one of the problems with Habermas' theory is that "the transcendence [he] speaks of is not something about which we could ever have any epistemological assurance so long as our reason is historical, for the historicity of subjectivity and reason places ontological limits on our ability to have such knowledge."⁷¹ This critique questions whether Habermas' philosophical position is tenable when he suggests that Foucault should provide an Archimedean point outside of history to justify genealogy. Indeed Habermas has no such point of his own in his theory of rational communication, the absence of which creates a performative contradiction in his own critical speech acts concerning Foucault's philosophy. Nevertheless, according to

⁷⁰ See Michael Kelly, "Foucault, Habermas, and the Self-Referentiality of Critique" in Michael Kelly, ed, *Critique and Power: Recasting the Foucault/Habermas Debate* (Cambridge: MIT Press, 1998) at 388.

⁷¹ *Ibid* at 388.

Habermas, without an Archimedean point outside of history, Foucault's genealogical approach will forever remain context-bound. This calls into question Foucault's historicist and contextual conception of relational rights.

Although Foucault certainly did not regard his methodology as context-transcending, it would also be a mistake to describe it as context-bound. Rather, the "limit attitude" that Foucault recommended explicitly recognizes that there are restrictions to moving beyond the limits of our current historical circumstances, and that we must "give up hope of our ever acceding to any complete and definitive knowledge of what may constitute our historical limits"⁷² As such, a "historical-critical attitude must always be experimental."⁷³ Problematizations of power relations must take place in local contexts, at "points where change is possible and desirable, and to determine the precise form this change should take."⁷⁴

James Tully has described this activity as "context-transgressing" and reflected in historical reflections on disciplinary institutions, which allows citizens to have new perspectives on how these institutions have operated and thereby open possibilities for thinking and acting differently.⁷⁵ This context-transgressive reflection is not a global normative vision for wholesale social transformation; rather it is an ongoing local endeavour of identifying arbitrary limits and possible changes that may be desirable. As Tully states, "this non-transcendent and non-dialectical but nevertheless scarcely context-bound view of the reciprocal relation between critique and practical activity embodies an "experimental

⁷² Foucault, "What is Enlightenment?" *supra* note 4 at 319.

⁷³ *Ibid* at 316.

⁷⁴ *Ibid* at 316.

⁷⁵ Tully, *supra* note 69 at 100.

attitude,” one that can lead to both personal and social transformation and liberation as the limits to current ways of thinking are queried, changed or rejected.⁷⁶ Tully emphasizes that the context-transgressing experimental attitude is not an activity that only trained scholars can engage in; it can be taken up by *all* citizens in their current struggles to change existing power relations, something that fits well with Foucault’s understanding of resistance (and the exercise of power), as well as the rights of the governed who “no longer want to be governed like that, by that, in the name of those principles...and by means of those procedures.”⁷⁷

Fostering this experimental attitude requires a commitment to the ongoing work of freedom, as well as a commitment to relational rights in respectful dialogic exchanges. It is through the concept of *parrhesia* that Foucault explores more fully a conception of governance that promotes the rights of citizens to engage in agonistic forms of public discourse concerning the legitimacy of current forms of law, medicine and other government institutions.

4.9 *Parrhesia* as a Form of Truthful Speech

In his final lectures delivered in the year before he died, Foucault elaborated on his conception of the “critical attitude,” rights within dialogic exchanges and activities of truth-telling that were at the centre of his ethics.⁷⁸ In these lectures, Foucault makes a distinction between the types of analyses that focus on “epistemological structures” used to assess the

⁷⁶ *Ibid* at 100.

⁷⁷ *Ibid* at 195; Foucault, “What is Enlightenment?” *supra* note 3 at 319.

⁷⁸ Michel Foucault, *The Courage of Truth: The Government of Self and Others II, Lectures at the College De France 1983-1984*, ed by Frederic Gros, translated by Graham Burchell (New York: Palgrave Macmillan, 2011).

truth-value of propositions and what he called “alethurgic forms.”⁷⁹ Alethurgic forms are described in terms of the “production of truth, the acts by which truth is manifested.”⁸⁰ The focus of Foucault’s analysis on alethurgic forms of speech is not on the content of the utterances, but rather on the *way* that the content is expressed, the context in which the speech occurs, and the stake that the speaker has in the speech act. For example, professors who give lectures, teachers who tutor students, and priests who make prophetic utterances are engaged in very different types of truth-telling *activities*. A professor’s lecture, for instance, may convey a true account of historical events, while the priest may be seen as channelling truth from a divine source.⁸¹ Both figures are using their authority to impart what they regard as true information and neither is necessarily placing him or herself in any risk in doing so. The alethurgic form that preoccupied Foucault’s thinking in his final lectures was what the ancient Greeks called “*parrhesia*,” a form of speech activity in which speakers put themselves at risk by challenging the authority of their interlocutors. Foucault found in ancient Greek philosophy and literature from between the Fifth Century B.C. to the Fifth Century C.E. a model for a form of care of the self that is connected to that way that certain people used *parrhesia*.⁸² Foucault summarizes the ancient Greek conception of *parrhesia* as:

A kind of verbal activity where the speaker has a specific relation to truth through frankness, a certain relationship to his own life through danger, a certain type of relation to himself or other people through criticism (self-criticism or criticism of other people), and a specific relation to moral law through freedom and duty. More precisely, *parrhesia* is a verbal activity in which a speaker expresses his personal relationship to truth, and risks

⁷⁹ *Ibid* at 3.

⁸⁰ *Ibid*.

⁸¹ *Ibid* at 15.

⁸² Michel Foucault, *Fearless Speech*, ed by Joseph Pearson (Los Angeles: MIT Press: 2001) at 11.

life because he recognizes truth-telling as a duty to improve or help other people (as well as himself). In *parrhesia*, the speaker uses his freedom and chooses frankness instead of persuasion, truth instead of falsehood or silence, the risk of death instead of life and security, criticism instead of flattery, and moral duty instead of self-interest and moral apathy.”⁸³

Foucault is not arguing that Greek ethics should be resuscitated in entirety and imported into modern life.⁸⁴ Rather, he suggests that some ancient Greek writings describe a general form of *parrhesiastic* activity that could be used as a model for understanding ethical self-formation and certain forms of confrontational speech in modern life. According to Foucault, in contrast to other forms of truth-telling activity, the *parrhesiastic* speaker confronts:

a risk which concerns his relationship with the person to whom he is speaking. For there to be *parrhesia*, in speaking the truth one must open up, establish and confront the risk of offending the other person, of irritating him, of making him angry and provoking him to conduct which may even be extremely violent. So it is the truth subject to risk of violence.⁸⁵

Understood in this way, the concept of *parrhesia* as risky truth-telling also “aims for the transformation of the ethos of the interlocutor.”⁸⁶ As such, *parrhesia* involves a “kind of pact” between the person who risks speaking and the interlocutors who listen and who have the power to create negative consequences for the speaker who initiates the exchange.⁸⁷ In the *parrhesiastic* pact the speaker not only aims to speak the truth, but to initiate a response from the more powerful interlocutor and establish a dialogue in which the truth is revealed.

⁸³ *Ibid* at 19.

⁸⁴ Paul Veyne, “The Final Foucault and His Ethics” in Arnold Davidson, ed, *Foucault and His Interlocutors* (Chicago: University of Chicago Press, 1997) at 231.

⁸⁵ Foucault, *supra* note 77 at 11.

⁸⁶ Frederic Gros “Course Context” in Michel Foucault, *The Courage of Truth: The Government of Self and Others II, Lectures at the College De France 1983-1984*, ed by Frederic Gros, translated by Graham Burchell (New York: Palgrave Macmillan, 2011) at 345.

⁸⁷ *Ibid* at 13.

Parrhesiastic exchanges provide a way of understanding the relationship between self-understanding and challenges to the legitimacy of discourse in modern society, such as the discourses of law and medicine. And just as human agents participate in creating a self from critical ethical reflection, so too is the status of social authority challenged and altered through *parrhesiastic* exchanges, which Foucault calls the “*parrhesiastic game*”.⁸⁸

4.10 *Parrhesia* and the Legitimacy of Authority

Nancy Luxon has argued that Foucault’s conception of truthfulness based on *parrhesia* provides a way to fill the void in the modern era that follows from the disappearance of traditional authoritative social structures, such as “nature, custom, religion and tradition,”⁸⁹ with forms of social practice based on openness to critical speech. According to Luxon this loss of traditional and broadly accepted authoritative doctrines requires a rethinking of the ethical basis for regarding any political authority as having legitimacy. She states that if political authority is to avoid simply being a forceful assertion of order and if authority is to be regarded as legitimate, it must be based on three interrelated relationships, all of which were explored in the last phase in Foucault’s career. The first is the ethics of care of the self, rooted in a reflection of self to self; the second is one’s relationship to others; and the third is *parrhesiastic* truth-telling. All of these relationships involve critical reflection that is necessarily social and political.

According to Luxon, Foucault’s views on *parrhesia* promote a type of political community that fosters trust by supporting *parrhesiastic* activity that necessarily involves confrontation

⁸⁸ *Ibid* at 12.

⁸⁹ Nancy Luxon, *Crisis of Authority: Politics, Trust, and Truth-telling in Freud and Foucault* (Cambridge: Cambridge University Press, 2013) at xi.

with existing authorities. As she states: “These speech activities also seek to be generative (of ethical selves, commitments, responsiveness) which opens the possibility for them to be more politically transformative”⁹⁰, which “democratically involves members of a political community in the authorial practices that would define a polity.”⁹¹ Seen in this way, *parrhesiastic* activities have both personal and interpersonal transformative effects, as well as political consequences in the way that governance is regarded as having any legitimate and authoritative force. In the same way that genealogical critique does not aim to arrive at some unchanging knowledge, a political society that supports *parrhesia* does not strive for eternal truths, but rather a way of life that is perpetually open to the potentially transformative effects of confrontational truth-telling, and thereby supports the “undefined work of freedom.”⁹²

4.11 *Parrhesia* as Prescriptive and Descriptive

This articulation of Foucault’s late philosophy might appear purely prescriptive, insofar as it provides a vision of how society might be ordered to promote human freedom incorporating an ethics of care of the self and practices that support confrontation with existing socially sanctioned norms through genealogical critique and *parrhesia*. While there is no doubt that Foucault is making recommendations about personal ethics and political practices, he is also *describing* social activities. When people challenge political authority through *parrhesiastic* truth-telling, they are, whether they know it or not, involved in the transformation of themselves as ethical subjects, as well as engaging in

⁹⁰ *Ibid* at 43.

⁹¹ *Ibid*.

⁹² Foucault, “What is Enlightenment?” *supra* note 4 at 315-316.

activity that may be politically transformative. Foucault's aim is to make these forms of personal and political activity more deliberate and to support them on a community level.⁹³

The descriptive and normative dimensions of Foucault's thoughts on critique and *parrhesia* provide a valuable way of understanding activities in many institutional contexts, including Review Panel hearings in which all of the participants assume that they are engaged in some form of truth-telling and truth-seeking. In terms of Foucault's description of alethurgic forms, the patients' speech acts have all the hallmarks of *parrhesiastic* activity. These hearings, by their very nature, involve individual patients confronting and questioning the legitimacy of institutional authorities that are attempting to define the patients' identities and to restrict their freedom. I explore forms of *parrhesiastic* discourse in greater detail in Chapters 7 and 8 when I do a critical discourse analysis of Review Panel hearings.

Foucault's thoughts on *parrhesia* are not only useful for describing the events in Review Panel hearings, but also in providing a normative basis for making recommendations regarding confrontational speech in the hearings themselves and in revising mental health laws to support patients' rights.⁹⁴ As Luxon states, the liberty that involves a confrontation with authority "revises and engages the very terms on which that authority is

⁹³ *Ibid* at 244.

⁹⁴ Other scholars have recently used Foucault's concept of *parrhesia* to advance models of truth-telling in nursing, health care research and the practice of law in relation to health issues in tort law. See Genevieve Rail, Stuart Murray & David Holmes, "Human Rights and Qualitative Health Inquiry: On Biofascism and the Importance of *Parrhesia*" in Norman Denzin and Michael Giardina, eds, *Qualitative Inquiry and Human Rights* (Walnut Creek, Left Coast Press, 2010) 218-241; Stuart Murray, Dave Holmes, Amelie Perron & Genevieve Rail, "Towards an ethics of authentic practice" (2008) 14 *Journal of Evaluation of Clinical Practice* 682-689; Anne Bloom "Speaking Truth to Biopower" (2008) 41 *Southwestern Law Review* 241. In each of these papers the authors advocate the cultivation of ethical practices rooted in risky truth-telling by professionals, who act on behalf of people who are the subject of health care. The contribution of my research is to take the analysis of *parrhesia* closer to the ground, to the level of the subjects themselves.

understood.”⁹⁵ The confrontation with authority, such as with the authority of the law, draws on many resources in the community, including the techniques that lawyers use to challenge the constitutionality of mental health legislation that violates people’s rights. This view of using legal argument in *parrhesiastic* confrontation is not a lapse into a civil libertarian view of laws, which is associated with conceptions of atomistic agents in social contracts who pursue their individual ends constrained by laws that minimize mutual harms. Indeed, this conception of law is rooted in juridical forms that Foucault rejected. When laws are seen as historical products of changing communities, the legal argumentation that challenges these laws must be regarded in the same light, as contingent strategic resources that help to revise and create new laws and new rights. This view of legal challenges to existing laws is explored further in the next chapter, which examines whether British Columbia’s mental health laws violate the *Charter*.

4.12 Conclusion

Foucault’s writings show how the nature of genealogical critique and the practice of problematization provide a coherent and consistent normative framework for understanding and promoting human rights associated with his conception of freedom. Genealogical critique is a particularly productive way of understanding the operation of legal systems and assists us in problematizing the complex relationship between juridical and disciplinary forms of discourse, thereby opening progressive possibilities for advancing human rights, including relational rights in dialogic exchanges that challenge the authority of government and legislation. According to Foucault, human rights are not universal and unchanging but rather products of social and historical activity that are always subject to critique and

⁹⁵ *Ibid* at x.

transformation through, for example, acts of transgression and *parrhesia*. The critical attitude expressed in genealogical critique is also manifest in *parrhesia*. *Parrhesia* is one of the key concepts used in the model of critical discourse analysis developed and applied in chapters 7 and 8 and provides valuable ways of explaining what occurs in these hearings, as well as providing the normative basis for recommendations to change British Columbia's mental health law system and advance patients' rights. In the next two chapters I describe this mental health law system, the discourse of human rights that has arisen from court challenges to these laws based on the *Charter of Rights and Freedoms*, and how this discourse can be used for enhancing patients' rights.

Chapter 5 British Columbia's Mental Health Law Regime and the *Charter*

5.0 Introduction

As Foucault's genealogies on juridical forms demonstrate, the discourse of law is instrumental in shaping social institutions and human identity. Laws are used to govern social relations, confirm the consolidation of power in persons and institutional entities, and discipline bodies and minds. In modern democracies like Canada, constitutional laws, such as the *Canadian Charter of Rights and Freedoms*¹ (the "*Charter*"), are used to regulate other laws, including criminal law, civil law, and legislation related to administrative activities. The analysis of *Charter* decisions can reveal significant features of how Canadian society is governed through law and how the law itself can shape disciplinary activities, such as medico-legal practices related to civil commitment. Even between provinces in Canada, such as British Columbia and Ontario, the different ways that the courts have dealt with questions of the constitutionality of mental health laws have significantly affected the nature and operation of these laws in each province.²

The purpose of this chapter is to explore human rights discourse through texts of *Charter* decisions rendered by courts in British Columbia addressing the constitutionality of laws for the involuntary medical treatment of people diagnosed as having serious mental

¹ The *Charter* was enacted in 1982 as Part I of the *Constitution Act, 1982*, enacted by *Canada Act, 1982* (UK) c 11, Part I., amending the *Constitution Act 1867*, which, among other things, sets out the fundamental divisions of power between provincial and federal governments and the jurisdiction of each branch of government over various aspects of Canadian life, such as criminal law, health and control of property. The enactment of the *Charter* constitutionally entrenched certain freedoms, such as freedom of religion, expression, and association, and a number of rights, such as rights to life, liberty, security of the person, and equality.

² John Gray & Richard O'Reilly, "Clinically Significant Differences Among Canadian Mental Health Acts" (2001) 26:11 *Canadian Journal of Psychiatry* 315.

illnesses. Although my focus in this chapter is on the laws in this province, I also examine cases on involuntary psychiatric treatment from courts in other jurisdictions in Canada. The comparison of decisions can problematize the discourse of mental health law in British Columbia and provide discursive resources, framed as both legal and moral claims, for considering ways to change mental health laws in this province that may conflict with expressions of rights set out in the *Charter*.³ As I stressed at the end of chapter 4, the analysis in this dissertation of whether British Columbia's *Mental Health Act* violates *Charter* rights is not an expression of civil libertarian forms of legal argumentation. Rather the overarching view is that the analysis in this chapter, while drawing on terms that lawyers use in courts and legal academics employ in their writings, is a form of dialogic engagement with legal authority that is consistent with Foucault's notions of genealogical critique and *parrhesia*.

In the first section of this chapter, I describe the two main sources of provincial mental health law systems arising from legislation and case law. I also set out the basic procedural features of advancing *Charter* cases in Canada. In the second section, I describe the core features of British Columbia's contemporary mental health law system related to civil commitment and give an account of some of the cases that have come before British Columbia's courts since the early 1990s to consider the constitutionality of these laws. I

³ A number of scholars across Canada have expressed concerns that British Columbia's laws of civil commitment are contrary to the *Charter*. See especially Simon N. Verdun-Jones & Michelle S. Lawrence, "The Charter Right to Refuse Psychiatric Treatment: A Comparative Analysis of the Laws of Ontario and British Columbia Concerning the Right of Mental-Health Patients to Refuse Psychiatric Treatment" (2013) 46 UBC LR 489. The analysis in that paper was restricted to section 7 *Charter* rights. Also see Peter J. Carver, "Mental Health Law in Canada" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 3d ed (Toronto: LexisNexis, 2007) at 418; Sheila Wildeman, "Access to Treatment of Serous Mental Illness: Enabling Choice or Enabling Treatment?" in Colleen M. Flood, ed, *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) at 242; and Joaquin Zuckerberg, "Canadian Health Law and Its Discontents: A Reappraisal of the Canadian Experience" in Bernadette McSherry & Penelope Weller, eds, *Rethinking Rights-based Mental Health Laws* (Portland: Hart, 2010) at 307.

show how one of these cases, *McCorkell v. Riverview Hospital*, has been instrumental in shaping the discourses of medicine and law in this province toward the empowerment of psychiatric discretion over patients, whose capacity to consent to the treatment is now legally irrelevant. In the third section I describe court cases from Ontario that have also shaped medico-legal discourse in that province, apparently toward the prioritization of patient's capacity to consent to treatment, and have influenced social institutions in ways that are significantly different from what is found in British Columbia. In the fourth section, I return to the mental health law system in British Columbia to show how legal texts from the Supreme Court of Canada and Ontario courts problematize mental health laws in British Columbia and raise questions as to whether the mental health laws in this province violate rights to security of the person. In section 5, I describe how Supreme Court of Canada cases on equality rights under section 15 of the *Charter* may clarify whether the differential treatment of people diagnosed as having mental illnesses in British Columbia is discriminatory. Finally, in section 6 I explore how sections 7 and 15 of the *Charter* might be justified by the operation of section 1.

5.1 Sources of Laws and Principles of *Charter* Litigation

5.1(A) The Sources of Provincial Mental Health Laws

In Canada, health care is under the jurisdiction of the provincial governments and, as such, each province has its own mental health care system, expressed in statutes and regulations. These laws concern, among other things, involuntary medical treatment of patients and guardianship of adults considered incapable of handling their own affairs. The provincial mental health laws are diverse and exhibit a wide variety of levels of commitment to

assessments of mental capacity to consent to medical treatment.⁴ The mental health laws in each province are found not only in legislation but also in texts of courts cases that interpret the meanings of the statutes and, among other things, make pronouncements on whether they are in compliance with laws set out in other statutes. Although mental health legislation differs between provinces, there are principles that guide *Charter* litigation in every province. Before I describe British Columbia's mental health legislation, I set out these common principles of *Charter* litigation.

5.1(A)(i) Principles of *Charter* Litigation

5.1(A)(i)(a) Burden of Proof for *Charter* Cases

In the cases that consider *Charter* challenges, the person alleging that a *Charter* violation has occurred bears the burden of proving that a right set out in one of the sections of the *Charter* has been breached. Since the *Charter* only applies to actions of the government, an agent of the government is always named as the defendant or respondent in the lawsuit.⁵ If the applicants satisfy the court that they have provided enough evidence to meet the burden of proof at this initial stage, the government then has the burden of proving that this violation is nevertheless saved under section 1 of the *Charter*.⁶ In the most general terms, section 1 justifications involve identifying important community objectives that place reasonable limits on individual rights. For example, persons who are imprisoned following the commission of serious violent criminal offences, such as murder, may be able to prove

⁴ Gray & O'Reilly, *supra* note 2 at 315.

⁵ It is important to note that, while *Charter* litigation can include legal remedies for individuals and address the way that government agencies and administrative tribunals exercise their discretion, the *Charter* cases discussed in this dissertation concern challenges to the constitutionality of the legislation that empowers these bodies.

⁶ Section 1 of the *Charter* states: "The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

that their right to liberty under section 9⁷ of the *Charter* has been violated, but the government will likely be able to demonstrate, under section 1, that this prima facie infringement is justified as a reasonable measure for the protection of the public or the deterrence of crime.

5.1(A)(i)(b) Adversarial Nature of *Charter* Challenges

Like all other lawsuits in adversarial settings, the parties to the dispute and not the judges define issues to which evidence is relevant at the hearings. The parties that have standing to commence *Charter* challenges must be affected by laws that they claim violate their rights. If these parties retain lawyers to represent them in court, then the lawyers must act on the instructions of the parties. The lawyers are the parties' agents and act as strategic resources through which the parties extend their challenges to government authorities. The legal issues in dispute are set out in the documents, called pleadings, that applicants for *Charter* remedies use to initiate the lawsuits or in the responding documents filed by the defendants. If the applicants restrict the legal basis of their claim in their pleadings to one section of the *Charter*, such as liberty rights, the judge cannot, on his or her own initiative, reframe the case as one involving equality rights. As I describe below, the nature of the pleadings in the British Columbia's most significant *Charter* cases narrowly defined the issues that the judges could consider.

5.1(A)(i)(c) The Effects of Courts' *Charter* Declarations

Laws or acts of government that, on their face or in their effect, violate *Charter* rights may be declared unconstitutional under section 52 of the *Constitution Act* as being inconsistent

⁷ According to section 9 of the *Charter*, "Everyone has the right not to be arbitrarily detained or imprisoned."

with the laws of Canada and therefore of “no force or effect”.⁸ The declaration that a law is unconstitutional is commonly referred to as an act of “striking down” that law, which is a constitutional remedy permitted under section 24(1) of the *Charter*. Frequently, however, courts will suspend the effect of such a declaration to give governments a transition period to amend laws in order to avoid disorder or confusion that otherwise may result from the sudden negation of a set of laws.⁹

5.1(A)(i)(d) Jurisdictions in which *Charter* Decisions are Binding

A court’s declaration in one province that a law contravenes the *Charter* is not binding on any court in other provinces, even if it applies to the same laws. For example, the Ontario Court of Appeal (the highest court in Ontario) upheld the Ontario Superior Court of Justice’s decision of *Bedford v. Canada (Attorney General)*¹⁰ to strike down sections of the *Criminal Code of Canada*¹¹ (the “*Criminal Code*”) concerning prostitution. This appellate decision was binding on the Ontario government and all courts in Ontario, but it was not binding on any court in British Columbia. Courts in British Columbia continued to enforce provisions of the relevant sections of *Criminal Code*, which no longer have any force in Ontario. However, when the Supreme Court of Canada, as the highest court for all jurisdictions in Canada, affirmed the Ontario Court of Appeal’s decision in *Bedford*, the

⁸ 9 S. 52 (1) states that: “The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.”

⁹ See for example *R. v. Swain*, [1991] SCJ No. 32, 1 SCR 933 in which the Supreme Court struck down the law that permitted the indefinite detention of persons found not guilty by reason of mental disorder. The Supreme Court suspended the effect of the constitutional declaration for several months to give the federal government time to amend the relevant criminal laws and procedures.

¹⁰ [2010], OJ No. 4037, 102 OR (3d) 321.

¹¹ *Criminal Code of Canada* RSC 1985, c C-46.

provision in the *Criminal Code* became invalid in all provinces.¹² This point is particularly important to bear in mind when analyzing the effects of *Charter* decisions concerning mental health laws in provinces outside of British Columbia.

5.1(B) Summary of Section 5.2

The two principle sources of mental health laws in Canada are legislation and court cases that interpret the legislation.¹³ Although mental health statutes differ between provinces in Canada, there are principles of *Charter* litigation that apply to *Charter* cases in all provinces in Canada.

5.2 British Columbia's Mental Health Law on Civil Commitment

British Columbia's mental health laws related to civil commitment are set out in a number of interlocking statutes and regulations, as well as in cases that interpret this legislation, the most important of which are *Charter* court cases. The legislation and the court cases are examined in turn.

5.2(A) Relevant Mental Health Legislation

5.2(A)(i) The *Health Care (Consent) and Care Facility (Admission) Act*

The most important place to begin an examination of British Columbia's mental health legislation is section 2 of the *Health Care (Consent) and Care Facility (Admission) Act*,¹⁴ (hereafter the *HCCA*), which specifically states that the *Act* does not apply to a certain

¹² *Canada (Attorney General) v. Bedford* [2013] S.C.J. No 72, 3 S.C.R. 1101 [*Bedford*]. The Supreme Court of Canada suspended the effects of its judgment in *Bedford* for a year to give the Federal Government time to amend the *Criminal Code*.

¹³ Written decisions from administrative hearings also interpret legislation and are another source of law, but in this chapter I am concerned only with statutes and court cases.

¹⁴ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181 [*HCCA*].

group of people who are thought to have mental disorders. In order to understand the implications of section 2, it is necessary to first identify the rights given to other adults under sections 3 and 4 of that statute. These sections state:

Presumption of Capability

3. (1) Unless the contrary is demonstrated, every adult is presumed to be capable of
 - (a) giving, refusing or revoking consent to health care, and
 - (b) deciding to apply for admission to a health care facility, to accept a facility care proposal, or to move out of the care facility.
- (2) An adult's way of communicating with others is not, by itself, grounds for deciding that he or she is incapable of understanding anything referred to in subsection 1.

Consent Rights

4. Every adult who is capable of giving or refusing consent to health care has
 - (a) the right to give consent or refuse consent on any grounds, including moral or religious grounds, even if the decision results in death,
 - (b) the right to select a particular form of available health care on any grounds, including religious or moral grounds,
 - (c) the right to revoke consent,
 - (d) the right to expect that a decision to give, refuse or revoke consent will be respected, and
 - (e) the right to be involved to the greatest degree possible in all case planning and decision making.

By operation of section 2 of the *HCCA*, all these rights to informed consent and presumptions of capacity are abrogated for persons subject to civil committal under section 22 of the *Mental Health Act*.¹⁵ Section 2 of the *HCCA* states:

Application of this Act

2. This Act does not apply to:

¹⁵ *Mental Health Act*, RSBC 1996, C.238 [*Mental Health Act*].

- (a) admission of a person to a designated facility under sections 22, 28, 29 and 30 of the *Mental Health Act*
- (b) The provision of treatment or psychiatric care under sections 22, 28, 29, 30 or 42 of the *Mental Health Act*
- (c) The provision of psychiatric care or treatment under the *Mental Health Act* to a person released on leave or transferred to an approved home under sections 37 or 38 of the *Mental Health Act*
- (d) The provision of professional services, care or treatment to a person for the purposes of sterilization or non-therapeutic purposes.

5.2(A)(ii) The *Mental Health Act*

The question of whether the right to the informed consent removed under section 2 of the *HCCA* is resurrected anywhere in the *Mental Health Act* can only be answered by examining closely the wording in that *Act*, particularly section 31 where the issue of consent is addressed directly. According to that section:

Deemed consent to treatment and request for a second opinion

- 31 (1) If a person is detained in a designated facility under sections 22, 28, 29, 30 or 42 or is released on leave or is transferred to an approved home under section 27 or 38, treatment authorized by the director is deemed to be given with the consent of the patient
- (2) A patient to whom section 1 applies, or a person on the patient's behalf may request a second opinion on the appropriateness of the treatment authorized by the director once in each of the following periods:
- (a) a one month period referred to in section 23 or 24(1)(a);
 - (b) a three month period referred to in section 24(1)(b)
 - (c) a six month period referred to in section 24(1)(c) [emphasis added]

This provision, along with the sections of the *HCCA* noted above, confers power on psychiatrists to impose treatment on persons whom they diagnose as having mental disorders, with the “director” acting on a statutory presumption that the patients consent to whatever the director considers necessary for treatment, even in the face of opposition from patients who are capable of refusing consent. As section 1 of the *Mental Health Act*

confirms, the director may delegate his power to agents, which includes all psychiatrists in hospitals.¹⁶

There is nothing in the current civil commitment criteria found in sections 1 or 22 of the *Act* that would require a psychiatrist to consider issues of capacity to consent to treatment.

Section 1 of the *Mental Health Act* defines “person with a mental disorder” as follows:

Definitions

1. “person with a mental disorder” means a person who has a disorder of the mind that requires treatment and seriously impairs the person’s ability:
 - (a) to react appropriately to the person’s environment, or
 - (b) associate with others.

Section 22 allows the director or his agents to detain a person for 48 hours and this detention may be extended if the person is examined by a physician who completes Form 4 of the *Mental Health Act Regulations* confirming compliance with section 22(3) which states:

- 22 (3) Each medical certificate under this section must be completed by a physician who has examined the person to be admitted, or the patient admitted, under subsection (1) and must set out
 - (a) a statement by the physician that the physician
 - (i) has examined the person or patient on the date or dates set out, and
 - (ii) is of the opinion that the person or patient is a person with a mental disorder,
 - (b) the reasons in summary form for the opinion, and
 - (c) a statement, separate from that under paragraph (a), by the physician that the physician is of the opinion that the person to be admitted, or the patient admitted, under subsection (1)
 - (i) requires treatment in or through a designated facility;

¹⁶ A “director” is defined in section 1 of the *Mental Health Act* as “a person appointed under the regulations to be in charge of a designated facility and included a person authorized by a director to exercise a power or carry out a duty conferred or imposed on a director under this *Act* or under the *Patient’s Property Act*.”

- (ii) requires care, supervision and control through a designated facility to prevent the person's substantial mental or physical deterioration¹⁷ or for the protection of the person or patient or the protection of others, and
- (iii) cannot suitably be admitted as a voluntary patient. [emphasis added]

The definition of “mentally disordered person” in section 1 and the three requirements in 22(3)(c) together comprise the four necessary and jointly sufficient conditions for civil commitment (the “Four Criteria”). Since consent is deemed to be given under section 31, the patient’s actual capacity to consent or capacity to refuse treatment is irrelevant. After physicians complete Form 4 of the *Mental Health Act Regulations*, hospitals are empowered to impose further involuntary treatment on patients who are then labelled as “certified.”

The patient’s right to have the initial committal order reviewed by the Review Panel is set out in section 25 of the *Act*, which does not give the Panel any residual discretion to consider issues of capacity to consent to treatment. The relevant portions of section 25 are as follows:

- 25 (1) A patient detained under section 22 is entitled, at the request of the patient or a person on the patient’s behalf, to a hearing by a review panel.
- (2) The purpose of a hearing under this section is to determine whether the detention of the patient should continue because section 22(3)(a)(ii) and (c) continues to describe the condition of the patient.
 - (2.1) A hearing by a review panel must include
 - (a) consideration of all reasonably available evidence concerning the patient’s history of mental disorder including
 - (i) hospitalization for treatment, and
 - (ii) compliance with treatment plans following hospitalization, and

¹⁷ The emphasis has been added to highlight the amendment that was made in 1998 to the civil committal criteria found in the former section 20 of the *Act*, which was examined in the 1993 case of *McCorkell v. Riverview Hospital (Director)*, [1993] BCJ 1518, 81 BCLR (2d) 273 as described below. Otherwise the criteria are the same.

- (b) an assessment of whether there is a significant risk that the patient, if discharged, will as a result of mental disorder fail to follow the treatment plan the director or physician authorized by the director considers necessary to minimize the possibility that the patient will again be detained under section 22.
- (2.2) Despite any defect or apparent defect in the authority for the initial or continued detention of a patient detained under section 22, a review panel must conduct a hearing and determine whether the detention should continue because of factors in section 22(3)(a)(ii) and (c) continue to describe the condition of the patient. [emphasis added]

The highlighted portions of section 25 confirm that the Review Panel’s discretion is bound by the committal criteria set out in section 22, in which a patient’s actual capacity to consent to treatment is irrelevant. Although the Review Panel is inquisitorial in its power to gather evidence, it would exceed its jurisdiction if it considered issues of consent, which is always deemed conclusively given through the director under section 31 of the *Act*. Under the *Act* the *only* relevant consideration for imposing involuntary treatment on patients who are not a danger to others is whether the treatment is in their “best interests.”¹⁸

5.2(B) Charter Challenges to British Columbia’s Mental Health Legislation

In this section I describe the most important British Columbia court case that has considered the question of whether the Four Criteria set out in section 22 of the *Mental Health Act* are contrary to the *Charter*.

5.2(B)(i) *McCorkell v. Riverview Hospital*

In the 1993 case of *McCorkell v. Riverview Hospital (Director)*,¹⁹ (“*McCorkell*”) the Supreme Court of British Columbia upheld the constitutionality of this province’s *Mental*

¹⁸ The Review Panel cannot consider *Charter* challenges at a hearing. Indeed section 44f(1) of the *Administrative Tribunal Act* R.S.B.C. 2004 c 45 specifically states that: “the tribunal does not have jurisdiction over constitutional questions.”

¹⁹ *McCorkell v. Riverview Hospital (Director)* [1993] BCJ 1518, 81 BCLR (2d) 273 [*McCorkell*].

Health Act, as it existed at that time. *McCorkell* involved a patient, Joseph McCorkell, who had been committed as an involuntary patient at Riverview Hospital in 1991. A psychiatrist had diagnosed him as having a bi-polar disorder and chronic alcoholism and had made an order that he be detained in a treatment centre at Riverview. The Review Panel upheld the detention order, though one of the panel members filed a dissenting opinion. McCorkell then brought an application for judicial review of the Review Panel's decision and a constitutional challenge to the involuntary commitment criteria, pursuant to section 7 *Charter*, which states that:

Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with principles of fundamental justice.

McCorkell's lawyer restricted his argument to his client's liberty interests under section 7 and did not address issues of security of the person. The constitutional challenge was based on the argument that the civil committal criteria in effect at the time of McCorkell's detention were vague, overbroad and arbitrary.²⁰ The lawyer argued that the only criterion that should be used for the involuntary detention and treatment of persons found to have a mental disorder is whether they are "physically dangerous" to themselves or others.

When considering the section 7 arguments, the presiding judge, Donald J. noted that McCorkell had a two-step burden of proving, on a balance of probabilities, that: 1) his rights to liberty had been violated; and 2) that these violations had not been in accordance with principles of fundamental justice. Donald J. found that the *Mental Health Act* had deprived McCorkell of his right to liberty, and then directed his attention to the question of

²⁰ Section 20 was later amended in 1998 in a way that probably does not make a difference to the *Charter* arguments found in *McCorkell*.

whether this had been done in accordance with principles of fundamental justice, which includes, as McCorkell's lawyer argued, the principle that laws must not be unduly vague. In addressing this issue, Donald J. referred to a passage from the Supreme Court of Canada case of *R. v. Nova Scotia*²¹, in which Gonthier J. stated that:

The doctrine of vagueness can therefore be summed up in this proposition: a law will be found unconstitutionally vague if it so lacks in precision as not to give sufficient guidance for legal debate.²²

Donald J. rejected McCorkell's argument that the committal criteria in the *Act* lacked sufficient precision. He held the required level of precision must be viewed in the context of the purpose of the *Act*, which he found to be "the treatment of the mentally disordered who need protection and care in a provincial psychiatric hospital."²³ According to Donald J., the legislation must be flexible and general enough to allow for medical discretion and the wording of the committal criteria are clear enough to guide legal debate even when there are competing interpretations of their meaning. According to Donald J. "overly detailed language may only serve to confuse those who have to apply it and it may leave out unforeseen circumstances that should be included in the scheme."²⁴

Donald J. also rejected McCorkell's argument that the only criterion that should be used for civil commitment is whether patients are dangerous to themselves or others. Donald J. found that the "*parens patriae*"²⁵ jurisdiction of the Crown to take care of people in need is

²¹ 22 23 *R. v. Nova Scotia* [1992] SCJ No. 67, 2 SCR 606.

²² *Ibid* para 72.

²³ *McCorkell*, *supra* note 18, at para 51.

²⁴ *Ibid* at para 52.

²⁵ "*parens patriae*" is a translation of the Latin term "parent of the country" and is the power of the Crown and the superior court to deal with matters involving persons with disabilities and, under appropriate

a principle of fundamental justice that permits the government to treat people involuntarily who may not be dangerous to themselves or others. He therefore concluded that British Columbia's legislation is a fair and rational approach for the treatment of persons who are diagnosed as having mental disorders, but are nonetheless not dangerous.²⁶ According to Donald J., the reference to "protection" in section 20 of British Columbia's *Mental Health Act* implies the notion of "harm", which according to him is not simply physical harm but "harms that relate to social, family, vocational or financial life of the patient."²⁷

Through his lawyer, McCorkell narrowly defined in his pleadings the issues that Donald J. could consider at trial. Due to the nature of the pleadings, Donald J. could not consider whether civil committal criteria of the *Mental Health Act* violated the security of the person provision in section 7 of the *Charter* on the grounds that these laws permitted involuntary medical treatment to be imposed on persons who may be mentally capable of withholding consent to treatment, as was argued successfully in the Ontario case of *Fleming v. Reid*,²⁸ which I examine below. The issue of the deemed consent provisions in section 31 was never raised at trial and was not addressed in the judgment. Moreover, Donald J. could not consider whether the *Mental Health Act* was contrary to equality rights in the *Charter* because, again, that section was never mentioned in the pleadings. The decision in *McCorkell* was never appealed and therefore, according to the law, it stands as binding precedent in British Columbia.

circumstances, to make decisions on their behalf. *Canadian Law Dictionary*, 2d ed, sub verbo "*paran patriae*."

²⁶ *McCorkell*, *supra* note 18, at paras 68 and 73.

²⁷ *Ibid* note 18 at para 58.

²⁸ *Fleming v. Reid*, [1991] OJ No. 1083, 4 OR (3d) 74 [*Fleming*].

5.2(C) Summary of Section 5.3

In British Columbia, mental health legislation is set out in two interlocking statutes: the *Mental Health Act* and the *HCCA*, which together establish a regime in which involuntary medical treatment can be imposed on patients who have the mental capacity to withhold consent to treatment. Unlike all other adults in British Columbia who, pursuant to the *HCCA*, can withhold consent for health care treatment they do not want, patients who are subject to civil commitment orders do not have that statutory protection. Such patients can be subjected to involuntary psychiatric treatment regardless of whether they have the capacity to withhold consent to that treatment. The only significant case that ruled on the constitutionality of these statutes was *McCorkell*, which did not consider whether those statutes violated patients' rights to security of the person or equality under sections 7 and 15 of the *Charter* respectively. In addition, that decision did not consider the deemed consent provisions in section 31 of the *Mental Health Act*. Instead, in *McCorkell* Donald J.'s decision was focused on liberty interests under section 7 of the *Charter*. Contrary to McCorkell's arguments at trial, Donald J. decided that these provisions were not too vague and that the Crown's *parens patriae* jurisdiction is a principle of fundamental justice that permits the involuntary treatment of people who are not dangerous. Donald J. therefore dismissed McCorkell's application.

The legacy of the *McCorkell* judgment is that it reinforced British Columbia's mental health law system as one that places high priority on medical paternalism, ostensibly for the patient's benefit. *McCorkell* is frequently cited in Review Panel hearings and has had a

significant effect in shaping the medico-legal discourse on civil committal and its institutional enforcement in British Columbia in the past twenty years.²⁹

5.3 Court Cases Outside of British Columbia

This section concerns two court cases from Ontario, *Fleming* and *Starson v. Swayze*³⁰ that considered the civil commitment provisions of Ontario's former mental health legislation. The result of these two decisions is that Ontario's mental health law discourse changed quite significantly to one that appears to place priority on issues of patients' capacity to consent to psychiatric treatment. Before I scrutinize those Ontario cases, I first elaborate on the reference to the section 7 protection of security of the person which was not considered in *McCorkell*, but which was at the centre of the *Fleming* case.

5.3(A) Section 7 and Security of the Person

Applicants claiming legal remedies pursuant to section 7 in relation to security of the person bear the two-step burden of proving, on a balance of probabilities, that: 1) their right to security of the person has been violated; and 2) these violations have not been in accordance with principles of fundamental justice.

²⁹ In a study applying a semiotic methodology to written judicial decisions concerning civil commitment in the United States, Bruce Arrigo demonstrates how appellate courts in that country have consistently adopted paternalistic psychiatric language that is pervasively prejudicial to patients. See Bruce Arrigo, *Madness, Language and the Law* (Albany: Harrow & Heston, 1993). As Arrigo states at page 137, "This clinicolegal attitude (language and thought) speaks to a particular posture toward the profoundly ill that has significant justice policy implications for this group of citizens or individuals within it." Arrigo's observations concerning the deleterious implications of judicial pronouncements that shape justice policies are applicable to the *McCorkell* decision and its aftermath, as I demonstrate at greater length in chapter 7 when I examine data from civil commitment hearings in British Columbia.

³⁰ *Starson v. Swayze* [2003] S.C.J. No. 33, 2 S.C.R. 357.

5.3(A)(i) Security of the Person

As the Supreme Court confirmed in *R. v. Morgentaler*³¹ (*Morgentaler*), there is overlap between the right to liberty and right to security of the person, grounded in a conception of human dignity.³² In striking down the former abortion laws set out in the *Criminal Code*, the Supreme Court in *Morgentaler* found that these laws violated women's rights to liberty and security of the person in a manner that was not in accordance with fundamental justice.

As Dickson C.J.C. stated:

the case law leads me to the conclusion that state interference with bodily integrity and serious state imposed stress, at least in the criminal law context, constitutes a breach of security of the person. It is not necessary in this case to determine whether the right extends further to protect interests central to personal autonomy, such as a right to privacy, or interest unrelated to criminal justice.³³

Later, the Supreme Court extended the right to security of the person to include distress in civil law contexts, such the physical and emotional stress caused by Ministry of Health child custody orders³⁴ and by delays and waiting lists for medical treatment.³⁵

5.3(A)(ii) Principles of Fundamental Justice

In reaching its decision that the violations of the rights to liberty and security of the person were not in accordance with principles of fundamental justice, the court in *Morgentaler*

³¹ *R. v. Morgentaler* [1988] SCJ No. 1, 1 SCR 30 [*Morgentaler*].

³² *Ibid* at para 229.

³³ *Ibid* at para 22.

³⁴ *New Brunswick v. J.G.*, [1999] SCJ No. 47, 3 SCR 46.

³⁵ *Chaoulli v. Quebec*, [2005] SCJ No. 33, 1 SCR 791.

referred to its earlier decision in *Reference Re: Motor Vehicle Act*³⁶ in which Lamer J. stated that:

The term “principle of fundamental justice” is not a right, but a qualifier of the right not to be deprived of life, liberty, and security of the person; its function is to set the parameters of that right.

Sections 8 to 14 address specific deprivations of the “right” to life, liberty and security of the person in breach of the principles of fundamental justice, and as such, violations of s. 7. They are therefore illustrative of the meaning, in criminal and penal law, of “principles of fundamental justice”; they represent principles that have been recognized in the common law, the international conventions and by the very fact of the entrenchment of the *Charter*, as essential elements of a system for the administration of justice which is founded upon a belief in the dignity and worth of the human person and the rule of law.

Consequently, the principles of fundamental justice are to be found in the basic tenets and principles, not only of our judicial process, but also of the other components of our legal system.

Whether any given principle may be said to be a principle of fundamental justice within the meaning of s. 7 will rest upon an analysis of the nature, sources, rationale and essential role of that principle within the judicial process and our legal system as it evolves.³⁷

As this quotation indicates, principles of fundamental justice can change as the legal system evolves, a consideration that forces the Court to identify developments in social policies and values that underlie the law. In the 2013 case of *Canada (Attorney General) v. Bedford* the Supreme Court of Canada reviewed its decisions on principles of fundamental justice since 1985 and, while continuing to adopt *Reference Re: Motor Vehicle Act*, augmented it as follows:

The overarching lesson that emerges from the case law is that the law runs afoul of our basic values when the means by which the state seeks to attain

³⁶ *Reference Re: Motor Vehicle Act* [1985], SCJ No. 73, 2 SCR 486, at para 61.

³⁷ *Ibid* at para 61.

it objective is fundamentally flawed, in the sense of being arbitrary, overbroad, or having effects that are grossly disproportionate to the legislative goal. To deprive citizens of life, liberty and security of the person by laws that violate these norms is not in accordance with principles of fundamental justice.³⁸

In *Bedford*, the Court struck down prostitution laws because they violated rights to security of the person of sex trade workers in a manner that was not in accordance with principles of fundamental justice because the law to curtail activities such as street solicitation created situations that put such women in physical danger. Thus the laws were overbroad and had harmful effects that were grossly disproportionate to the legislative goal.³⁹

5.3(B) *Fleming v. Reid*

The Ontario Court of Appeal case of *Fleming* is the highest court in Canada to have fully considered the constitutionality of involuntary treatment orders and, while not binding upon courts in other provinces, it could be regarded persuasive. The significance of that case was recognized by the Supreme Court of Canada in the 2003 case of *Starson*, which, while not a *Charter* case, adopted much of the reasoning in *Fleming* in relation to the right to informed consent to psychiatric treatment.

5.3(B)(i) Psychiatrists' Conduct in *Fleming*

The case of *Fleming* involved two men who had been diagnosed as having schizophrenic disorders and, having committed serious criminal offences, were detained in a secure facility in the Penatanguishene Mental Health Centre in northern Ontario. Being so detained, they were considered “involuntary patients” who nevertheless had the right, under Ontario law, to refuse unwanted psychiatric treatment when they had the capacity to make

³⁸ *Bedford*, *supra* note 12.

³⁹ *Ibid* at paras 139-140.

competent medical decisions. An important fact in the case, admitted by the lawyers for the government, was that while these men were competent to make decisions concerning their medical treatment, they gave advance directives to the Public Guardian and Trustee (a legal guardian appointed by the government of Ontario) that if they lost the capacity to make medical decisions they were not to be treated with psychiatric medication because they did not believe the medication was effective and also because it caused very serious adverse effects for their physical health. Sometime after providing these advance directives, psychiatrists at Penatanguishene concluded that the patients' mental condition had deteriorated and that they no longer had the capacity to make competent medical treatment decisions. The psychiatrists then ordered that the patients be subject to the forcible administration of psychiatric medication, the very treatment they were adamantly opposed to receiving. Pursuant to section 1(a) of the *Mental Health Act*, the Official Guardian then advised the psychiatrists of the patients' competent refusal to consent set out in the advance directives, effectively preventing the psychiatrists from imposing pharmaceutical treatment. The psychiatrists then applied under section 35a(1) of the *Act* to Ontario's Review Board (as it was called then) for an order to enforce the involuntary treatment.

5.3(B)(ii) The Review Board Decision in *Fleming*

The Review Board upheld the physicians' order for involuntary treatment and in its decision referred to sections 35(2) of Ontario's *Mental Health Act*.⁴⁰ The *Act* stated that:

35(2) Psychiatric and other medical treatment shall not be given to a patient,

⁴⁰ *Mental Health Act*, RSO 1980, c 262.

- (c) where the patient is mentally competent, without the voluntary, informed consent of the patient,
- (d) where the patient is not mentally competent,
 - i. without the consent of a person authorized by section 1a to consent on behalf of the patient,
 - ii. unless the review board has made an order authorizing the giving of the specified psychiatric and other related medical treatment, or
 - iii. unless a physician certifies in writing that there is imminent and serious danger to the life, a limb or vital organ of the patient requiring immediate treatment and the physician believes that delay in obtaining consent would endanger the life, limb or a vital organ of the patient.

The scope of the Review Board's discretion to review the nonconsensual psychiatric treatment for persons found to not be mentally competent under section 35(2)(b)(ii) (which applies even when prior competent instructions are communicated to the Official Guardian) is defined under section 35a(4) as follows:

35a(4) The review board by order may authorize the giving of psychiatric and other related treatment if it is satisfied that:

- (a) the mental condition of the patient will be or is likely to be substantially improved by the specific psychiatric treatment;
- (b) the mental condition of the patient will not improve or is not likely to improve without the specified psychiatric treatment;
- (c) the anticipated benefit from the specified psychiatric treatment and other related medical treatment outweigh the risk of harm to the patient; and
- (d) the specified psychiatric treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (a), (b) and (c).

As with all administrative tribunals, the Review Board only had the power and jurisdiction specifically granted in the legislation that both constituted it as a legal entity and defined the scope of its discretion. The Review Board noted that when engaged in a review under sections 35(b)(ii) and 35a(4), it *must* follow the criteria set out in those sections, all of which are related to weighing the benefits of the treatment against any potential harm, with

a view to determining the “best interests” of the patients. These sections, however, prevented the Review Board from considering the prior competent instructions of the patients. In other words, since the issue of consent was not specifically raised in 35a(4) it *could not* form part of the Review Board’s reasons.

5.3(B)(iii) The *Fleming* Court of Appeal Decision

These patients sought judicial review of the Review Board’s decision in the Ontario District Court and also brought a constitutional challenge to sections 35(2)(b)(ii) and 35a(4) of Ontario’s *Mental Health Act* on the grounds that these sections violated their rights to security of the person under section 7 of the *Charter*. The Ontario district court dismissed the patients’ application and the patients then appealed that decision to the Ontario Court of Appeal, which overturned the lower court’s decision on the basis that its analysis of the principles of fundamental justice was incorrect. Before analyzing the principles of fundamental justice in this context, Robins J.A., writing the unanimous decision of the Ontario Court of Appeal, reviewed the medical literature on the effects of psychiatric medication to determine whether the psychiatrist’s proposed treatment was a violation of the patient’s security of the person. In passages later quoted by the Supreme Court of Canada in *Starson*, Robins J.A. observed that:

Few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side-effects. To deprive involuntary patients of any right to make competent decisions with respect to such treatment when they become incompetent, and force them to submit to such medication, against their competent wishes and without the consent of their legally appointed substitute decision-makers, clearly infringes their *Charter* right to security of the person.⁴¹

⁴¹ *Fleming*, *supra* note 42 at 12.

When articulating the applicable principles of fundamental justice, the Court of Appeal disagreed with Tobias J. that the Crown's *parens patriae* jurisdiction (one of the purposes of the statute) was the overriding consideration. Robins J.A. referred to the Supreme Court of Canada's decision in *E. (Mrs.) v. Eve*⁴² in which the court stated that:

Though the scope or sphere of operation of the *parens patriae* jurisdiction may be unlimited, it by no means follows that the discretion to exercise it is unlimited. It must be exercised in accordance with its underlying principle. Simply put, the discretion is to do what is necessary for the protection of the person for whose benefit it is exercised. The crown's *parens patriae* jurisdiction exists for the benefit of those who cannot help themselves, not to relieve those who may have the burden of caring for them.⁴³

After noting the Supreme Court of Canada's express limitations on the use of the *parens patriae* jurisdiction in *Eve*, Robins J.A. stated that it could not be invoked to overturn the instructions of competent patients who expressly state that they would refuse the administration of psychiatric medication, even after they become incompetent. Robins J.A. stated that the right to informed consent to medical treatment is a right deeply rooted in the common laws and the values of Canadian society:

The right to determine what shall, or shall not be done with one's body, and to be free from nonconsensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination. The doctrine of informed consent ensures that the freedom of individuals to make choices about medical care. It is the patient, not the doctor, who ultimately must decide if treatment – any treatment – is to be administered...This right must be honoured, even though the treatment may be beneficial or necessary to

⁴² *E. (Mrs.) v Eve* [2003], SCJ No. 60, 2 SCR 357 [*Eve*].

⁴³ *Ibid* at para 77 [emphasis added].

preserve the patient's life or health, and regardless of how ill-advised the patient's decision may appear to others.

These traditional common law principles extend to mentally competent patients in psychiatric facilities. They, like competent adults generally, are entitled to control the course of their medical treatment. Their right of self-determination is not forfeited when they enter a psychiatric facility. They may, if they wish, reject their doctor's psychiatric advice and refuse to take psychotropic drugs, just as patients suffering from other forms of illness may reject the doctor's advice and refuse, for instance, to take insulin or undergo chemotherapy. The fact that these patients, whether voluntary or involuntary, are hospitalized in a mental institution in order to obtain care and treatment for mental disorder does not necessarily render them incompetent to make psychiatric treatment decisions. They may be incapacitated for particular reasons but nonetheless be competent to decide upon their medical care.⁴⁴

What the Ontario Court of Appeal found most offensive in Ontario's *Mental Health Act* was that section 35a(4)(b) required the Review Board to determine whether involuntary treatment was in the best interests of the patients without *any* consideration of their prior express wishes; in other words, without any regard for informed instructions of persons capable of withholding consent to treatment. Robins J.A. found this to be a violation of a principle of fundamental justice.

A legislative scheme that permits the competent wishes of a psychiatric patient to be overridden, and which allows a patient's right to personal autonomy and self-determination to be defeated, without affording a hearing as to why the substitute consent-giver's decision to refuse consent based on the patient's wishes should not be honoured, in my opinion, violates "the basic tenets of our legal system" and cannot be in accordance with principles of fundamental justice.⁴⁵

The Ontario Court of Appeal found that the violation of section 7 rights caused by section 35a(4) was not saved by section 1 of the *Charter* because it did not impair the right to consensual medical treatment as little as possible; rather it completely ignored that right. In

⁴⁴ *Fleming, supra* note 42 at 10.

⁴⁵ *Ibid* at 11.

addition, Robins J.A. concluded that this analysis of section 7 was sufficient to strike down the legislation and therefore he did not consider, or make a ruling on, the patients' arguments that their right to equality had been violated under section 15. The Ontario government's application for leave to appeal the judgment to the Supreme Court of Canada was denied.

5.3(B)(iv) The Legal and Institutional Consequences of the *Fleming* Appeal

As a result of the *Fleming* decision, Ontario's *Mental Health Act* was amended to expunge the impugned provisions in section 35. The Review Board (now renamed the Consent and Capacity Review Board) in that province must always take account of the informed competent wishes of persons, either directly or through their legal guardians. The *Fleming* decision has altered a number of medico-legal practices related to the civil committal in Ontario.⁴⁶

5.3(C) *Starson v. Swayze*

The case of *Fleming* was referred to frequently in the later case of Supreme Court of Canada case of *Starson*. *Starson* was not a *Charter* case, and it specifically dealt with the current provisions of Ontario's *Mental Health Act*⁴⁷ and *Health Care Consent Act*.⁴⁸ The *Starson* case focused on the interpretation of the statutory provisions in Ontario for determining patients' capacity to consent to treatment. It was not concerned with whether those Ontario provisions were constitutional. Nevertheless, *Starson* would be relevant for

⁴⁶ Brian F. Hoffman, *The Law of Informed Consent to Treatment in Ontario* (Toronto: Butterworths, 1997) at 16.

⁴⁷ *Mental Health Act*, RSO 1990, c M.7

⁴⁸ *Health Care Consent Act*, RSO 1996, c 2.

courts in British Columbia that consider issues of informed consent of patients who have the capacity to make decisions about their treatment and, as I argue below, may have relevancy for British Columbia's statutory provisions concerning consent to psychiatric treatment.

5.3(C)(i) Psychiatrists' Conduct in *Starson*

In the *Starson* case, Scott Starson was arrested and charged under the *Criminal Code* for uttering death threats. He was then involuntarily hospitalized following a psychiatric examination in which Dr. Swayze, the named defendant, diagnosed Starson as having a schizoaffective disorder. The undisputed evidence was that Starson was a highly intelligent theoretical physicist. Following Starson's involuntary detention in a hospital, he refused treatment with antipsychotic drugs because he found the side effects, which included a slowing of his thought processes and creativity, unbearable. He also disagreed with Dr. Swayze's conclusion that he was incapable of making medical treatment decisions for himself.

5.3(C)(ii) Review Board Decision and Ontario Courts' Decisions in *Starson*

Dr. Swayze's decision was later reviewed by the Ontario Consent and Capacity Board (the "Board") which affirmed Dr. Swayze's finding that Starson lacked the capacity to consent or withhold consent to treatment. One of the Board's most important findings was that Starson did not appreciate the foreseeable consequences of the treatment because he refused to acknowledge that he had a psychiatric illness. The Board's decision was appealed to the Ontario High Court of Justice (formerly the District Court), which

overturned the Board's decision. The High Court's decision was, in turn, affirmed by the Ontario Court of Appeal.

5.3(C)(iii) The Supreme Court of Canada's Decision in *Starson*

The government then appealed that decision to the Supreme Court of Canada, which agreed with the Ontario Court of Appeal that the Board was in error and, in the result, affirmed Starson's right to refuse treatment with psychiatric medication. The Supreme Court's judgment was based primarily on a consideration of the evidence the Board considered at the hearing. Starson did not file a constitutional challenge to Ontario's *Mental Health Act* and therefore *Charter* rights were not specifically at issue before the Supreme Court. Writing for the majority, Major J. found that the Board either completely ignored or failed to properly consider relevant evidence concerning Starson's capacity to consent to treatment. The majority of the Supreme Court found that the presumed presence of a mental disorder, in itself, does not justify an inference that the person is incapable of making treatment decisions. Major J. stated that:

The law presumes that a person is capable to decide to accept or reject medical treatment; 4(2) of the *Act*. At a capacity hearing, the onus is on the attending physician to prove that the patient is incapable...As a result, patients with mental disorders are presumptively entitled to make their own treatment decisions.⁴⁹ The Board must avoid the error of equating the presence of mental illness with incapacity.

The Supreme Court of Canada's adoption of the reasoning in *Fleming* can also be seen throughout Major J's judgment.

The right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy. The right is equally important in the

⁴⁹ *Starson*, *supra* note 32 at para 77.

context of treatment for mental illness: see *Fleming v. Reid* (1991), 4 O.R. (3d), *per* Robins J.A. at p. 88:

Few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side-effects.

Unwarranted findings of incapacity severely infringe upon a person's right to self-determination.⁵⁰

Although McLachlin C.J.C. wrote a dissenting decision on behalf of herself and two other judges, her dispute with Major J. turned on the issue of whether the Board properly considered all the relevant evidence at the hearing. However, she shared Major J.'s concern for the respect that must be given to persons capable of making treatment decisions for themselves. The majority and the dissenting judgments in *Starson* therefore appear to establish that the right of a capable patient to refuse unwanted psychiatric treatment in civil contexts is regarded as a fundamental principle in Canada's legal system.

5.3(D) Summary of Section 5.3

Applicants attempting to prove that a law violates their rights to security of the person must produce evidence of this violation in court and show that the violation is not in accordance with principles of fundamental justice. In the Ontario case of *Fleming*, the Ontario Court of Appeal stated that involuntary treatment of patients with psychiatric medication is a violation of their rights to security of the person and this treatment is contrary to principles of fundamental justice when it is imposed against their competent wishes. The Supreme Court of Canada adopted many of the statements in *Fleming* concerning the importance of consensual medical treatment being in accordance with patients' competent instructions.

⁵⁰ *Ibid* at para 75.

5.4 Revisiting *McCorkell* in the 21st Century

The statements and the pronouncements from *Fleming* and *Starson* problematize ways of speaking about mental health law in British Columbia and may call into question the current legal authority of *McCorkell* as well as the medico-legal discourse of consent to treatment in this province ostensibly supported by that decision.

5.4(A) Security of the Person under section 7 of the *Charter*

Although Donald J. in *McCorkell* found that the civil committal criteria in the *Act* are an infringement of liberty rights under section 7 (though in accordance with principles of fundamental justice), arguably the nonconsensual treatment with psychiatric drugs in British Columbia is as much a violation of patients' security of the person as it is in Ontario. Thus, it is likely that courts in British Columbia would concede that nonconsensual medical treatment is a prima facie violation of a person's right to security of the person. The more difficult question of whether this violation is in accordance with principles of fundamental justice must be answered by examining the factors set out in *Reference Re: Motor Vehicle Act*, including, "the basic tenets and principles, not only of our judicial process, but also of the other components of our legal system" and must include an analysis of "the nature, sources, rationale and essential role of that principle within the judicial process and our legal system as it evolves."⁵¹ When considering the sources within Canadian law, *Fleming* is the case that is most relevant when considering whether the nonconsensual treatment resulting in violations of the right to liberty and security of the person under British Columbia's *Mental Health Act* is in accordance with principles of fundamental justice.

⁵¹ *Reference Re: Motor Vehicle Act*, *supra* note 19 at para 61.

Recall that in *Fleming* the court struck down provisions in Ontario's *Mental Health Act* that effectively prohibited the Review Board from considering whether the individual patients had the capacity to consent to treatment, and which forced the Review Board to refer only to the best interests of the patients. In *Fleming* the Court of Appeal held that the past competent wishes of the patients had to be respected, even if it were assumed that they had later lost the capacity to consent. In British Columbia, the joint operation of the *HCCA* and the *Mental Health Act* is such that any capacity to consent to treatment, past or present, *cannot* be considered by the Review Panel and the competent expression of a refusal to consent to treatment *must* be ignored. In this respect the law in British Columbia operates in a manner that is similar to the provisions of Ontario's *Mental Health Act* that were found to be unconstitutional. When the court in *Fleming* investigated principles of fundamental justice it conducted a review of the history of the law in Canada related to a patient's right to refuse nonconsensual medical treatment in civil contexts and found that:

a legislative scheme that permits the competent wishes of a psychiatric patient to be overridden, and which allows a patient's right to personal autonomy and self-determination to be defeated...violates "the basic tenets of our legal system" and cannot be in accordance with principles of fundamental justice.⁵²

Although *Fleming* is an Ontario case and is therefore not binding on any court in British Columbia, it may be regarded as persuasive in this province, particularly in view of the Supreme Court of Canada's statement in *Starson* that: "The right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy. The right is equally

⁵² *Fleming*, *supra* note 42 at 10.

important in the context of treatment for mental illness: see *Fleming v. Reid* (1991), 4 O.R. (3d), *per* Robins J.A. at p. 88.”⁵³

5.4(B) *Parens Patriae* Jurisdiction as a Principle of Fundamental Justice

A central difference between the judgments in *Fleming* and *McCorkell* concerns the role of the Crown’s *parens patriae* jurisdiction in the section 7 analysis of principles of fundamental justice. Donald J.’s analysis of principles of fundamental justice in *McCorkell* was based on the Supreme Court of Canada Case of *Cunningham v. Canada*, in which McLachlin J., as she was then, stated that, in criminal law contexts, fundamental justice related to liberty rights under section 7 requires that a fair balance be struck between a person’s interest in liberty and the protection of society.⁵⁴ Donald J. then used this notion of “fair balance” between liberty and protection of the public in criminal law contexts to conclude that the civil committal criteria in British Columbia’s *Mental Health Act* strike a “fair balance” between “the rights of the individual to be free from restraint by the state and society’s obligation to help and protect the mentally ill.”⁵⁵ However, there appears to be a dis-analogy between balancing liberty interests and protection of the public in a criminal law context, and balancing involuntary psychiatric constraint with the Crown’s *parens patriae* obligation to protect “the mentally ill.” As the Supreme Court of Canada stated in the case of *Eve*, as quoted in *Fleming*, the *parens patriae* jurisdiction is exercised when persons *cannot* take care of themselves, and therefore this jurisdiction reaches its limit at the point where persons are *capable* of doing so. Since some patients who are considered mentally ill are capable of making treatment decisions for themselves, it is difficult to

⁵³ *Starson*, *supra* note 32 at para 77.

⁵⁴ *Cunningham v. Canada*, [1993] SCJ No 47, 2 SCR 143.

⁵⁵ *McCorkell*, *supra* note 18 at para 66.

justify, as a principle of fundamental justice, the Crown's *parens patriae* jurisdiction as a rationale for violating these patients' rights to security of the person.

5.4(C) The Articulation of Principles of Fundamental Justice in *Bedford*

In the recent decision of *Bedford*, the Supreme Court of Canada clarified the case law on principles of fundamental justice, reviewing the developments in this area of constitutional law since 1995, noting that the law has changed considerably since 1990. Recall that *McCorkell* was decided in 1993. It is thus necessary to consider the Court's latest statement of the features of laws that violate principles of fundamental justice to assess whether British Columbia's *Mental Health Act* violated section 7 in a manner that is not in accordance with principles of fundamental justice. The Court's articulation of principles of fundamental justice in *Bedford* does not render the analysis of section 7 in earlier cases such as *Fleming* obsolete. Rather the Court's decision in *Bedford* is an attempt to clarify common elements in earlier decisions that address principles of fundamental justice.

As noted in section 5.3(A) of this chapter, the three principles of fundamental justice articulated in *Bedford* are that the impugned legislation must not 1) be arbitrary, 2) be overbroad, or 3) involve social harms or rights violations that are grossly disproportionate to the purpose of the legislation.⁵⁶ The Court in *Bedford* noted that:

All three principles – arbitrariness, overbreadth, and gross disproportionality – compare the rights infringement caused by the law with the objective of the law, not with the law's effectiveness. That is, they do not look to how well the law achieves its object, or to how much

⁵⁶ *Bedford*, *supra* note 12 at para 105.

the population benefits. They do not consider ancillary benefits to the general population.⁵⁷

This is not a three-part test; each principle stands alone as a principle of fundamental justice, even though they may at times overlap.⁵⁸ I examine each of these three principles in turn and then relate them to the operation of British Columbia's *Mental Health Act*.

According to the Court in *Bedford*, arbitrariness is the disconnection between the facts the legislation is supposed to address and the purpose of the legislation.⁵⁹ The principle of overbreadth concerns legislation that imposes legal restrictions on a larger class of persons than is required to fulfil the legislative purposes, thereby unfairly and unnecessarily interfering with their lives.⁶⁰ Finally, the concept of gross disproportionality applies to legislation that has negative effects that greatly and unreasonably exceed the intended purpose of the law.⁶¹

5.4(D) Application of *Bedford* to British Columbia's Mental Health Law

As noted above in section 5.3(A)(ii), one of the stated purposes of British Columbia's *Mental Health Act*, as set out in section 31, is to provide consensual treatment to patients, but "the treatment authorized by the director is deemed to be given with the consent of the patient." Section 31 is an example of a legislative expression of the Crown's *parens patriae* jurisdiction to care for patients with sufficiently diminished mental capabilities.

The presumption that patients give consent to the directors to authorize their treatment

⁵⁷ *Ibid* at para 108 [emphasis added].

⁵⁸ *Ibid* at 107. This three-part test was subsequently applied in the Supreme Court of Canada case of *Carter v. Canada (Attorney General)* [2015] SCJ No. 5, SCC No. 5, which struck down *Criminal Code* provisions prohibiting physician assisted suicide.

⁵⁹ *Ibid* at para 111.

⁶⁰ *Bedford*, *supra* note 12 at para 101.

⁶¹ *Ibid*.

cannot be rebutted by any evidence concerning patients' actual capacity to consent or refuse to consent to treatment because, according to section 2 of the *HCCA*, the presumption that adults are capable of consenting to medical treatment as stipulated under the *HCCA* does not apply to the *Mental Health Act*. Moreover, there are no criteria in the *Mental Health Act* for assessing a patient's capacity to consent to treatment. Therefore the deemed consent provision under section 31 of the *Mental Health Act* appears to be disconnected from any assessment of a patient's *actual* mental capability of consenting or withholding consent to treatment. As such there are grounds for arguing that the imposition of involuntary treatment on patients is arbitrarily disconnected from the limits of *parens patriae* jurisdiction of the Crown, as described in *Re Eve*, which is the foundation for the underlying purpose of the *Mental Health Act* and defines its limits.⁶²

In addition, the *Mental Health Act* appears to be overly broad because it authorizes involuntary medical treatment of some adults, pursuant to sections 1 and 22(3) of that *Act*, described above in section 5.3(A)(ii), even when they are mentally capable of consenting or withholding consent to treatment and are not currently a risk to themselves or others. The *Mental Health Act* therefore captures patients beyond the limits of the Crown's *parens patriae* jurisdiction, the exercise of which is one of the implied purposes of that legislation. As the court held in *Fleming*, the right to consensual medical treatment for mentally capable patients limits the Crown's *parens patriae* jurisdiction and laws that attempt to expand this jurisdiction by ignoring these rights is overly broad.

⁶² This complete disconnection between assessments of patients' capacity to consent to treatment and the imposition of involuntary medical treatment as a necessary consequence of civil commitment is unique in Canada. See Jocelyn Downie, Timothy Caulfield & Colleen Flood, *Canadian Health Law and Policy* 4th ed (Markham: LexisNexis, 2011) at 362.

Finally, the forcible imposition of psychiatric medication on the mentally capable adults who are not at risk of harming themselves or others results in anxiety, personal disruption, and the risk of serious side effects from the medication. Thus, the operation of the *Mental Health Act* arguably involves harms and violations of patients' rights to security of the person that are grossly disproportionate to the purpose of mental health care law and the *parens patriae* jurisdiction of the Crown.

In response to these assertions, a person defending British Columbia's *Mental Health Act* might argue that its treatment scheme has overall benefits for the population of people diagnosed as having mental disorders because it can be applied to some people who are currently mentally capable but who may be at risk of physical or mental deterioration, and that it is better to err on the side of involuntary treatment for this population of people. Such a person might therefore maintain that, when viewed in terms of the benefits to this population, the legislation is not arbitrary and is proportional to reasonable assessments of risks to individuals and a particular group of people. However, as the above underlined quotation from *Bedford* indicates⁶³, an assessment of whether the impugned legislation is arbitrary, overbroad or has harmful consequences grossly disproportionate to the purpose of the legislation is not determined by whether the law benefits a population of people. Rather it is determined by the logical relationship between rights violations that the legislation permits and the purpose of that legislation. In Chapter 7, my critical discourse analysis of Review Panel hearing transcripts discloses, in concrete detail and with specific examples, the ways in which British Columbia's mental health laws are arbitrary,

⁶³ *Infra*, note 60.

overbroad, and have harmful effects for individual patients that are grossly disproportionate to the purpose of mental health law.

5.4(E) Summary of Section 5.4

The pronouncements of the courts in *Fleming* and other cases on principles of fundamental justice cast doubt on the current legal authority of *McCorkell*, particularly since *Starson*, which adopted a number of principles from *Fleming*, was decided ten years after *Fleming* and concerned the rights of capable patients to refuse unwanted medical treatment. Cases that originated outside of British Columbia, such as *Fleming* and *Re Eve* also call into question Donald J's reference to the Crown's *parens patriae* jurisdiction to justify violating section 7 rights of mentally competent patients. In addition, an application of the principles in *Bedford* indicate that the provisions in British Columbia's *Mental Health Act* related to civil commitment are arbitrary, overbroad and violate rights in ways that are grossly disproportionate to the purpose of that legislation.

In view of the principles expressed in these cases, a strong argument could be made that British Columbia's *Mental Health Act* violates patients' rights to security of the person in a manner that is not in accordance with principles of fundamental justice. The next question is whether the government could successfully argue that these violations of section 7 rights can be justified under section 1 of the *Charter*. I examine this argument below in section 6 when I also consider how section 1 applies to section 15 of the *Charter*.

5.5 Equality Rights under section 15 of the Charter

An examination of Supreme Court of Canada cases on section 15 equality rights in the *Charter* reveals significant features of the discourse of discrimination in Canadian society.

These cases provide a useful context for scrutinizing differential treatment of people labelled as mentally disordered under British Columbia's *Mental Health Act* and *HCCA* compared to people who are not so labelled. In this subsection I first describe section 15 and refer to Supreme Court of Canada cases that set out the definition of discrimination. I then explore more recent cases that review the history of section 15 jurisprudence and articulate legal tests for determining whether equality rights are violated in particular situations. Finally, I consider whether, in case law, it could be said that British Columbia's *Mental Health* and *HCCA* violate section 15 equality rights.

5.5(A) Background to section 15 Charter Cases

According to section 15 of the *Charter*,

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability.

The Supreme Court of Canada has adopted a substantive equality approach for examining section 15 claims, based on recognizing the effects of the impugned law on groups that had been historically subject to discriminatory disadvantages arising from such things as racial or gender-based stereotyping. While the purpose of the impugned legislation is a relevant consideration, the focus of the inquiry is on the impact of the law on the people in question.

If the threshold tests for proving discrimination are satisfied, then the government has the burden of proving that the discrimination is justified, pursuant to section 1 of the *Charter*.

5.5(A)(i) *Withler v. Canada (Attorney General)*

The Supreme Court of Canada summarized and refined the various tests in its earlier decisions for identifying unjustifiable discrimination in the case of *Withler v. Canada (Attorney General)*,⁶⁴ which is now regarded as the leading case in Canada on section 15 equality rights. In that case the applicants, Hazel Withler and Joan Fitzsimonds, represented two class action groups. They argued that the federal supplementary death benefits scheme under the *Canadian Forces Superannuation Act*⁶⁵ was discriminatory because it reduced the amount of benefits paid to survivors by 10% for each year that the beneficiary exceeds a certain age. The applicants argued that this scheme was discriminatory because it targeted people based on age, contrary to the wording of section 15, and was implicitly based on the stereotypical assumption that one's financial needs are reduced as one gets older.

In its analysis of the law, the Court adopted the definition of discrimination from its 1989 decision of *Law Society British Columbia v. Andrews*, as follows:

discrimination may be described as a distinction, whether intentional or not, but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed on others or which withhold or limits access to opportunities, benefits, and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classified.⁶⁶

⁶⁴ *Withler v. Canada (Attorney General)*, [2011] SCJ No 12; 15 BCLR (5th) 1.

⁶⁵ *Canadian Forces Superannuation Act*, RSC 1985 c C-17.

⁶⁶ *Law Society of British Columbia v. Andrews*, [1989] S.C.J. 6, 1 S.C.R. 143 at para 37.

The Court in *Withler* then stated that there is a two-part test for determining whether a violation for section 15(1) has occurred, which requires answers to the following questions: “(1) does the law create a distinction that is based on an enumerated or analogous ground? and (2) does the distinction create a disadvantage by perpetuating prejudice or stereotyping?”⁶⁷ This is known as the “Two-Part Test”. The enumerated grounds refer to the reference to “race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability” to which specific reference is made in section 15(1). The criterion of analogous grounds refers to a distinction based on “a personal characteristic that is immutable or changeable only at unacceptable cost to personal identity,”⁶⁸ such as sexual orientation or marital status.

The Court in *Withler* stated that the second step in establishing discriminatory impact requires demonstrating that the law promotes stereotyping that “perpetuates prejudice or disadvantage to members of the enumerated or analogous groups.”⁶⁹ This stereotyping often promotes pre-existing historical prejudice and disadvantage in relation to historically marginalized groups. Stereotyping will also ground a section 15 claim where it leads to disadvantage to a group that has not suffered historically.⁷⁰ The Court noted that:

Where the claim is that the law is based on stereotypical views of the claimant group, the issue will be whether there is a correspondence with the claimants’ actual characteristics or circumstances. Where that impugned law is part of a larger benefits scheme, as it is here, the

⁶⁷ *Withler*, *supra* note 64 at 14.

⁶⁸ *Corbierre v. Canada (Minister of Indian and Northern Affairs)*, [1999] SCJ No 24, 2 SCR 203 at para 13, cited with approval in *Withler* at para 33.

⁶⁹ *Withler*, *supra* note 64 at para 35.

⁷⁰ *Ibid* at para 36.

ameliorative effect of the law on others and the multiplicity of interests will also colour the discrimination analysis.⁷¹

The Court in *Wither* summarized its review of its earlier decision as follows:

the theme underlying virtually all of this Court's s. 15 decisions is that the Court in the final analysis must ask whether, having regard to all relevant contextual factors, including the nature and purpose of the impugned legislation in relation to the claimant's situation, the impugned distinction discriminates by perpetuating a group's disadvantage or by stereotyping the group.⁷²

When applying these considerations to the applicants' situation, the Court in *Withler* found that the impugned legislation created a distinction between them and other people based on age, which is an enumerated ground under section 15(1). However, when applying the second branch of its two-part test the court found that this distinction did not "create a disadvantage by perpetuating a prejudice or stereotyping."⁷³ The reason for this conclusion is that the Court found that in the context of the entire pension benefits scheme, the applicants were not prejudicially affected because, among other things, they received benefits from other sources in the pension system based on age that could be balanced against reductions of death benefits.⁷⁴

⁷¹ *Ibid* at para 38.

⁷² *Ibid* at para 54.

⁷³ *Ibid* at para 61.

⁷⁴ *Ibid* at para 81.

5.6 Section 15 and British Columbia's *Mental Health Act*

5.6(A) Application of *Withler*

5.6(A)(i) Application of the *Withler Two-Part Test*

5.6(A)(i)(a) Does the law create a distinction based on an enumerated ground?

When applying the principles for a section 15 analysis, as set out in *Withler*, a person bringing a constitutional challenge to British Columbia's mental health laws must have standing to do so and therefore must concede that he or she is a person with a mental disorder. Assuming that the applicant makes this concession in his or her pleadings, a claim could be brought on behalf of the group of persons with mental disabilities, which is a group specifically enumerated in section 15(1).

The next step would be to show that British Columbia mental health statutes create a distinction based on this enumerated ground. This might be accomplished by first making reference to sections 3 and 4 of the *HCCA*, which state that all persons are presumed to be capable of consenting to medical treatment and which set out the tests for informed consent. Section 2, however, states that this presumption does not apply to persons with mental disorders subject to civil commitment under the *Mental Health Act*. This creates a distinction between persons thought to have disabilities based mental disorder and other people who are not considered mentally disordered.

5.6(A)(i)(b) Does the distinction create a disadvantage by perpetuating a stereotype?

Arguably the discriminatory effect of the civil committal criteria in British Columbia is found when viewing how *HCCA* and the *Mental Health Act* work together. The *Mental*

Health Act permits treatment to be imposed on persons who are thought to be mentally disordered without any regard for their capacity for informed consent to psychiatric treatment. The *HCCA* in turn legislatively removes any presumption that they have these capacities. Consequently, psychiatric treatment is imposed on these persons as if they do not have the capacity to make their own decisions regarding their treatment. Together these statutes appear to result in the imposition of stereotypes and disadvantages on persons thought to be mentally disordered, and therefore deprive them of the advantages enjoyed by others. The denial of a presumption of mental capacity to consent to treatment is the type of historically discriminatory stereotyping that the Supreme Court of Canada warns against in *Starson*. For example, Major J. states that:

Professor D.N. Weisstub, in his *Enquiry on Mental Competency: Final Report* (1990), at p. 116 (“Weisstub Report”), notes the historical failure to respect this presumption:

The tendency to conflate mental illness with lack of capacity, which occurs to an even greater extent when involuntary commitment is involved, has deep historical roots, and even though changes have occurred in the law over the past twenty years, attitudes and beliefs have been slow to change. For this reason it is particularly important that autonomy and self-determination be given priority when assessing individuals in this group.⁷⁵

The imposition of nonconsensual medical treatment permitted by British Columbia’s *Mental Health Act* can occur even if a physician finds that the patient has the capacity to withhold consent to treatment. According to the test in *Withler*, the applicants would have to show that they are disadvantaged by the imposition of stereotype. As the Court stated in

⁷⁵ *Starson*, *supra* note 32, at para 77.

Withler, “the focus of the inquiry is on the actual impact of the impugned law, taking full account of social, political, economic and historical factors concerning the group.”⁷⁶

Major J.’s quotation from *Starson* in the preceding paragraph would likely carry considerable weight when assessing whether British Columbia’s civil commitment laws have discriminatory effects. Nevertheless, it is important to bear in mind that in section 15 deliberations, courts have considerable latitude in assessing whether laws create disadvantages. This was highlighted in the case of *Quebec (Attorney) v. A* in which the Supreme Court of Canada noted that *Withler* recommends “a flexible and contextual inquiry into whether a distinction has the effect of perpetuating arbitrary disadvantage on the claimant because of his or her membership in an enumerated or analogous group. As *Withler* makes clear, the contextual factors will vary from case to case – there is no rigid template.”⁷⁷ Therefore, in examining the discriminatory effects of British Columbia’s *Mental Health Act*, courts would likely want to receive evidence of the impact of involuntary psychiatric treatment in the context of patients’ lives and in the context of the health care system in this province. In Chapter 8 of this dissertation I provide this type of evidence, based on my analysis data from patients’ Review Panel hearings. The analysis shows discriminatory effects of the *HCCA* and the *Mental Health Act*, based on stereotypical presumptions that persons who are considered mentally disordered are incapable of making competent treatment decisions for themselves. The involuntary treatment that is imposed on these people undoubtedly has significant detrimental effects in their lives, thereby creating disadvantages.

⁷⁶ *Withler*, *supra* note 62 at para 39.

⁷⁷ *Quebec (Attorney) v. A*, *supra* note 61 at para 331.

5.6(B) Summary of Section 5.6

The Supreme Court of Canada in *Withler* summarized the test for assessing applicants' claims that their rights to equality had been violated under section 15 of the *Charter*. The test, among other things, requires answers to two questions: 1) does the law create a distinction based on an enumerated or analogous ground? and 2) does the distinction create a disadvantage by perpetuating a stereotype? When applying these tests to British Columbia's *HCCA* and *Mental Health Act* it appears that this legislation creates a distinction based on the ground of "mental disability" specifically described in section 15. Statements from the Supreme Court of Canada in *Starson* support the contention that this type of distinction prejudicially perpetuates the stereotype that people with mental illness are incapable of making decisions for themselves. However, evidence should be produced to show that the distinction has the impact of creating disadvantages for patients in the contexts of their lives and in this province's health care system. The critical discourse analysis in Chapter 7 provides evidence of this type of prejudicial impact on patients.

5.7 Analysis of sections 7 and 15 Violations under section 1 of the *Charter*

5.7(A) The *Oakes* Test

Even if applicants in cases before the courts in British Columbia could satisfy judges that the civil commitment provisions of the *Mental Health Act* violate sections 7 and 15 of the *Charter*, the government might still argue that the provisions could be saved under section 1, which states that:

1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

A section 1 analysis would be carried out by invoking a number of criteria as articulated by Dickson C.J.C. (as he was then) in *R. v. Oakes*,⁷⁸ which recognize that the pursuit of collective objectives at times requires limitations on certain individual rights in particular contexts (the “*Oakes Test*”). The first two criteria are that the objective “must be pressing and substantial in a free and democratic society”, and that when such an objective is recognized, the means chosen must be “reasonably and demonstrably justified.”⁷⁹ The test for reasonableness and justification of means involves a type of proportionality test, which has three components. First, the measure used cannot be arbitrary and must be rationally connected to the objective. Second, even if such a rational connection is demonstrated the means must “impair as little as possible the right or freedom in question.”⁸⁰ And third, there must be a final weighing of the proportionality between the means and objectives such that the greater the violation of rights, the more pressing and important the objectives must be. This final standard implies that, even if all of the other parts of the *Oakes* test are satisfied, the law in question may still be struck down because a tremendous intrusion on human rights outweighs an admittedly important social objective.⁸¹

5.7(B) Section 7 and the *Oakes* Test

If a judge in British Columbia found that this province’s civil commitment provisions violated the right to security of the person in a way that was not in accordance with principles of fundamental justice, the government might have a difficult time convincing the judge this could be justified under section 1. Indeed, the Supreme Court of Canada has

⁷⁸ *R. v. Oakes* [1986] SCJ No 7, 1 SCR 103 [*Oakes*].

⁷⁹ *Ibid* at para 69.

⁸⁰ *Ibid* at para 70.

⁸¹ Fleming, *supra* note 42 at para 125.

stated that a violation of section 7 will be saved by section 1 only “in cases arising out of exceptional circumstances, such as natural disasters, the outbreak of war, epidemics and the like.”⁸² The Supreme Court, as noted in *Bedford*,⁸³ continues to apply these tests from *Oakes*. The Court in *Bedford* stated that the analyses under section 7 and section 1 are analytically distinct because the “question of the justification on the basis of an overarching public goal is at the heart of s. 1, but it plays no part in the section 7 analysis, which is concerned with the narrower question of whether the impugned law infringes individual rights.”⁸⁴ When applying these principles from *Bedford* to the decision in *McCorkell*, it can now be seen that Donald J. incorrectly referred to public goals in his section 7 analysis of a balance of fairness being a principle of fundamental justice when he stated that “In determining the fairness of the balance, I take into account my perception that Canadians want to live in a society that helps and protects the mentally ill and that they accept the burden of care which has always been a part of our tradition.”⁸⁵ In view of the principles concerning the relationship between sections 7 and 1 articulated in *Bedford*, it is unlikely that Donald J.’s analysis of section 7 would be regarded as persuasive in courts in British Columbia today.

In contrast, the analysis of section 7 and 1 in *Fleming* is consistent with the principles set out in *Bedford*. Recall that the court in *Fleming* denied the government’s section 1 argument because the impugned legislation, permitting involuntary medical treatment contrary to patients’ previously expressed capable wishes, did not impair the right to

⁸² *Suresh v. Canada*, [2002] 1 SCR 3, DLR (4th) 1 at para 78.

⁸³ *Bedford*, *supra* note 11.

⁸⁴ *Ibid* at para 125.

⁸⁵ *McCorkell*, *supra* note 18 at para 68.

security of the person as little as possible, under the second branch of the *Oakes* Test. Arguably, British Columbia's mental health law system does not impair the right to security of the person as little as possible and therefore these laws probably would not be saved under section 1 of the *Charter*.

5.7(C) Section 15 and the *Oakes* Test

The government would also have the burden of proving that section 15 violations are justified under section 1. As Wilson J. stated in *Andrews*, "given that section 15 is designed to protect those groups who suffer social, political and legal disadvantage in our society, the burden resting on the government to justify the type of discrimination against such groups is appropriately an onerous one."⁸⁶ However, governments have successfully argued against striking down legislation on grounds of violations of section 15 when they satisfy the court that the differential treatment is justified because the overall purpose of the legislation establishes a "correspondence to the needs" of the applicants.⁸⁷ The government might use this to argue that since the overall purpose of the *Mental Health Act* is to provide medical treatment to those in need, the overall effect is that, as a group, the people who receive treatment benefit from this care. In view of the cases on section 15 in Canada and the latitude the courts give to governments in fashioning health laws, it is difficult to predict how courts would conduct a section 15 and section 1 analysis of British Columbia's *Mental Health Act*.

⁸⁶ *Andrews*, *supra* note 66 at para 10.

⁸⁷ See *Law v. Canada (Minister of Employment and Immigration)* [1999] SCJ No 12, 1 SCR 497 at paras 69-71, as referenced in Peter J. Carver, "Mental Health Law in Canada" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 3d ed (Toronto: LexisNexis, 2007) at 418.

5.7(D) Summary of Section 5.7

Under section 1 of the *Charter*, the government would have the burden of proving that violations of sections 7 and 15 were justified as reasonable limits under section 1. The test for assessing section 1 arguments is set out in *Oakes*. The government in British Columbia would probably be unable to prove that violations to security of the person related to involuntary treatment with psychiatric medication are justified under section 1. The government may have an easier time arguing that the discriminatory treatment of psychiatric patients contrary to section 15 is justified under section 1 because of the Supreme Court of Canada's tendency to grant latitude to government in their discretion to fashion health care laws and policies.

5.8 Chapter Conclusion

Although the *Charter* analysis in this chapter employs forms of legal argumentation that lawyers and judges deploy in court cases, the analysis does not endorse an interpretation of these laws and legal practices in terms of juridical forms of thinking that Foucault criticized, nor is it a lapse into civil libertarianism. Rather, the legal argumentation that effective lawyers may use to challenge laws that violate human rights can be seen as strategic extensions of the *Charter* applicant's *parrhesiastic* engagement with legal authorities that begins at the level of Review Panel hearings and may extend to the highest courts in the country. Moreover, while *Charter* rights are expressed in the written texts of federal legislation the nature of these rights is not immutable but is transformed through social change.

With these considerations in mind, in this chapter I investigated the discourse on rights in mental health law as found in legislation and in *Charter* cases on the constitutionality of that legislation. In particular, I explored the discourse in British Columbia's mental health care system by examining a number of *Charter* cases related to section 7 and section 15 in this province and in other jurisdictions. In the 1993 case of *McCorkell*, the presiding judge, Donald J., dismissed McCorkell's application to strike down the civil commitment provisions in British Columbia's *Mental Health Act*, and he found that they did not violate his right to liberty rights under section 7 of the *Charter*. The cases of *Fleming* and *Starson* endorse the principle that mentally competent patients have a right not to have involuntary medical treatment imposed on them and that this is a fundamental principle in the Canadian legal system. I also argued that, following the principles set out in *Bedford*, the involuntary treatment provisions of British Columbia's *Mental Health Act* are arbitrary and overbroad, and have consequences for patients that are grossly disproportionate to the purpose the legislation. In view of these cases, one could argue that the civil commitment provisions of British Columbia's mental law system violate patients' rights to security of the person in a manner that is not in accordance with principles of fundamental justice.

In this chapter I also reviewed Supreme Court of Canada cases on the right to equality and I applied the tests from *Withler* to investigate whether the civil commitment provisions in British Columbia's mental health legislation are discriminatory. A review of Supreme Court of Canada cases should cause one to question seriously whether the mental health laws in this province violate equality rights and whether they do so in a systemic and discriminatory manner, regardless of whether this discrimination be justified under section 1 of the *Charter*.

The critical discourse analysis of Review Panel hearings in Chapter 7 of this dissertation shows the discriminatory effects of these provisions in the lives of four patients and may be used to illustrate forms of systemic and harmful prejudice in psychiatric practices based on stereotypical labelling of the patients as incompetent. In the next chapter I provide an account of Foucault's writings on discourse in order to develop the critical discourse analysis methodology that I use to disclose the effects of discriminatory laws and practices in Review Panel hearings.

Chapter 6 Discourse and Research Methodology

6.0 Introduction

Mental Health Review Board hearings are remarkable windows into the operation of British Columbia's mental health law system, a system that brings into sharp focus issues of human agency and ascriptions of mental disability. As Chapters 3 and 4 have demonstrated, Michel Foucault's philosophy provides an effective way of understanding agency and the operation of power in modern society, particularly as it is disclosed in biomedical discourse. This chapter shows that Foucault's philosophy can also form the basis of an empirical methodology for the analysis of discourse, one that is particularly effective in my interdisciplinary investigation of the medico-legal discourse of Review Panel hearings governed by British Columbia's *Mental Health Act*. This chapter also reviews the literature on discourse analysis that is relevant to my research and describes the empirical research methodology most suitable for analyzing data gathered from transcripts and written decisions of Review Panel hearings. This chapter is divided into five sections.

In the first section, I provide an account of Foucault's views on discourse, beginning with his early work on archaeology. I show how his later writing on agency and care of the self supports the notion that the analysis of discourse is an effective means of understanding knowledge, power and identity. Rather than setting out a complete chronology of Foucault's writings, I focus on representative works from his early writings on archaeology and in his later writing on genealogy and care of the self. In the second section I demonstrate how Foucault's views on discourse, knowledge and power have had considerable influence on the development of discourse analytic methodologies for

empirical research and I review the literature on methodology that is the most appropriate for my research on Review Panel hearings. In the third section, I describe discourse analysis research in medical and legal contexts, to which I refer in the next chapter when I analyze in detail transcript material from Review Panel hearings. In the fourth section I describe the form of my own five-step model of critical discourse analysis methodology, which draws upon all of this literature. Finally, in the fifth section I summarize how I apply my model of critical discourse analysis to data from Review Panel hearings and decisions in the next chapter.

6.1 Foucault and Discourse Analysis

Michel Foucault's later philosophy has provided a variety of productive conceptual tools that have been the inspiration for a large amount of empirical social research.¹ This research has been based on two interconnected aspects of his philosophy. The first is his concept of governmentality discussed earlier, further developed by scholars such as Nikolas Rose² and applied in such diverse realms of research as social welfare policies in Canada³ to economics reform in Indonesia.⁴ The second is his writing on the nature of discourse, which could be argued is a discipline in itself.⁵ Still, there is considerable debate

¹ See Gavin Kendall & Gary Wickham, *Using Foucault's Methods* (London: Sage, 1999); David Howarth, *Discourse* (Buckingham: Open University Press, 2000) at 1; Rainer Diaz-Bone, Andrea Buhrman, Encarnacion Guierrez Rodriguez, Werner Schnieder, Gavin Kendall & Francisco Tirado, "The Field of Foucauldian Discourse Analysis: Structures, Developments and Perspectives (2007) 8(2) *Forum: Qualitative Social Research* 1; Majia Holmer Nadesan, *Governmentality, Biopower and Everyday Life* (New York: Routledge, 2008); and Deborah Lupton, *Medicine as Culture: Illness, Disease and the Body in Western Societies*, 3d ed (London: Sage Publications, 2012) at 14.

² Nikolas Rose, *Governing the Soul: The Shaping of the Private Self* (London: Free Association Press, 1999).

³ Wendy Larner, "Neo-Liberalism: Policy, Ideology, Governmentality" (2000) 63 *Studies in Political Economy* 5 at 14.

⁴ Tania Murray Li, *The Will to Improve* (Durham: Duke University Press, 2007).

⁵ R. Keith Sawyer, "A Discourse on Discourse: An Archeological History of an Intellectual Concept" (2002) 16:3 *Cultural Studies* 433.

about the model of research on discourse that is most consistent with Foucault's philosophy or whether, in the final phase of his philosophy, he even recommended analysis of discourses as a valuable form of research.⁶ In this section I demonstrate that, far from abandoning a concern with discourse, Foucault continued to develop this concept in his later philosophy, while at the same time placing it within a broader theoretical context including the concepts of governmentality, care of the self, and *parrhesia*. I argue that Foucault's later philosophy provides a strong foundation for empirical discourse analysis with a critical orientation.

My argument in support of this view develops in the following way. First, I provide some general definitions of discourse. I then give an account of Foucault's conception of discourse in his earlier writings, particularly *The Order of Things*⁷ and *The Archaeology of Knowledge*.⁸ I follow this by exploring the extent to which Foucault expanded the concept of discourse to include reference to broader social phenomena and institutional forces. The section concludes with a review of Foucault's works concerning discourse in the last phases of his career, which provides the theoretical basis for discourse analysis in my empirical research using British Columbia's Mental Health Review Panel hearings.

6.1(A) What is Discourse?

Terms such as "discourse", "discursive", "discourse analysis" and "discourse theory" are now ubiquitous in academic research, in fields as diverse as linguistics, social psychology,

⁶ *Ibid* at 447.

⁷ Michel Foucault, *The Order of Things: An Archaeology of the Human Sciences* (London: Tavistock, 1970).

⁸ Michel Foucault, *The Archaeology of Knowledge*, translated by Sheridan Smith (London: Tavistock, 1972).

literary theory and cultural studies.⁹ The term “discourse” has multiple meanings, one of which refers to *linguistic forms* found in a texts and another to the *activity* of conversing and talking. On the most basic level, the study of discourse in linguistics focuses on units of language that are larger than sentences and examines sequences of sentences in speech and writing and formal rules that govern use in speech acts.¹⁰

Since the latter part of the twentieth century there has been a growing interest in the examination of language as a form of practice in social settings. This development has moved the study of language from an analysis of decontextualized linguistic phenomena, based on cognitive events or linguistic forms, to theorizing about language as pragmatic speech acts that are socially situated.¹¹ This area of study has drawn on the writings of theorists such as the philosopher J.L. Austin, who developed a theory of speech acts to understand the purpose and effects of linguistic behaviour in social settings, thereby providing the groundwork for the study of pragmatics, which was very influential in early sociolinguistics.¹² At this level of linguistic research, reference is rarely if ever made to larger political forces bearing on the production of speech acts.

Some contemporary linguistic research still remains narrowly focused on the way that discourse is constructed in the formation of texts and speech, but most modern research on discourse now makes reference to much more than bare linguistic forms and speech acts, particularly when it is informed by Foucault’s philosophy. It tends to focus intensely on

⁹ Carol Bacchi, “Discourse, Discourse Everywhere: Subject “Agency” in Feminist Discourse Methodology” (2005) 13:3 *Nordic Journal of Women’s Studies* 198 at 199.

¹⁰ Sawyer, *supra* note 5 at 434.

¹¹ Jan Blommaert, *Discourse: A Critical Introduction* (Cambridge: Cambridge University Press, 1997).

¹² J.L. Austin, *How to do Things with Words: The William James Lectures Delivered at Harvard University in 1955, 1962*, ed by J.O. Urmson and Marina Sbisà (Oxford: Clarendon Press, 1962).

the uses of language in social and cultural contexts and how this shapes human agency.¹³

This is reflected in Foucault's description of discourse as:

Sometimes...the general domain of all statements, sometimes as an individualizable group of statements, and sometimes as a regulated practice that accounts for a number of statements.¹⁴

For Foucault and other scholars doing discourse analysis today, discourses are “communicative action(s) in the medium of language,”¹⁵ which are descriptive of the objects with which they are concerned, but also productive: “they produce the objects of which they speak.”¹⁶ This highlights the inextricable relationship between discourse and power as a productive force in human relations.

Foucault, of course, was not the only or even the earliest scholar to investigate the relationship between power and discourse. It was a central concern, for example, in much Marxist and structuralist philosophy that preceded Foucault's writing on discourse.¹⁷ Yet, many scholars attribute the preoccupation with discourse in contemporary academic research to Foucault, and for good reason: Foucault's philosophy provides one of the most coherent ways of understanding the role of discourse in modern society. However, Foucault's concept of discourse and how it shapes human agency changed in very important ways over the course of his career, a point that is sometimes missed by theorists

¹³ David Howarth, Aletta Norval & Yannis Stavrakakis, *Discourse Theory and Political Analysis: Identities, Hegemonies and Social Change* (Manchester: Manchester University Press, 2000) at 9.

¹⁴ Michel Foucault, *Archaeology of Knowledge*, *supra* note 8 at 8, as quoted in Jean Carabine, “Unmarried Motherhood 1830-1990: A Genealogical Analysis” in Margaret Wetherell, Stephanie Taylor & Simon Yates, eds, *Discourse as Data: A Guide for Analysis* (London: Sage, 2001) at 268.

¹⁵ Jean Carabine, “Unmarried Motherhood 1830-1990: A Genealogical Analysis” in Margaret Wetherell, Stephanie Taylor & Simon Yates, eds, *Discourse as Data: A Guide for Analysis* (London: Sage, 2001) 268.

¹⁶ *Ibid* at 268.

¹⁷ Sawyer, *supra* note 5 at 442.

who assume, based on a narrow reading of his early works, that Foucault claims that agents are completely and helplessly constructed by discourses. It is important, therefore, to trace Foucault's thinking about discourse from some of his earliest writing to his latest writings on the care of the self to show how he offered a view of human beings as active agents in social and personal transformation.

6.1(B) *The Archaeology of Knowledge*

In *The Archaeology of Knowledge* Foucault offers ways of understanding the nature of discourse in order to displace traditional assumptions about the role of the human subject in the history of ideas. For Foucault, archaeology:

does not imply the search for a beginning; it does not relate to geological excavation. It designates the general theme of a description that questions that already said at the level of its existence, of the enunciative function that operates within it, of the discursive formation, and the general archive system to which it belongs. Archaeology describes discourses as practices specified in the element of the archive.¹⁸

In this archaeological period in his philosophical writings, the central theoretical construct was the “discursive formation”, which is a set of statements meeting four criteria: sharing objects that are the subject matter of the statements; having a place from which statements are permitted to be enunciated; sharing concepts that shape the formation of the statements; and the themes they develop, which Foucault calls strategies.¹⁹ Discursive practices are understood historically, beginning with inchoate forms of communication. When certain discursive practices become sufficiently prevalent, stable, and autonomous, they cross a threshold that Foucault describes as a “positivity”, which is the first level at which

¹⁸ Foucault, *Archaeology of Knowledge*, *supra* note 8 at 131.

¹⁹ Sawyer, *supra* note 5 at 436.

discourse achieves unity, while at the same time being “the loosest and least regulated form of discourse formation.”²⁰

Another central concept Foucault uses to understand discursive formations is the “archive”, which he describes as follows:

I mean the set of rules which at a given period and for a definite society defined: 1.) the limit and forms of expressibility; 2.) the limits of forms of conservation; 3) the limits and forms of memory; and 4) the limits and forms of reactivation.²¹

Arguably, Foucault used the concept of the archive to deepen his concept of what he called the episteme, developed in *The Order of Things* to describe the manner in which discourse constrains what a culture can think.²² In contrast with the reference to thoughts and ideas in the episteme, the archive, with its connotation of a storehouse of texts, highlights the pervasively linguistic nature of these constraints. The archive is therefore the linguistic rules and material used in discursive formations that shape and constrain the episteme.

A significant aspect of Foucault’s research was to show the historical contingency of scientific knowledge, which people in the modern age view as based on ahistorical truths corresponding to a reality existing independent of human activities. When describing the historical conditions that discourse must satisfy before becoming regarded as a discourse of scientific knowledge, Foucault identified three stages beyond positivity, which he described as epistemolization, scientificity, and formalization.²³ None of these stages

²⁰ *Ibid* at 437.

²¹ Michel Foucault, *The History of Sexuality: An Introduction, Vol. 1* (London: Penguin, 1972) at 14, as quoted in Sara Mills, *Discourse* (London: Routledge, 1997) at 63.

²² Sawyer, *supra* note 5 at 437.

²³ Howarth, *supra* note 1 at 59.

involves getting closer to an objective reality; rather they describe degrees to which discourses come to be regarded as the unquestioned background of other discourses. At each of these stages three rules of discursive formation are operating, which determine how discursive objects are created. The first involves describing social practices that become the focus of scientific concern and scrutiny; the second involves identifying the authorities empowered to decide which objects belong to particular discursive formations; and the third determines how objects are created in their location in “grids of specification” used to categorize objects. These discursive formations leading to scientific knowledge construct the episteme of modern Western society and constrain the way people in this society even begin to identify and categorize objects of knowledge worth investigating for the purpose of creating scientific knowledge.

Despite his recognition of the role of power in the creation of knowledge in *The Archaeology of Knowledge*, Foucault focuses on discourses as systems of statements created by historically conditioned formation rules. Foucault emphasizes the role that discursive *practices* play in constituting objects, in contrast with philosophical realism or positivist theories of language in which the truth-value of propositions is determined by reference to external pre-constituted objects in the world. At this stage in Foucault’s career, discourse was emerging conceptually as constitutive of human subjects, which, far from being the source of discourses, are rather their effect.²⁴ It is through discourses, understood as social practices, that subjects acquire their identity and have a position in society. As such, the subject positions that people occupy, the way in which they are

²⁴ Sara Mills, *Discourse* (London: Routledge, 1997) at 33.

empowered to speak due to factors such as professional training or recognition and the institutional places individuals occupy, all play a role in determining which statements are taken seriously. This in turn shapes the construction of persons and the objects of which they speak. Later in this chapter I give examples of the way that institutional roles people occupy as lawyers, doctors or Review Panel members empower them to make certain types of statement in institutional contexts, such as legal hearings. As a result of the privileged positions they occupy, these speakers can be influential in shaping the identities of the persons who are the subjects of the hearings.

It would be a mistake to assume that even in *The Archaeology of Knowledge* Foucault regarded archives and discursive formations as monolithic structures forming texts that deterministically construct persons and objects. Nevertheless, at this stage in his philosophical writings Foucault did not emphasize the active role that agents play in power relations or indeed that power expressed through discourse can provide new opportunities for identity formation. Moreover, he placed little emphasis on the interrelation between discursive functions and non-discursive practices. After *The Archaeology of Knowledge*, Foucault continued to regard discourse as having an important conceptual role in his philosophy, but he increasingly emphasized the interrelationship between discourse and non-discursive practices. This can be seen in his later genealogical writings in which he articulated his concepts of problematization and care of the self.

6.1(C) Genealogy and the Care of the Self

According to David Howarth, Foucault never abandoned the archaeological perspective; rather he regarded it as an aspect of the method of problematization in the larger framework

of genealogical inquiry.²⁵ Thus, theories of discourse and discursive formations do not disappear from Foucault's thinking; they are still used after *The Archaeology of Knowledge*, but he comes to view discourse and discursive formations as the products of power relations seen in a richer context of historically developing institutional and social processes. In a further move away from the notion of epistemes, Foucault increasingly used the term "dispositif"²⁶ to describe the interrelationship between discourses, including laws and scientific statements, which together have strategic functions as networks of power relations in a society.²⁷

In addition to the notion of intertextuality implied in *dispositif*, Foucault increasingly suggested that discursive formations must be analyzed in terms of complex interaction with non-discursive formations. This is clearly seen in writings such as *Psychiatric Power* and *The History of Sexuality*, in which Foucault gives an account of the disciplining and monitoring of human bodies to increase productivity and efficiency in the past 300 years in Europe.²⁸ This resulted in a proliferation of both medical and sexual discourses, which in turn were shaped by non-discursive forces, including the material conditions of institutions such as psychiatric hospitals and their geographical locations in relation to neighbouring communities.

According to Howarth, these shifts in Foucault's thinking about the relationship between discourse and non-discursive formations confirm that Foucault had an entirely new

²⁵ Howarth, *supra* note 1 at 67.

²⁶ According to David Macey, the word "dispositive" is difficult to translate into English, but "approximates to...apparatus." David Macey, *Dictionary of Critical Theory* (London: Penguin Books, 2000) at 101.

²⁷ *Ibid.*

²⁸ Michel Foucault, *The History of Sexuality*, translated by Robert Hurley (New York: Vintage Books, 1990).

conception of discourse after *The Archaeology of Knowledge*.²⁹ Foucault's view is well summarized as follows:

What is said about sex must not be analyzed simply as the surface projection of...power mechanisms. Indeed, it is in discourse that power and knowledge are joined together. And it is for this very reason we must conceive of discourse as a series of discontinuous segments whose tactical function is neither uniform nor stable. To be more precise, we must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies...Discourses are not once and for all subservient to power or raised up against it, any more than silences are. We must make allowance for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it.³⁰

With the focus on the question of subject in this later writings Foucault provides a picture of identity formation in which subjects are both constructed and active participants in their identity formation, all through complex discursive relations in which they are actively and creatively engaged. At the same time, however, Foucault continued to emphasize the way that human beings become subjects, which occurs through three types of objectification.³¹ The first is the "author-function", which recognizes that subjects are ways of speaking within a discourse and not isolated constitutive sources of discourse. The second is a logic of dividing practices, which, for example, separates the healthy from the sick, the sane from the mentally ill, and the intelligent from the non-intelligent. The third logic is

²⁹ *Supra* note 1 at 67.

³⁰ Foucault, *The History of Sexuality*, *supra* note 28 at 100.

³¹ Michel Foucault, "The Subject and Power" in Hubert Dreyfus and Paul Rabinow, eds, *Michel Foucault: Beyond Structuralism and Hermeneutics* (Brighton: Harvester, 1982) at 208.

subjectivation, whereby subjects work on themselves through disciplinary practices and self-monitoring.

Foucault further analyzes the relationship between subjectivation and discourses regarding truth claims in his essay “The Ethics of the Concern for Self as a Practice of Freedom.”³² In that essay, Foucault argues that knowledge claims, in fields such as psychiatry or mathematics, are established through “games of truth.”³³ These games are forms of discursive procedures that,

lead to a certain result, which, on the basis of its principles and rules of procedure, may be considered valid or invalid, winning or losing...In a given game of truth, it is always possible to discover something different and to more or less modify this or that rule, and sometimes even the entire game of truth. Who speaks the truth? Free individuals who establish a certain consensus, and who find themselves within a certain network of practices of power and constraining institutions.³⁴

The conception of games of truth that Foucault describes in this quotation is one in which discourses concerning knowledge claims are based on the speech of individuals who are free because they are capable of self-reflection and resistance to established rules. Nevertheless, this freedom will always be exercised in the context of “practices of power and constraining institutions.”³⁵

Thus, while this new conception of discourse allows for a much greater role for the care of the self even in relation to powerful institutions, Foucault continued to emphasize the way that institutions maintain and protect their discourses. Foucault explores these issues in *The*

³² Michel Foucault, “The Ethics of the Concern for Self as a Practice of Freedom” in Robert Hurley, ed, *Ethics, Subjectivity and Truth* (New York: New Press, 1997) at 281.

³³ *Ibid* at 296.

³⁴ *Ibid* at 297.

³⁵ *Ibid*.

Order of Discourse, a paper he delivered as a lecture in 1981, in which he states that institutions police their discourses through excluding other discourses by regarding them as taboo, irrational or insane.³⁶ Less obvious forms of exclusion centre on selecting what counts as a true statement by screening mechanisms, such as institutionalized academic standards and professional accreditation that determine which theories or statements come to be regarded as knowledge in particular disciplines. In academic settings, these factors are seen, for example, in the determination of which scholars have their writing published and in which journal the publications are accepted.³⁷ In addition, discourses remain in circulation by being reinforced through citation in other publications.

The policing of discourse is also seen in legal settings. For instance, once psychiatrists are accepted as expert witnesses in court proceedings, their reference to the *Diagnostic and Statistical Manual* (DSM) then forms part of the qualified expert testimony that becomes, in legal parlance, “the record.” The published cases in which these experts’ opinions are accepted then become described in the legal community as “precedents” and “authorities”, which in turn reinforce the further use of the discourse of the DSM in the future. Persons who question the use of the DSM or who base an opinion concerning a person’s mental status on considerations outside of the DSM might not even be regarded as experts at all, or may find their opinions given little weight in judicial decision-making. This point may be particularly relevant when analyzing the dissenting opinions expressed by layperson members of panels in mental health review board hearings, or indeed by the patients themselves.

³⁶ Michel Foucault, “The Order of Discourse” in Robert Young, ed, *Untying the Text: A Post-structuralist Reader* (London: Routledge, 1981).

³⁷ *Ibid.*

6.1(D) Discourse and *Parrhesia*

As discussed in Chapter 4, in the final lectures in his career, Foucault explored forms of speech activities that focused on types of truth-telling found in ancient Greek texts,³⁸ which confirms that he remained concerned about the nature of discourse until the end of his life. In these lectures, Foucault made a distinction between the types of analyses that focus on “epistemological structures” used to assess the truth-value of propositions and what he called “alethuric forms.”³⁹ These forms are described in terms of the “production of truth, the acts by which truth is manifested.”⁴⁰ The focus of Foucault’s analysis on alethuric forms of speech was not on the content of the utterances, but rather on the *way* that the content is expressed, the context in which the speech occurs, and the stake that the speaker has in the speech act. The alethuric form that preoccupied Foucault’s thinking in his final lectures was what the ancient Greeks called “*parrhesia*”, a form of speech activity in which speakers put themselves at risk by challenging the authority of their interlocutors. The concept of *parrhesia* as risky truth-telling also “aims for the transformation of the ethos of the interlocutor”⁴¹ and provides a way of understanding the relationship between self-understanding and challenges to the legitimacy of discourse in modern society, such as the discourses of law and medicine. And just as human agents participate in creating a self from critical ethical reflection, so too is the status of social authority challenged and altered through exchanges.

³⁸ Michel Foucault, *The Courage of Truth: The Government of Self and Others II, Lectures at the College De France 1983-1984*, ed by Frederic Gros, translated by Graham Burchell (New York: Palgrave Macmillan, 2011).

³⁹ *Ibid* at 3.

⁴⁰ *Ibid*.

⁴¹ Frederic Gros, “Course Context” in Michel Foucault, *The Courage of Truth: The Government of Self and Others II, Lectures at the College De France 1983-1984*, ed by Frederic Gros, translated by Graham Burchell (New York: Palgrave Macmillan, 2011) at 345.

Foucault's thoughts on *parrhesiastic* discourse provide a valuable way of understanding activities in many institutional contexts, including Review Panel hearings in which all of the participants assume that they are engaged in some form of truth-telling and truth-seeking. The patients' speech acts have all the hallmarks of *parrhesiastic* activity. These hearings, by their very nature, involve a confrontation between individual patients who question the legitimacy of institutional authorities that are attempting to define the patients' identities and to restrict their freedom. Speech activity is defined as *parrhesiastic*, not by its content (the patients might be mistaken in some of their statements) but by the manner in which it is expressed and the context in which it occurs. The patients are sworn to tell the truth at the commencement of the hearings and their testimony frequently involves strong assertions concerning their lack of trust in the hospital authorities and, in some hearings, the legitimacy of psychiatry itself. As I illustrate with extracts from Review Panel hearings in the next chapter, this truth-telling certainly involves risk because the hospital authorities wield tremendous power to impose restrictions on the patients' liberty or to administer treatments such as medications and electro-shock therapy, both of which are recognized as having serious health risks. The patients are aware of this risk before the commencement of the hearing. At the same time, the patients' truth-telling aims to transform the hospital's interlocutors by attempting to change their minds about the patients' mental capacity or to have the Review Panel curtail the hospital's authority.

6.1(E) Summary of Section 6.1

Throughout his philosophical career, Foucault was concerned with the inextricable connection between discourse, power, and knowledge. In his later writing on genealogy, care of the self and *parrhesia*, he emphasized the importance of human agency in being

shaped by, but also in actively changing, discourses. In providing a comprehensive theoretical vision of the relationship between discourse and agency, Foucault's philosophy can be an effective basis for empirical research on discourse, particularly when norms of human conduct are being discursively enforced and simultaneously resisted.

6.2 A Review of Literature on Discourse Analysis Methodologies

Although much of Foucault's writing focuses on the nature and effects of discourse, he did not develop a systematic empirical methodology for the investigation of discourse.⁴² As such, the term "Foucauldian discourse analysis" in contemporary social scientific research refers to a "field" of many forms of discourse analysis inspired by concepts from Foucault's philosophy rather than an integrated research paradigm.⁴³ In particular, the form of critical discourse analysis that I develop later in this chapter is inspired by and compatible with some of Foucault's ideas concerning power, knowledge and discursive formation, while at the same time drawing on the work of other scholars, such as Gramsci and J.L. Austin.

6.2(A) Operationalizing Foucault's Theory of Discourse

It may sound peculiar to speak of operational definitions of Foucault's ideas because the notion of an operational definition was coined by logical positivists – theorists at the opposite end of Foucault's philosophical universe – in an attempt to reduce ideas to scientific operations used in measurements of observable events. Nevertheless, even researchers using discourse analysis inspired by Foucault's philosophy, who certainly do

⁴² Dieter Freundlieb, "Foucault's Theory of Discourse and Human Agency" in Colin Jones & Roy Porter, eds, *Reassessing Foucault: Power, Medicine and the Body* (London: Routledge, 1994) 152.

⁴³ Rainer Diaz-Bone, Andrea Buhrman, Encnacion Guierrez Rodriguez, Werner Schnieder, Gavin Kendall & Francisco Tirado, "The Field of Foucauldian Discourse Analysis: Structures, Developments and Perspectives, *supra* note 1 at 2.

not share the logical positivist's epistemological commitments, make reference to operational definitions of their terms to add rigour to their research.⁴⁴ A review of some of these efforts reveals how compatible Foucault's ideas are with empirical research on discourse.

Within contemporary social psychology, one of the most productive and influential researchers using discourse analysis is Jonathan Potter, who provides the following general definition:

Discourse analysis is an analytic commitment to studying discourse as *texts and talk in social practices*...the focus is...on language as...the medium of interaction; analysis of discourse becomes, then, analysis of what people do. One theme that is particularly emphasized here is the rhetorical or argumentative organization of talk and texts; claims and versions are constructed to undermine alternatives.⁴⁵

According to Potter, social psychologists working in the field of discourse analysis tend to share a set of three common assumptions, namely anti-realism, constructionism and reflexivity.⁴⁶ These assumptions mean that at the very minimum, discourse analysts are centrally concerned with the constructions of participants in discourse and how these constructions are generated and understood. The reflexive element in discourse analysis relates to the way constructions are subject to challenge and transformation in dialogic and reflexive processes.

⁴⁴ Howarth, *supra* note 1 at 2. Also see: Gavin Kendall & Gary Wickham, *Using Foucault's Methods* (London: Sage, 1999) at 42.

⁴⁵ Jonathan Potter, "Discourse analysis as a naturally-occurring talk" in David Silverman, ed, *Qualitative Research: Theory, Method and Practice* (London: Sage, 2004) at 203.

⁴⁶ *Ibid* at 202.

Forms of discourse analysis inspired by Foucault's philosophy have been used in interdisciplinary research of discourses of mental health/illness in contemporary society. This research has included investigations of discourses in community mental health policies and practices,⁴⁷ the construction of diagnostic identities of patients who have received psychiatric diagnoses,⁴⁸ and narratives of recovery from psychiatric disabilities.⁴⁹ I examine some of this research in greater detail in section 6.7(f) of this chapter.

A full account of the dialogic processes in discourse analysis requires some reference to the operation of networks of power relations Foucault called governmentality, as well as to the historical processes that generate the constructions shaping discourses and are the subject of genealogical research. Examples of governmentality and genealogical research are examined in turn.

6.2(B) Governmentality Research

An empirically driven approach to understanding the nature and effects of governmentality is taken up by Mariana Valverde and Nikolas Rose in their research, which promotes a view of Foucault's thinking about legal institutions that avoids any attempt to define what law is.⁵⁰ Instead, their project is geared toward conducting empirical examinations of legal systems using governmentality methodologies. In this type of empirical investigation,

⁴⁷ Michael Mancini, "Understanding Change in Community Mental Health Practices through Critical Discourse Analysis" (2011) 41(4) *British Journal of Social Work* 645-667.

⁴⁸ Ian Tucker, "'This is for Life': A Discursive Analysis of the Dilemmas of Constructing Diagnostic Identities" 2009 10(3) *Forum: Qualitative Social Research* 1-14.

⁴⁹ Michael Mancini, "Narratives of Recovery from Serious Psychiatric Disabilities: A Critical Discourse Analysis" (2006) 1(2) *Critical Approaches to Discourse Analysis across Disciplines* 35-50.

⁵⁰ Nikolas Rose & Mariana Valverde, "Governed by Law?" (1998) 7 *Soc & Leg Stud* 543 at 545.

traditional legal concepts are de-centred. That is, rather than framing problems in terms of, for example, *mens rea* in criminal law or foreseeability in the law of negligence, their research starts with the assumption that laws are always interfused with “extra-legal practices and processes” and that “productive possibilities” are identified when investigating areas of social conflict involving law.⁵¹ Their focus, therefore, is on conducting research on problems within social practices where contestation arises between legal rules and norms that are “inherently open to justification and contestation.”⁵² Their form of inquiry entails, among other things, an investigation of the “surfaces” of the emergence of problems for government, such as the historical conflicts arising from workers’ assertions of rights to safety in the workplace, which only later were recognized in legislation.⁵³ It could also involve examining contests between various types of authorities and explanatory justifications seen, for example, in the historical tension between psychiatry and law.⁵⁴

There is certainly considerable merit and usefulness in de-centring preconceptions about law’s traditionally privileged place when examining social problems, particularly problems in which legal discourse appears to play a highly influential role. Indeed, Rose and Valverde’s work has provided me with numerous ways of formulating my empirical research on the contestations and multiple forms of resistance found in British Columbia’s mental health law system because it has offered means of looking beyond legal justifications for the treatment of people subjected to civil commitment orders to see how

⁵¹ *Ibid* at 546.

⁵² *Ibid* at 545.

⁵³ *Ibid* at 546.

⁵⁴ *Ibid*.

the law operates in field that is inherently open to contestation. In focusing on social conflict, Rose and Valverde's view of law is consistent with the model of critical discourse analysis I develop later in this chapter.⁵⁵

There has been a considerable amount of research using governmentality analysis to examine mental health law policies in Western industrial societies⁵⁶ and in contemporary Canadian society.⁵⁷ These studies include an analysis of government employment policies concerning depression in the workplace in British Columbia that reinforce neoliberal discourses of employee "responsibilization."⁵⁸ Other Canadian governmentality studies have analyzed federal mental health policy documents for mental health law reform promoting a model of "recovery" from mental illness that privileges neoliberal models of individual resilience while shifting focus away from patients' social disadvantages.⁵⁹ I return to this governmentality research in chapter 8 when examining the social contexts of patients who become subject to British Columbia's civil commitment laws.

⁵⁵ For an examination of the way that some governmentality research avoids a critical focus see Pat O'Malley, Lorna Weir & Clifford Shearing, "Governmentality, Criticism, Politics" (1997) 26 *Economy and Society* at 501. The thesis I advance in this dissertation is that Foucault's philosophy includes a normative dimension that is consistent with using governmentality research to criticize social structures and make recommendations for changing them.

⁵⁶ See Nadesan, *supra* note 1. In particular, the chapter entitled "Governing Population: Mind and Brain as Government Spaces" provides a governmentality analysis of governing at a distance through psychopharmacological intervention and the marketing of neurological scanning technologies.

⁵⁷ Marina Morrow, "Recovery: Progressive Paradigm or Neo-liberal Smokescreen?" in Brenda LeFrancois, Robert Menzies & Geoffrey Reaume eds, *Mad Matters: A Critical Reader in Canadian Mad Studies* (Toronto: Canadian Scholars' Press, 2013).

⁵⁸ Kathy Teghtsoonian, "Depression and Mental Health in Neoliberal Times: A Critical Analysis of Policy and Discourse" (2009) 69(1) *Social Science and Medicine* 28-35.

⁵⁹ Pat O'Malley, "Resilient Subjects: Uncertainty, Warfare and Liberalism" (2010) 39(4) *Economy and Society* 488-509.

6.2(C) Genealogical Research

An example of historical research explicitly drawing on Foucault's philosophy is found in the work of Jean Carabine, who uses a Foucauldian genealogical model to analyze the effects of numerous discourses in the construction of norms concerning unwed motherhood in Britain between 1830 and 1990.⁶⁰ According to Carabine, "Genealogy is concerned to map those strategies, relations and practices of power in which knowledges are embedded and connect."⁶¹ These practices of power are revealed in discursive strategies, namely the way that discourses are used and given force thereby constituting subjects and knowledge of them.⁶² According to Carabine, the construction of notions concerning the deviant nature of unwed mothers between 1830 and 1990 also conveyed messages about other social norms and consequently shaped conceptions about motherhood generally, as well as norms concerning acceptable heterosexual behaviour.

Carabine's work on this topic involved many years of archival research, reading court documents, government policy statements, legislation, and police records produced over a period of 160 years. This extensive research allows her to show the changes in norms over a long period of time. According to Carabine, a difficulty in doing this type of genealogical research is:

obtaining the accounts of ordinary people. So one limitation in this research is that there is an absence of accounts which reflect the experiences and views of the unmarried mothers themselves. This can make it difficult to assess the extent to which unmarried mothers accepted

⁶⁰ *Supra* note 15 at 268.

⁶¹ *Ibid* at 276.

⁶² *Ibid* at 268.

or challenged the construction of them...It may also be difficult to obtain accounts reflecting counter discourses or resistance.⁶³

Although my genealogy is not as detailed as Carabine's, I set out the history of the formation and confluence of medical and legal discourses in British Columbia related to civil committal in Chapter 2 in this dissertation. In contrast to Carabine's research, most of my research is focused on transcripts of Review Panel hearings that disclose the views of the participants in the hearings, including their counter discourses and multiple forms of resistance. The research methodology used here to analyze transcripts effectively incorporates some of Foucault's ideas concerning discourse, power, and knowledge has been developed by a school of social research called "critical discourse analysis." Critical discourse analysis is not presented in this dissertation as Foucauldian discourse analysis simpliciter, but rather as, in its modified version, a research methodology that is inspired by and compatible with Foucault's later philosophy.

6.2(D) Critical Discourse Analysis

Critical discourse analysts maintain that discourse, even on the most basic levels of text and discursive social practice, cannot be understood without first describing the institutional context in which it occurs. In addition, critical discourse analysts have argued that discourse is also shaped by institutional constraints in the material world.⁶⁴ Critical discourse analysts draw on Foucault's ideas concerning power and orders of discourse and at the same time adopting a theory of ideology and hegemony as developed by Gramsci.⁶⁵ They therefore view discourse as being largely influenced by ideology, which may not be

⁶³ *Ibid* at 305.

⁶⁴ Norman Fairclough, *Discourse and Social Change* (London: Polity, 1992) at 60.

⁶⁵ Ruth Wodak & Michael Meyer, *Methods of Critical Discourse Analysis* (London: Sage Publications, 2001) at 10.

apparent to many of the people involved in discursive activity. A number of these theoretical commitments are encapsulated in the following quotation, which is frequently found in the literature on critical discourse analysis:

Critical discourse analysis sees discourse – language use in speech and writing – as a form of “social practice”. Describing discourse as social practice implies a dialectical relationship between a particular discursive event and the situation(s), institution(s) and social structure(s), which frame it: the discursive event is shaped by them, but it also shapes them. That is, discourse is socially constitutive as well as socially conditioned – it constitutes situations, objects of knowledge, and the social identities of and relationships between people and groups of people. It is constitutive both in the sense that it helps to sustain and reproduce the social status quo, and in the sense that it contributes to transforming it. Since discourse is so socially consequential, it gives rise to important issues of power. Discursive practices may have major ideological effects – that is, they can help produce and reproduce unequal power relations between (for instance) social classes, women and men, ethnic/cultural majorities and minorities through the ways in which they represent things and position people.⁶⁶

6.2(D)(i) Norman Fairclough’s Model

Although researchers working within critical discourse analysis tend to share the theoretical commitments described in this quotation, they may use very different approaches to analyzing discourse. For example, Fairclough uses a highly detailed form of analysis based on the linguistic theories of Michael Halliday.⁶⁷ Other critical discourse analysts do not use this methodology and have developed other approaches for understanding discourse, such as the identification of interpretive frames within discourse that are shaped by metaphor and myth.⁶⁸ A number of critical discourse analysts have also buttressed their qualitative

⁶⁶ Norman Fairclough & Ruth Wodak, “Critical Discourse Analysis” in T.A. van Dijk, ed, *Discourse as Social Interaction* (London: Sage, 1997) at 258.

⁶⁷ Norman Fairclough, *Discourse and Social Change* (Cambridge: Polity Press, 1992).

⁶⁸ Ruth Wodak, “Critical Discourse Analysis and the Study of Doctor-Patient Interaction” in Bjorn Gunnarsson, Per Linell & Bengt Norberg, eds, *The Construction of Professional Discourse* (Essex: Addison Wesley Longman, 1997) at 173.

analysis of discourse with statistical quantitative data, to ensure that their research cannot be labelled as “cherry picking”, that is, choosing examples of discourse which best fit the researcher’s assumptions.⁶⁹

Despite having fuzzy theoretical boundaries and a heterogeneous approach to methods, critical discourse analysis is now widely used research paradigm found in many different disciplines. The commitment that scholars using critical discourse analysis tend to share is an interest in de-mystifying ideologies by showing the detailed workings of power through the systematic and reproducible empirical investigation of linguistic data. As such, critical discourse analysis is problem-oriented and identifies social issues in which there are injustices that require examination, thereby providing an opportunity to confront hidden oppression and inequalities in order to bring about social change.⁷⁰

Following Fairclough’s model, after identifying a social problem, critical discourse analysts then select samples of discourse related to the problem in issue. The material used in these types of analyses ranges from texts, such as written advertisements, to oral communications that are transcribed. For Fairclough these sets of material are the “corpus”, which can be expanded by further interviews with subjects. He states that one of the major hurdles in commencing this type of empirical research is the initial selection of samples from the corpus, which will then be the subject of detailed analysis. In addition to the obvious step of consulting with other researchers in relevant disciplines, he recommends doing a preliminary survey of the corpus, much like I have done in reviewing a large number of review board hearing decisions, and “taking advice where one can get it from those being

⁶⁹ *Ibid* at 11.

⁷⁰ Fairclough & Wodak, “Critical Discourse Analysis”, *supra* note 55 at 258.

researched,”⁷¹ as I have done by consulting with Review Panel members and patient advocates who appear at the hearings. In selecting samples from the corpus, Fairclough’s further recommendation is to focus on what he calls “cruces” or “moments of crises” in discourse because:

Such moments of crisis make visible aspects of practices which might normally be naturalized, and therefore difficult to notice; but they also show change in process, the actual ways in which people deal with problematization of practices.⁷²

This recommendation demonstrates a consistent Foucauldian orientation by highlighting the importance of problematization, not only for the researcher, but also for the participants themselves.

According to Fairclough, discourse involves the construction of interpersonal social relations through interactional control, such as turn-taking and agenda setting; in addition, discourse constructs social reality through devices such as lexical choice, metaphorical meanings and structural cohesion in texts.⁷³ Fairclough borrows concepts and methods offered by conversation analysis⁷⁴ for examining the construction of social relations. However, he adds a number of dimensions to the analysis that he believes allow him to comment on the construction of what he calls “ideational meaning” seen in, for example, metaphor and word choices and found in texts and conversations. He acknowledges that it is somewhat artificial to make a division between interactional control and ideational

⁷¹ Fairclough, *Discourse and Social Change*, *supra* note 56 at 226-227.

⁷² *Ibid* at 230.

⁷³ *Ibid* at 10.

⁷⁴ Conversation analysis, described in detail later in this section, is a school of social research that focuses on naturally occurring conversational exchanges.

meaning; both are always linked together, but it can be helpful for methodological purposes to examine each separately.⁷⁵

In addition to the distinction between interactional control and ideational meaning, Fairclough outlines a three-dimensional framework for understanding discourse.⁷⁶ The first dimension is discourse as text, in which there is an analysis of discrete examples of the linguistic features of concrete examples of written language. At this level of analysis, types of vocabulary, grammatical forms, structures of text, and forms of questioning and answering are analyzed in detail. The second dimension is discourse as discursive practice. At this level of analysis, focus is placed on speech acts and intertextuality, which connect the text to a larger social context. The third dimension in the framework is discourse as social practice. At this level, there is analysis of the effects of ideology and hegemony on discursive practices and even on the creation of texts. Of the third component of the analysis, Fairclough states that:

The aim is to specify the social and hegemonic relations and structures which constitute the matrix of this particular instance of social and discursive practice; how this instance stands in relation to these structures and relations (is it conventional and normative, creative and innovative, oriented to restructuring them, oppositional, etc.); what effects it contributes to, in terms of producing or transforming them.⁷⁷

Although the reference to hegemonic relations appears to take Fairclough's recommendations for analysis outside of Foucault's philosophy and into Gramscian terrain, the general recommendations are consistent with Foucault's theory that discursive

⁷⁵ Fairclough, *Discourse and Social Change*, *supra* note 56 at 169.

⁷⁶ Norman Fairclough, *Language and Power* (Essex: Pearson Education, 1989) at 91.

⁷⁷ *Ibid* at 237.

formation must make reference to non-discursive forces and institutions, which shape and are, in turn, shaped by discourses.

According to Fairclough, hegemonic processes occur when alliances are created within groups with certain interests. Power is exerted through discursive processes in which people consent to reproduce forms of discourse, thereby creating norms that are broadly accepted and create what come to be regarded as social realities. While Fairclough provides detailed descriptive analyses of texts, he also describes large-scale hegemonic process such as “commodification” and “technologisation” which shape texts and social practices.⁷⁸ Fairclough’s research highlights the numerous and complex ways that individuals’ identities are shaped by hegemonic discursive regimes in which they live and in which social realities are constructed.

6.2(D)(ii) Janet Thornborrow’s Research on Institutional Talk

In recent years there has been a growing tendency to develop critical discourse analysis methodologies that draw on insights from conversation analysis, particularly for research on discourse in legal settings.⁷⁹ One of the models of discourse analysis that best integrates critical discourse analysis and conversation analysis is found in Janet Thornborrow’s research.⁸⁰ The model she has developed for examining institutional discourse (which she calls institutional “talk”) has two dimensions. The first is a structural dimension, in which power is expressed in the institutional roles and identities that speakers can occupy and the

⁷⁸ *Ibid* at 215.

⁷⁹ Kate Haworth, “The Dynamics of Power and Resistance in Police Interview Discourse” (2006) *Discourse and Society* 17:6 739-759.

⁸⁰ Janet Thornborrow, *Power Talk: Language and Interaction in Institutional Discourse* (London: Pearson Education, 2002).

procedures and rules which govern who has access to discursive resources. Therefore, identifying the structure of the participants' rights and obligations in the institutional context is a critically important first step in the analysis. The second is an interactional dimension in which the discourse occurs and through which speakers achieve certain goals. The institutional context is created by the interaction between the structural and interactional dimensions, which occur at a local level and in which social meaning is jointly created by the parties in the interaction.

Thornborrow agrees with Fairclough's view that background assumptions must be identified and recognized as having a very important role in discourse. She uses the term "ideological coherence" to describe the set of premises that shape a speaker's discourse on the level of representation, and "orderliness" to describe the conversational norms with which conversation analysis has been preoccupied. Control of institutional talk is strongly influenced by the underlying ideology expressed in institutional norms on both a representational and procedural level. However, institutional talk is not determined by underlying ideology because there is rarely a uniform mapping of the institutional roles with the discursive roles that participants occupy in the unfolding process of the discursive practices. Consequently, dominant categories for representing social reality can always be challenged by participants in discursive interaction when they contest the legitimacy of the other participants' institutional roles and the authority of their discourse. Thornborrow therefore agrees with Foucault's theory that both power and resistance are always present in discourse and her view of institutional discourse meshes well with Foucault's notion of

“games of truth” occurring in “a certain network of practices of power and constraining institutions”.⁸¹ The approach Thornborrow adopts to understanding power

is to see it as a contextually sensitive phenomenon, as a set of resources and actions which are available to speakers and which can be used more or less successfully, depending on who the speakers are and which kind of speech situation they are in. From this perspective, power is accomplished in discourse both on a structural level, through the turn and type of space speakers are given or can get access to, and, on an institutional level, through what they can effectively accomplish in that space.⁸²

The particular strength of Thornborrow’s research is that it is grounded in empirical research of naturally-occurring institutional talk in a number of different settings, including police interviews, radio phone-in programs, media interviews, and classroom discussion talk. She employs the findings from a variety of empirical research studies to demonstrate that the relationship between power and institutional discourse cannot be explained merely by reference to pre-existing ideological structures imposed from above, but must be understood by analyzing closely the minute detail of institutional talk. At the same time, she emphasizes that the researcher must not lose sight of the importance of these structures in the discourse, structures that are an intrinsic part of wider regimes of power.

Thornborrow provides a comprehensive definition of institutional talk as:

1. Talk that has differentiated, pre-inscribed and conventional participant roles, or identities.
2. Talk in which there is a structurally asymmetrical distribution of turn types between participants such that the speakers with different institutional identities typically occupy different discursive identities; that is, they get different types of turns in which they do different kinds of things.

⁸¹ Michel Foucault, “The Ethics of the Concern for Self as a Practice of Freedom”, *supra* note 32 at 297.

⁸² *Ibid* at 8.

3. Talk in which there is also an asymmetrical relation between participants in terms of speaker rights and obligations. This means that certain types of utterances are seen as legitimate for some speakers but not for others (for example, an examining magistrate is expected to ask questions, a defendant is not).
4. Talk in which the discursive resources and identities available to participants to accomplish specific actions are either weakened or strengthened in relation to their current institutional identities.⁸³

In this delineation of institutional talk, Thornborrow, like Fairclough, borrows many ideas from conversation analysis, which has been used frequently for research on conversation in legal hearings and medical settings, some of which is described in Section 6.3 of this chapter. Below I provide an account of some of the concepts found in conversation analysis that are most relevant for my research and will assist in understanding research in legal and medical contexts.

6.2(E) Conversation Analysis

Conversation analysis had its initial inspiration in ethnomethodology's concern with investigating the way that actors can participate in social interaction that is mutually comprehensible and achieves social ends through forms of linguistic exchange that can support intersubjective understanding.⁸⁴ More recently, research using conversation analysis has been focused primarily on talk in institutional settings and distinguishes the talk that naturally occurs in those settings from ideal-type assumptions about ordinary non-institutional conversation. According to Jurgen Habermas, non-institutional talk, in its ideal form, assumes a complete symmetry between participants in their access to knowledge and opportunities to speak; institutional talk on the other hand is inherently

⁸³ *Ibid* at 4.

⁸⁴ David Silverman, *Interpreting Qualitative Data* (London: Sage, 1993) at 210.

power-laden and strategically directed to specific goals.⁸⁵ While one might object to the notion that there is any conversation that is not, at some level, shaped by social institutions, conversation analysis has used the theoretical assumption about symmetry found in ideal-type models of cooperative conversation to understand the deviations from these norms that occur in institutional contexts, particularly when contested talk is present. Thus, while conversation analysis makes reference to a model of ideal conversation based on symmetry in the speaker's control of the verbal exchange, it has been concerned primarily with the *asymmetries* found in conversations in which some speakers are able, through various discursive strategies, to control what is said.

Conversation analysts also have a methodological commitment to naturally occurring talk in which the analyst has not participated as an interviewer or intervener. In the literature on discourse analysis, the term "naturally occurring" talk "would not necessarily refer to whether the speakers were relaxed or unselfconscious, but to talk being uninfluenced by the presence of the observer/recorder."⁸⁶ Thus naturally occurring talk can occur even in highly structured settings, such as courtrooms. The conversation used as data can include casual talk, but the chief concern is with talk in which there is conflict or potential for conflict, such as police interrogations, talk radio programs or court hearings. Being data-driven and focused on naturally occurring talk, most conversation analysis uses transcripts of audiotape recordings of conversations. The use of transcripts also satisfies the empirical requirement for independence from the data and reproducibility because other researchers

⁸⁵ Jurgen Habermas, *The Theory of Communicative Action* (London: Heinemann, 1984)

⁸⁶ Stephanie Taylor, "Locating and Conducting Discourse Analytic Research" in Margaret Wetherell, Stephanie Taylor and Simon Yates, eds, *Discourse as Data: A Guide for Analysis* (London, Sage, 2001) at 27.

can listen to the audio recordings themselves and confirm the conversation analyst's observations.

When using data from transcripts, conversation analysis is focused primarily on investigating the sequential organization of speech acts and the various ways that people achieve social ends through producing and attempting to maintain orderly interaction in conversation. The basic linguistic units that conversation analysts look at are comment/response or question/answer pairings within conversational sequences. Conversation analysis tends to focus on three main features of conversational sequences: 1) conversational openings establishing topical agendas; 2) turn-taking and repair; and 3) the modification of the structure of ordinary conversation by institutional talk.⁸⁷ Each of these will be examined in turn.

6.2(E)(i) Conversational Openings and Topical Agendas

Conversation openings have an important role to play in conversation because they can establish topical agendas, which can then create presumptions about which topics are relevant in the dispute, thereby shaping the subsequent question and answer sequences. The clearest example of this is the power of an opening statement in a court hearing. In the context of Review Panel hearings, the psychiatrists appearing on behalf of hospitals seeking to detain patients use conversational openings to establish topical agendas at the beginning of the hearing with opening statements that refer to clinical records and interpretive summaries of the patients' clinical histories, including dealings with authorities such as the police. This can then influence what the participants at the hearing regard as

⁸⁷ Silverman, *Interpreting Qualitative Data*, *supra* note 72 at 212.

relevant, often to the patients' detriment. In the next chapter I provide examples of psychiatrists' opening statements that clearly guide the subsequent unfolding of dialogue and that participants refer back to in framing their questions.

6.2(E)(ii) Turn-taking and Repair

Following the conversational opening, the ensuing conversation results from the participants taking turns in verbal exchanges. A close analysis of the ways in which these turns unfold reveals important insights into the nature of the interaction and what it accomplishes. The purpose of these turns is to confirm that listening has occurred and for the respondent to display understanding. In the context of turn-taking in institutional settings, which so often involve conflict, the participants will frequently attempt to subvert or resist the utterances of the other parties to the conversation by various means, including refusing to answer questions, responding to questions with other questions, or interrupting another speaker. When this occurs "repair mechanisms" are often used to re-establish order in the conversation. Sometimes resistance is demonstrated in the ways in which the respondent does not overtly signal refusal to answer the preceding question, but simply evades the issue by changing the subject. This can be seen frequently in conversation analysis of court hearings in which a judge will order a witness to answer a question or interrupt a witness when their answer is deemed insufficiently responsive. In the next chapter, I describe how question and response units can disclose the ways that participants being questioned in Review Panel hearings can display multiple forms of resistance.

6.2(E)(iii) Modifications of Institutional Talk

As previously noted, conversation analysts regard ordinary conversation as a baseline against which departures from assumed norms are identified, and they observe how participants in institutional contexts orient themselves to the institutional constraints. Participants in institutional talk are both subject to institutional constraints and renew and modify the context as the talk unfolds. Context, therefore, is seen as inescapably local and always transmutable. Using these assumptions, conversation analysts Paul Drew and John Heritage have outlined a number of methods for analyzing institutional talk.⁸⁸ Drew and Heritage stress that talk in institutional settings is oriented toward certain tasks that allow the institution to continue functioning. As such, there are certain constraints on talk in institutions, related to “inference making” and patterns of reasoning, that are not found in ordinary free-flowing conversation. According to Drew and Heritage, what makes the talk institutional is not the setting per se, but rather how the participants orient their identities to certain goals. As they have stated:

Conversation analytic researchers cannot take “context” for granted nor may they treat it as determined in advance and independent of participants’ own activities. Instead, “context” and identity have to be treated as inherently locally produced, incrementally developed and, by extension, as transformable at any moment. Given these constraints, analysts who wish to depict the distinctively “institutional” character of some stretch of talk cannot be satisfied with showing that institutional talk exhibits aggregates and/or distributions of actions that are distinctive from ordinary conversation. They must rather demonstrate that the participants constructed their conduct over its course...turn by responsive turn...so as progressively to constitute...the occasion of their talk, together with their own social roles in it, as having some distinctively institutional character.⁸⁹

⁸⁸ Paul Drew & John Heritage, “Analyzing Talk at Work: An Introduction” in Paul Drew & John Heritage, eds, *Talk at Work: Interaction in Institutional Settings* (Cambridge: Cambridge University Press, 1992) at 3.

⁸⁹ *Ibid* at 21.

Identifying the roles and identities that participants in institutional talk have is also crucial to understanding other concepts found throughout research using conversation analysis. Of particular importance is the access to lexical choice related to professional discourse, such as law or medicine, which persons with professional institutional roles are adept at deploying, but which lay participants are much less inclined to use. This can reinforce the asymmetry that conversation analysts identify in the forms of question and answer patterns, particularly since lay participants have fewer opportunities to ask questions or to set agendas of topics to be addressed in institutional talk. In the next chapter I provide many examples of the role that institutional roles play in shaping the discursive exchanges between the participants in Review Panel hearings, not only between the patients and psychiatrists but also between the legal, medical and layperson members of the panel.

6.2(F) Summary of Section 6.2

Critical discourse analysis, guided by Foucault's philosophy, provides productive ways of understanding discourse in modern society. Recently, critical discourse analysts, such as Fairclough and Thornborrow, have incorporated much of the methodology from conversation analysis into their work, while providing a better way of understanding how institutional forces shape conversation. Critical discourse analysis, particularly when it uses methods drawn from conversation analysis, is therefore an effective methodology for understanding two of the most powerful forms of discourse in modern society: medicine and law. The next section of this chapter provides a literature review of critical discourse analysis in medical and legal contexts. This is not an exhaustive review but rather a selection of research papers that provide the most suitable methods and concepts for

understanding the discursive exchanges I have found in data arising from Review Panel hearings.

6.3 Critical Discourse Analysis on Medical and Legal Discourse

There has been a considerable amount of research using conversation analysis and critical discourse analysis to examine medical interviews and legal hearings. Researchers in these areas have identified four interactional features of discourse that are most relevant when examining naturally occurring institutional talk in legal settings, all of which are seen in transcripts of Review Panel hearings, as described in the next chapter. The first feature is the institutional contexts and the institutional roles that speakers have in these contexts. The second is control of topical agenda. The third is the control of the types of questions asked. The fourth is control of the sequence of questions or, in other words, the way that speakers have priority in the order in which questions are asked and the power to demand responses. I illustrate the presence of these four features of institutional discourse in the following review of the empirical research and also describe research on forms of resistance in legal settings relevant for my research.

In addition to these interactional features of legal institutional discourse, I also describe research in which the ideational content of the speech is as important as identifying interactional features of conversational exchanges. The ideational content is strongly influenced by interpretive frames or repertoires, which Potter describes as “systematically related sets of terms that are often used with stylistic and grammatical coherence and often

organized around one or more central metaphors.”⁹⁰ In the context of Review Panel hearings, these central concepts and metaphors are organized around, for example, ascriptions of disorder, insight, deterioration and risk, as well as tacit assumptions related to gender and age. I begin the following section by focusing on discourse in medical settings because the encoding of medical discourse in clinical records and statutory forms from the *Mental Health Act* provides part of the initial foundation for the legal discourse found in legal proceedings such as Review Panel hearings.

6.3(A) Medical Contexts

6.3(A)(i) Medical Interviews and Dismissal of Patients’ Lifeworld Concerns

Research using discourse analysis on the institutional talk found in medical interviews is relevant for my research because civil commitment almost always arises from interviews in which psychiatrists formulate their opinions regarding the patients’ mental status. The results of medical interviews are seen in the clinical records to which hospital presenters make reference in Review Panel hearings, as well as in the statutory documents provided under the *Mental Health Act* that physicians are required to complete regarding the patient’s psychiatric condition. These documentary records, summarized in the psychiatrist’s opening statement at the beginning of each hearing, create a topical agenda and form part of the interpretive frame used by members of the Review Panel. As such, they shape the ideational meaning of discourse as it unfolds in the hearings. This is illustrated in the following research using discourse analysis in medical settings.

⁹⁰ Jonathan Potter, “Discourse Analysis and Constructionist Approaches: Theoretical Background” in James Richardson, ed, *Handbook of Qualitative Research Methods for Psychology and Social Sciences* (London: Sage, 1996) at 131.

In his empirical research on medical interviews, Elliot Mishler found that the language of medical practice is roughly divided into two often competing forms of discourse: the bioscientific technical discourse of the doctor and the psychosocial lifeworld⁹¹ discourse of the patient.⁹² Mishler reviewed a large number of transcripts of doctor/patient interviews and found that the bioscientific voice of the doctors dominated the discourse while the patients' psychosocial lifeworld expressions of their concerns tended to be ignored. Mishler proposed reform to this model of doctor/patient interaction by challenging the hegemony of the bioscientific frame of interpretation and advocating patient-centred care that addresses both the medical and psychosocial aspect of the patients' lives.⁹³ As the critical discourse analysis on Review Panel transcripts discloses in the next chapter, patients' lifeworld concerns expressed in non-medical language are frequently disregarded and displaced by technical neurobiological descriptions of their lives.

Fairclough applied discourse analysis to one of the transcripts of a medical interview taken from Mishler's book and used it to provide a much more detailed discourse analysis of the role of power relations between doctors and patients than Mishler provides. According to Fairclough the transcript showed the doctor dominating the interview by frequently interrupting the patient and controlling, through various forms of questioning, interruptions

⁹¹ "Lifeworld" is a translation of the German word *Lebenswelt* originally used by phenomenologists such as Husserl and refers to a non-scientific way of understanding the world. More recently, Habermas has used the term lifeworld to refer to a form of understanding that is that is different from the "world of systems governed by the logic of instrumental reason. Lifeworld is a realm of shared intersubjectivity bounded by all those interpretations of the world that are presupposed by its members and provide a shared background knowledge. It gives the horizon for all the processes of reaching a common understanding and coordination through communicative action." David Macy, *The Dictionary of Critical Theory* (London: Penguin, 2000) at 230.

⁹² Elliot Mishler, *The Discourse of Medicine: Dialectics of Medical Interviews* (Norwood: Ablex, 1984).

⁹³ *Ibid* at 87.

and dismissive speech acts, what counts as an acceptable response from the patient.⁹⁴ The doctor thereby controlled the topics during the interview, steering the discourse toward bioscientific medical explanations rather than to the problems the patient appeared intent on articulating. According to Fairclough, the doctor was working through an established agenda expressed in question, response and assessment cycles that dismissed the lifeworld expressions of the patient and instead imposed a framework from the “technological rationality of the doctor.”⁹⁵ While the patient was often seen to be deferring to the medical model by accommodating the doctor’s voice, there was also evidence of the patient resisting the doctor’s control and attempting to assert her “common sense” view of her problems.⁹⁶ What the text showed is that these interviews often reveal struggles for dominance between different discourses and ideologies. I make a number of references to these types of struggles and competing discourses between psychiatrists and patients in the next chapter when I analyze transcripts from Review Panel hearings.

Similar concerns were addressed by Susan Fisher, who identified features of the discursive structures related to control of the interaction in doctor-patient interviews and contrasted them with the forms of discourse found in nurse-patient interaction.⁹⁷ Fisher found that doctors tended to ask questions that “both allow a very limited exchange of information and leave the way open for the doctor’s own assumptions to structure subsequent

⁹⁴ Fairclough, *Discourse and Social Change*, *supra* note 56 at 137.

⁹⁵ *Ibid.*

⁹⁶ For a summary of research on patients’ resistance to biomedicalization in clinical encounters with doctors see Deborah Lupton, *Medicine as Culture: Illness, Disease and the Body in Western Societies*, 3d ed (London: Sage Publications, 2012) at 105-136.

⁹⁷ Susan Fisher “A Discourse of the Social: Medical Talk/Power Talk/Oppositional Talk?” (1992) 2 *Discourse and Society* at 157.

exchanges.’’⁹⁸ Consequently, the doctors’ medical and technical concerns were dominant and the patients’ social concerns tended to be dismissed. Nurses, on the other hand, were much more inclined to ask open-ended questions and displayed a greater inclination to listen to the patient’s lifeworld concerns.

6.3(A)(ii) Decontextualization of Patients’ Language and Conduct

In his paper “Oracular Reasoning in a Psychiatric Exam: the Resolution of Conflict in Language”, Hugh Mehan analyzes a medical interview specifically concerning psychiatric issues.⁹⁹ Mehan examines a four-page transcript of an interview between a group of psychiatrists and a patient who was hoping to be released from detention in a psychiatric institution in the early 1960s. The transcript was taken from the film “Titicut Follies,” a documentary film made in 1967 concerning the treatment of psychiatric inmates in a state psychiatric in Bridgewater, Massachusetts. The interview occurred when the patient requested that the hospital release him from detention in the hospital on the grounds that he did not suffer from mental illness. There was no indication in either the film or Mehan’s paper that the patient was granted this interview because he had a legal right to it; rather it appears that his treating psychiatrist allowed the interview in response to the patient’s persistent requests to have someone listen to his plea to be released. Mehan uses the transcript to demonstrate how “competing definitions of the situation are constructed and revealed in ongoing interaction in an institutional setting, and to show how institutionalized

⁹⁸ *Ibid* at 159.

⁹⁹ Hugh Mehan, “Oracular Reasoning in a Psychiatric Exam: the Resolution of Conflict in Language” in Allan Grimshaw, ed, *Conflict Talk: Sociolinguistic Investigations of Arguments in Conversations* (Cambridge: Cambridge University Press, 1990) at 160.

power is displayed and used to resolve disputes over conflicting definitions of the situation.”¹⁰⁰

When examining the transcript, Mehan observes that all of the patient’s assertions that the institution itself was the cause of his unhappiness, that the medication imposed on him was distorting his thinking, and that he should be released were interpreted and described by the psychiatrists as further evidence that he remained ill and required even more medication. The patient’s explanation that his troubles were arising from his treatment in a particular social context was completely ignored by the psychiatrists who used a biomedical explanation for every one of his complaints, all of which resulted in a confirmation of the original diagnosis and prolonged detention. Mehan notes that the psychiatrists used a type of strategic decontextualization, which was a “selective invocation of background knowledge and the demand for literal (yes/no) answers to questions, [which] simultaneously frames and undercuts the speaker and the power of his discourse”.¹⁰¹

Mehan’s observation of the way that the psychiatrists in the study used discursive strategies to achieve a decontextualization of the patient’s conduct during the interview is also seen frequently in the submissions made by psychiatrists in Review Panel hearings. Like the psychiatrists in Mehan’s study, they use a “selective invocation of background knowledge” gleaned from clinical records and snippets of conversations from earlier interviews to impose a decontextualized account of patients’ behaviour and speech acts. In the next

¹⁰⁰ *Ibid.*

¹⁰¹ *Ibid* at 170. According to Mehan, the psychiatrists’ explanation of the patient’s behaviour was an example of “oracular reasoning”, examples of which are described in anthropological literature regarding groups of people who appear to have an unquestioning belief in the incorrigibility of shamanistic oracles and interpret all events as evidence to support that belief, even when the evidence on its face appears to contradict the oracle.

chapter, I apply these concepts to many extracts from Review Panel data and I also show how a psychiatrist even used a selective reference of evidence from a patient's first Review Panel hearing in an attempt to decontextualize the patients' behaviour at the same patient's second Review Panel hearing a month later.

6.3(B) Legal Contexts

In the following review on the use of conversation analysis and critical discourse analysis, I illustrate the way that researchers have used these methodologies to illustrate how evidence, findings of fact and institutional identities are shaped by discursive exchanges in contested legal hearings. I begin with some of the most widely cited studies in conversation analysis literature that demonstrate how outcomes of hearings are affected by certain participants' use of topical agendas and control of question and answer sequences. I then provide examples of how some concepts from conversation analysis are applied in an ethnomethodological study conducted in the 1980s on American court hearings concerning involuntary psychiatric treatment. In the next part of this section, I demonstrate how all this research using conversation analysis has limitations because it does not take sufficient account of the force of overarching legal institutional contexts. I then describe a study that uses critical discourse analysis to show the importance of describing in detail the effects of multilayered legal institutional contexts for understanding conversation in legal hearings. In the concluding part of this section, I describe research on discourse in legal settings to highlight the way that ideational content related to ways of describing human behaviours is constructed from interactional exchanges in legal hearings.

6.3(B)(i) Conversation Analysis and the Interactional Features of Discursive Exchanges

In this subsection I describe three articles that illustrate how certain parties in legal settings can control the proceeding by virtue of their institutional roles and socio-economic status. Although these articles are based on conversation analysis methodology, they highlight the role of power in discursive formations. The insights from these articles can be integrated with the critical discourse analysis methodology I describe in sections 6.4 and 6.5 below.

6.3(B)(i)(a) The Power of Controlling Agendas and Question Sequences

The power of controlling agenda, types of questions, and the sequence of the questions is explored in a paper entitled “Linguistic Manipulation, Power and the Legal Settings”.¹⁰² In this paper, Abigail Walker examines transcripts of testimony from depositions and trials in the United States. She found that the power that judges and lawyers have in legal settings has a sociocultural basis, which allows them to control topical agenda by having the entitlement to ask certain types of questions and to control the sequence of the questions asked. In the most general terms, the questions types are divided between “open” or “non-leading” questions, which have been described by linguists as “Wh” questions, relating to requests regarding “what, when, where, who and how” an event occurred. The second types of questions are called “leading” questions, which make implied assertions and demand assent; for example: “You were drunk when you drove home from the party last night, right?” Legal education involves training lawyers in the skilful use of these types of questions, as well as effective methods for establishing and attempting to control topical

¹⁰² Abigail Walker, “Linguistic Manipulation, Power, and the Legal Setting” in Leah Kedar, ed, *Power Through Discourse* (Norwood: Ablex, 1987) at 57.

agendas. Walker's observations about power and manipulation in legal settings should not be too surprising for those familiar with the general features of contested legal hearings and the nature of legal education. Nevertheless, the implications of her observations are important for a number of reasons. First, she notes that the type of communication found between lawyers and judges in court is very different from how they communicate with laypersons they assume lack legal knowledge. Second, Walker interviewed witnesses who had been questioned in court and found that they felt frustrated because they did not get a chance to tell their stories and therefore were not heard. She concludes her paper with the following cautionary observation:

It is certainly true that, as data from this and other studies has shown, informed witnesses properly prepared by their own legal counsel, carefully educated in what is about to happen in the legal adversary interview, can negotiate effectively for their own versions of the truth. But even these successful witnesses are, by virtue of being confined to the role of responders, without any real power. Although the stories they tell are their own, they have little if any choice in our system of justice over their presentation. Choice belongs to the examiner who, because of his socially sanctioned role in the deposition setting, has the right to present, characterize, limit, and otherwise direct the flow of testimony. It is in the hands of the questioner that the real power lies.¹⁰³

The importance of the forms of legal questions is explored by Paul Drew in his paper "Contested Evidence in Cross-examination: The Case for Rape." Drew uses conversation analysis to show how observations of the structure of turn-taking in a lawyer's questioning of a complainant in a criminal rape trial can be used to illustrate the way that the asymmetries in a legal institutional context can shape the speakers' discursive

¹⁰³ *Ibid* at 82.

performance.¹⁰⁴ Drew's analysis did not focus so much on creation of social meaning, but rather on how control of the sequence of question and answer can affect the outcome of the trial. The data that he examines is a transcript of a rape trial before a jury in which the accused claimed in his defence that the complainant had consented to the sexual activity, which occurred one night in his car. The complainant denied that there was any consent. The proceedings were tape recorded, as they are in all court hearings, to create a record of evidence in the event that the verdict at trial was appealed.

In his analysis, Drew avoids references to ideology or the effect of large cultural institutions on the events that occurred in the trial. He does, however, note that there are important institutional differences in hearings that are "adversarial" rather than "inquisitorial". In an adversarial system the parties to the dispute jointly create the evidence that is admissible through a process of eliciting evidence by asking questions through examination-in-chief of witnesses and then subjecting the witnesses to further questioning through cross-examination by the opposing lawyer. The hearers of the evidence, called the "triers of fact" do not actively participate in generating evidence; they only judge evidence that is properly adduced by the lawyers. The judge can intervene to clarify procedural matters concerning the rules of evidence and, if he or she is the trier of fact, to apply the law. If a jury is the trier of fact, then the jurors will receive instruction concerning the law from the judge, but they alone must make the relevant conclusions concerning the evidence. I explore at greater length the importance of determining whether

¹⁰⁴ Paul Drew, "Contested Evidence in Courtroom Cross-examination: The Case of a Trial for Rape" in Paul Drew and John Heritage, eds, *Talk at Work: Interaction in Institutional Settings* (Cambridge: Cambridge University Press, 1992) at 270.

a hearing is adversarial or inquisitorial in the next chapter in which I apply critical discourse analysis to the inquisitorial process in Review Panel hearings.

6.3(B)(i)(b) Rules versus Relations

The importance of speakers' skilful use of legal language and orientation to institutionally prescribed procedures found in courts of law is also highlighted in a paper entitled "Rules Versus Relationships in Small Claims Disputes" by John Conley and William O'Barr, who used conversation analysis to understand difference in outcomes for self-represented litigants in English small claims courts in the 1990s.¹⁰⁵ These researchers found that litigants who provided relation-based accounts of what had occurred in a dispute were much less likely to be successful than litigants who used rule-oriented accounts. The relation-based account focused on narrative elements of relations between the parties, similar to the descriptions of disputes people give in everyday life. Litigants using a rule-oriented approach ensured that their accounts adhered closely to legal rules and language. This might not seem too surprising, given, after all, that all of this occurs in courts of law. However, Conley and O'Barr found that the use of either form of presentation was unrelated to age, gender, ethnicity or their being a plaintiff or defendant. Rather they suggested that the two modes of presentation represent a complex set of social characteristics; that persons who used relation-based narratives tended to positions of relatively little power in society and persons who used the rule-oriented approach had greater access to the social power of law and business.

¹⁰⁵ John Conley & William O'Barr, "Rules versus Relationships in Small Claims Disputes" in Allan Grimshaw, ed, *Conflict Talk: Sociolinguistic Investigations of Arguments in Conversations* (Cambridge: Cambridge University Press, 1987) at 278.

The significance of Conley and O’Barr’s research is that it shows how access to discursive resources can affect outcomes in contested hearings, thereby shaping the institutional identities of the participants. Those who do not have access to accepted forms of discourse acquire the identities of “unsuccessful” litigants who are thereby saddled with debt or will fail to collect debt to which they believe they are entitled. The fact that the unsuccessful litigants are “unrepresented” by legal counsel may demonstrate the risk associated with disempowered and socially marginalized people not having this type of legal assistance in contested hearings, such as Review Panel hearings.

Another significant aspect of Conley and O’Barr’s research is that it highlights how important it is for adjudicators in court or administrative proceedings to be aware that people who appear at hearings may try to express their life-world concerns in narrative terms that may not conform to juridical forms and processes. Effective adjudication requires accommodation of many forms of self-expression to force adjudicators to be open to the perspective of others. As Jennifer Nedelsky says:

Our capacity for judgment allows us not only to (incompletely) transcend the limitations of personal experience, but also to assess the views of those around us and come to a judgment that is different from the dominant view...Judgment thus has a double edge to it. It requires community. It can only be exercised because we share a common sense that allows us to take the perspectives of others. If we do not share a core of common understanding we would not be able to understand others enough to take their perspective. And only when we do so, do we actually exercise judgment. And it is because we do so that we can claim that our judgments have validity for others. We rely on our community of judgment, and we make a claim on it.¹⁰⁶

¹⁰⁶ Jennifer Nedelsky, “The Reciprocal Relation of Judgment and Autonomy” in Jocelyn Downie & Jennifer Llewellyn, eds, *Being Relational: Reflections on Relational Theory and Health Law* (Vancouver: University of British Columbia Press, 2012) at 44-45.

Consistent with Nedelsky's views, the relational normative vision I am arguing for in this dissertation indicates that effective adjudication requires dialogic engagement between the parties at hearings that must include openness to diverse ways of communicating about events and interests, including the narrative accounts that unrepresented parties use in legal proceedings.

6.3(B)(ii) Resistance in Legal Discursive Exchanges

One of the most noticeable features of Review Panel hearings is the frequency with which patients challenge the authority of psychiatrists, and indeed the Review Panel itself, to evaluate them and control their lives. The way that parties in a legal hearing challenged the legitimacy of authority figures is explored in Susan Harris' "Defendant Resistance to Power and Control in Court."¹⁰⁷ This paper is based on research Harris conducted using the transcripts of hearings that were recorded in magistrates' courts in England, involving 26 self-represented defendants and five different magistrates. Magistrate courts in England are analogous to Provincial Courts in British Columbia (as compared with superior courts, namely the British Columbia Supreme Court and the Court of Appeal) in which parties often appear without a legal advocate. Harris does not describe the nature of all of the hearings; however the ones she does describe appear to be related to the magistrates' questions directed at parties against whom there is a court order for the collection of debt. Each of the parties appeared before a magistrate because he or she had not complied with the court order, either through unwillingness or inability to pay.

¹⁰⁷ Susan Harris, "Defendant Resistance to Power and Control in Court" in Hugh Coleman, ed, *Working with Language: A Multidisciplinary Consideration of Language Use in Work Contexts* (Berlin: Walter de Gruyter, 1989) at 131.

Harris' study provides many ideas I use when I analyze the transcripts and Review Panel decisions. Most importantly, Harris noted that magistrates are empowered to ask questions and defendants are rarely allowed to question the magistrate. As noted earlier, there is considerable power in simply in being entitled to ask a question and demand an answer. In courts of law, a magistrate or judge can hold a party in contempt of court for refusing to answer a question and can apply legal sanctions, including fines or imprisonment, to such persons. Harris found that defendants sometimes exhibit resistance by interrupting the magistrate's question as it is being asked, thereby implicitly and often not so subtly challenging the magistrate's authority to interrogate. At other times defendants responded to the magistrate's question, not with an answer, as required by law, but rather with another question. Harris described this as the "rule of embedded requests", whereby the defendant responds to a question by asking for more information, which the respondent knows the questioner does not require.

6.3(B)(iii) Ideological Resistance

The most important strategy of resistance Harris examines is what many researchers regard as the explicitly ideological form of resistance to a court's power in contested hearings, namely challenges to pre-conditions of the authoritative roles occupied by judges or magistrates. Harris adopts a conceptual framework for this type of challenge found in the work of sociolinguistics William Labov and David Fanshel.¹⁰⁸ These researchers developed a framework in which assumptions about the legitimacy of requests and the requirement for responses in certain contexts are seen as occurring within an ideological

¹⁰⁸ Wilhelm Labov & Daniel Fanshel, *Therapeutic Discourse: Psychotherapy as Conversation* (London: Academic Press, 1979).

framework in which the rules for discursive exchanges have the status of pre-conditions that act as shared social knowledge. Harris notes that in courtroom settings these pre-conditions have different values for various participants. The magistrates, for example, do not question the pre-conditions of their authority, because that is what gives them their institutional identity. Individuals appearing as defendants in court have a different stake in the legal process and may be more inclined to display resistance by challenging the pre-conditions for the court's authority. Harris adopted Labov and Fanschel's definition of a challenge as: "a speech act that asserts or implies a state of affairs that, if true, would weaken a person's claim to be competent in filling the role associated with the valued status."¹⁰⁹ As quoted in Harris¹¹⁰, Labov and Fanschel also define the Rule for Challenging propositions as: "If A asserts a proposition that is supported by A's status, and B questions the proposition, then B is heard as challenging the competence of A in that status."¹¹¹ My observation is that this type of ideological form of resistance is also found throughout Review Panel hearings in which patients question the authority of psychiatrists who make civil committal orders, as well as members of the Panel who may affirm these orders. In the next chapter I provide several examples of this form of ideological resistance. This type of resistance is a paradigmatic example of Foucault's conception of *parrhesia*, when the parties who are the subject of a hearing confront and question the legitimacy of authorities and thereby put themselves at risk of having legal sanctions or unwanted medical treatment imposed on them.

¹⁰⁹ *Ibid* at 64.

¹¹⁰ Harris, *supra* note 94 at 152.

¹¹¹ Labov & Fanshel, *supra* note 95 at 91.

6.3(B)(iv) Conversation Analysis of Civil Commitment Trials

In *Court-ordered Insanity: Interpretive Practice and Involuntary Commitment*, James Holstein uses ethnomethodology and elements of conversation analysis to scrutinize the operation of habeas corpus¹¹² court hearings involving individuals subject to civil commitment in five different states in the United States of America in the 1980s.¹¹³ Holstein states that his goal is not to criticize these legal systems or to make any recommendations to change them, but rather simply to observe and documents what occurs in these settings. In the 1980s, patients who had been civilly committed in the states being researched were permitted to attend at hearings before a judge to argue that they should be released from custody. At these hearings, the hospital psychiatrists seeking to keep the patient in hospital were represented by a District Attorney (DA), the equivalent of prosecutors in Canada, who also acted on behalf of the state of California in supporting the hospital. Patients were always represented in hearings by court-appointed lawyers in the role of public defenders (PD). Procedurally, the hearings are analogous to criminal trials, with the DA first calling the hospital psychiatrists, who are qualified as expert witnesses. In California in the 1980s, where most of Holstein's research occurred, the DA has the burden of proving, with "clear and convincing evidence", that the patient has a serious mental disorder, is "gravely disabled", and is a danger to him or herself or to others.¹¹⁴ If the DA meets this evidentiary burden, then civil committal orders are upheld and the patient remains detained. While the patients are not obligated to testify, they most often do

¹¹² The writ of habeas corpus, a Latin term meaning "that you have the body" is a legal remedy for releasing a person from custody. *The Dictionary of Canadian Law* (Toronto: Thompson Canada, 1995) at 539.

¹¹³ James A. Holstein, *Court Ordered Insanity: Interpretive Practice and Involuntary Commitment* (New York: Adline De Gruyter, 1993) Holstein states that he made observations based primarily on attending hearings in California and all of the data in his book refers to California cases and law (*Ibid* at xviii).

¹¹⁴ *Ibid* at 31. Holstein observes, without giving further detail, that the committal criteria in the other states in his study were analogous to the criteria in California.

and are guided at the hearing through questions from the PD before being cross-examined by the DA.

Holstein uses ethnomethodological techniques, such as attending court and observing hearings, interviewing participants at hearings, and listening to informal conversations between all of the parties in hallways and in interview rooms. His observation is that, despite the apparent adversarial form of the hearings, DAs, PDs and judges often work collaboratively together to fashion an outcome that they believe is viable for the patient, regardless of the legal civil committal criteria or the wishes of the patient.¹¹⁵ Holstein's thesis is that the judge's ascription of the patient's level of mental illness is constructed through interactional manoeuvres between the parties at the hearing, but that the patient is disadvantaged at the outset of the hearing by a presumption that they are disabled by mental illness.¹¹⁶ The psychiatrist's opinion elicited by the DA at the commencement of

¹¹⁵ Carol Warren also came to this conclusion in her research on psychiatric patient habeas corpus hearings in California the 1970s. Warren's research drew more heavily than Holstein's study on private interviews she had with judges before, during, and after the hearings. Carol A.B. Warren, *The Court of Last Resort* (Chicago: Chicago University Press, 1982) at 117.

¹¹⁶ Stefan Sjostom made similar observations in his study on civil committal in Sweden in the early 1990s, as described in his book *Party or Patient?: Discursive Practices Relating to Coercion in Psychiatric and Legal Settings* (Stockholm: Fritzes Offentliga Publikationer, 1997). Like Holstein, Sjostom uses ethnomethodological techniques for entering a field of study and recording direct observations. However, while Holstein restricted his study to observations made in court settings, Sjostom also attended at hospitals and clinics to make his initial observations and then followed patients as they left these medical settings and entered courts to challenge civil committal orders. Sjostom's conclusion, and the inspiration for the title of his book, is that parties in legal hearings have identities that are recontextualized when they enter courtrooms. They are accorded numerous legal protections because the facts in such settings are fundamentally in dispute. However, the courts' assumptions concerning the identities of patients as medical subjects do not change when they enter legal hearings. The court's background assumption is that the patients are in need of paternalist treatment rather than being legal agents involved in a legal process in which the facts in issue are contestable (*Ibid* at 40). Recontextualization of identity ascription does not occur for the patients. Sjostom's observation is that courts at that time in Sweden used this background assumption to interpret all of the patients' conduct and speech (*Ibid* at 40). Like Holstein, Sjostom gives a limited analysis of the legal framework of the court hearings. Sjostom also affirms that he is engaged in a purely descriptive endeavour and therefore does not make any recommendations for changing any of the practices he observes (*Ibid* at 23).

the hearing has a strong effect in prejudicially colouring the judge's perception of all of the patient's behaviour and speech during the hearing.

According to Holstein, one of the assumptions that DAs and PDs share is that if patients in these hearings are allowed to speak freely they will engage in "crazy talk", talk that is hostile, discloses delusions or that is tangential and not relevant to the issues at the hearing. PDs use questions that the patient can answer with few words and they guide the patient's testimony to demonstrate that they have a rational plan for their life. In contrast, DAs use particular types of question sequences during cross-examination in a deliberate attempt to elicit "crazy talk" from the patient. The DAs would often do this by allowing the patient to finish answering a question and then not asking another question for an extended period of time. In this awkwardly silent situation, the patient would begin speaking on their own initiative and the DA would not intervene, instead allowing the patient to express whatever was on their mind, even if it did not seem relevant to the proceedings. This gave the appearance that the patient produced this speech on their own. However, as Holstein observes, topic continuity in normal conversation is a mutual achievement between speakers. He cites research that suggests that "Topic changes (that is, utterances that utilize new referents and implicate new lines of talk unrelated to talk in prior turns) and topic shifts (lesser changes in the ongoing line of talk) are common solutions to problems of producing continuous talk."¹¹⁷ Thus the patient's crazy talk in these court hearings is *interactional* accomplishment. Yet according to Holstein, judges in committal hearings tend to regard patients as the *sole author* of crazy talk, and regard this testimony as confirmation of the background interpretive frame regarding the patient's mental illness,

¹¹⁷ Holstein, *Court Ordered Insanity*, *supra* note 100 at 109.

which the psychiatrist sets out at the commencement of the hearing.¹¹⁸ Seen in this way, the crazy talk then becomes part of evidentiary record, a finding of fact guiding the judge's decision to uphold the committal order.

6.3(B)(v) The Power of Legal Institutions

One of the limitations in Holstein's study is that, although most of the data he collected was found in legal settings, he provides little analysis of the role of the law itself in the construction and ascription of mental disability. Instead, the laws are treated as neutral containers, as conversational tools, "rhetorical assets"¹¹⁹ and "accounting resources rather than directives for conduct."¹²⁰ According to Holstein, the law is used as a stamp to give an authoritative appearance to judgments, which are otherwise strongly influenced by labels drawn from medicine, as well as ascriptions about mental abilities and the tenability of living arrangements based on assumptions concerning gender, race and age. As Holstein puts it, the law is "an interpretive practice for rendering arguments accountable, thus rhetorically compelling."¹²¹ Unfortunately, Holstein does not give detailed examples of judges' decisions arising from committal hearings and does not demonstrate how judges apply legal criteria to their findings of fact. Consequently, there is no way to even begin to

¹¹⁸ Holstein states that in his research, conducted over nine years, he "very rarely" observed patients or PDs challenging the psychiatrists' diagnoses of the patients, focusing instead on whether the patient had suitable living arrangements outside of the hospital (*Ibid* at 45), which is in sharp contrast with my observations in the past six years that patients at Review Panel hearings frequently and vociferously challenge psychiatric diagnoses. While there are, to be sure, many historical and socio-cultural facts that may explain these differences between patients' conduct in the United States in the 1980s and British Columbia between 2008 and 2012, it is likely that counter-discourses have arisen in North American society in the past 20 years to challenge and resist hegemonic psychiatric discourse.

¹¹⁹ *Ibid* at 182.

¹²⁰ *Ibid*.

¹²¹ *Ibid*.

determine whether changes in legal criteria or procedural directives would make a difference for patients' outcomes.

The tendency of conversation analysis to downplay the overarching structural influence of institutional contexts such as law may blind researchers using this method to the way law is not just a rhetorical resource for putting a veneer of legitimacy on judgments, but that law and its institutions can structure and shape medical discourse and practice even at the most basic conversational level, creating forms of medico-legal discourse. The strength of critical discourse analysis is that it highlights the importance of these legal institutional contexts and how power is channelled through them. Any attempt to make recommendations for changing discursive practices that prejudicially affect patients, which Holstein admits is not his goal, must take account of the force of legal institutional contexts and the way they can shape presumptions in medical discourse well before the patient sees a psychiatrist, is arrested by a police officer, or appears in a hearing.

Research demonstrating the benefit of using resources from both conversation analysis and critical discourse analysis is found in a paper by Kate Haworth entitled "The Dynamics of Power and Resistance in Police Interview Discourse".¹²² In that study Haworth scrutinizes a transcript of an interview between English police and a murder suspect. The interview took place in 1998 in early stages of the investigation. Haworth uses a multi-method approach to discourse analysis, drawing on the detailed resources that conversation analysis provides for examining naturally occurring talk, as well as the critical resources from critical discourse analysis, particularly its view of power and the contextual forces

¹²² Haworth, "The Dynamics of Power and Resistance in Police Interview Discourse", *supra* note 68.

controlling institutional roles and identities. She describes the dynamic interplay between institutional context and the moment-to-moment verbal interactions uncovered by close analysis of conversational sequences. While she acknowledges that the outcome of the police interview was determined in part by the discursive techniques used by the parties in the exchange, she also makes observations about the institutional forces that shape the discourse in powerful ways, but which would be difficult or impossible to identify in the conversational exchange alone. For example, Haworth observes that the police, who have dominant institutional identities when questioning a suspect, may allow the suspect to resist answering a question directly when it appears that by doing so the interviewee provides other information that the police find useful when creating a record of evidence to use for pressing criminal charges. In other words, the police are allowing the suspect to create the rope with which they will hang him. As Haworth notes, the relevance of the police allowing what appears to be a relinquishment of their control of the discourse is that they will then have direct evidence from the suspect in the transcript that can then be used in the criminal prosecution.¹²³ In other legal systems, such as Sweden's, transcripts of police interrogations cannot be used, and instead the police draft a brief report of the events. Allowing interviewee resistance for the purpose of gaining recorded admissions would not be as important in Sweden.¹²⁴ The significance of this observation is that the conduct of the English police in allowing this resistance for a wider purpose could only be recognized if the observer had a pre-existing understanding of the procedural framework in which the police interrogation occurs. Moreover, the context of the police interrogation can only be understood as part of a much broader context of the entire legal process. In the next

¹²³ *Ibid* at 755.

¹²⁴ *Ibid* at 756.

chapter I return to the importance of this observation when describing the many layers of institutional discourse that provide the contexts for the Review Panel hearings and when I show that the discourse cannot be understood without first describing these multiple contexts.

6.3(B)(vi) Ideational Meaning and Interpretive Frames

As noted in Section 7.2 in this chapter, while Fairclough advocates the use of techniques for understanding interactional exchanges provided by conversation analysis, he also emphasizes the importance of ideational meaning in the creation of social realities. An example of discourse analysis of a legal hearing, which focuses on the construction of ideational meaning and social identity, is found in Ehrlich's paper entitled "The Discursive Reconstruction of Sexual Consent".¹²⁵ In this study, Ehrlich uses a transcript of a university administrative hearing that was held to determine whether the male defendant had sexually assaulted the female complainant, thereby facing a possible sanction of expulsion from York University in Toronto, Ontario. Ehrlich's focus in the paper is on the way that ideological assumptions frame the institutional discourse, allowing certain interpretations to become dominant, while at the same time dismissing or suppressing other types of interpretations.

When analyzing the evidence seen in the transcript, Ehrlich found that the defendant successfully constructed himself as innocent by implicitly using what she described as a "deficiency model of communication between men and women".¹²⁶ The defendant

¹²⁵ Sharon Ehrlich, "The Discursive Construction of Sexual Consent" (1998) 9(2) *Discourse and Society* at 149.

¹²⁶ *Ibid* at 149.

testified that he interpreted the complainant's failure to strongly object to his sexual advances as providing implicit consent. He claimed that he interpreted this deficiency of vocalization to mean that consent had been given. The complainant testified that she had initially said "no" to the defendant's initial physical advance, but made no further objection when the advances continued. She testified that she was afraid that the defendant would become violent if she protested too much. According to this deficiency model, men, as the traditionally dominant sex, have made a disproportionately larger contribution to the "pervasive and implicit interpretive perspectives,"¹²⁷ which the three-member administrative tribunal shared. Although Ehrlich does not give examples of the type of detailed discursive exchanges found in most conversation analysis research, she provides examples of tribunal members persisting in their questioning in ways that indicated that they were using the deficiency model. Ehrlich notes that their institutional status allowed the tribunal members to control the sequence of the questions and constrain responses in the very way that they formulated their questions.¹²⁸ She concludes that the defendant was able to discursively construct himself as innocent by appealing to gendered forms of communication and miscommunication based on certain cultural norms that the tribunal members implicitly shared.¹²⁹ Similarly, in Review Panel hearings, the psychiatrist advocating that a patient be civilly committed may appeal to an interpretive frame that the some Review Panel members implicitly share, a frame that is rooted in a reductionist biomedical view of human nature.¹³⁰ As I argue in Chapter 2, these interpretive frames

¹²⁷ *Ibid* at 167.

¹²⁸ *Ibid* at 169.

¹²⁹ *Ibid* at 170.

may be established and reinforced by a legal system with a long history of being shaped by biomedical discourse itself.

It is also important to note that the type of administrative hearing that Ehrlich scrutinizes is different from courts of law in two significant ways. The first is that the rules of evidence are less stringent than in court, and the setting may not be as overtly adversarial. The second is that the panel members who consider the evidence and render a decision may be the same persons who ask question of the witnesses. This highlights the importance of distinguishing who the listening audience is. As the creations of statute for the purpose of considering very specific types of issues, there are many different types of administrative tribunals with different powers and different types of panel members. Since one of the fundamental guiding premises in my research is that the events that occur in institutional discourse require close attention to local contexts, considerable attention must be paid to the detailed nature of the institutional context of the Review Panel as a tribunal embedded within many layers of legal institutions, as well as a group of people dealing with circumstances in the local community.

¹³⁰ Ehrlich's notion of interpretive frames in discursive exchanges can be understood as involving the use of words that are interpretive resources for the participants, words that have multiple layers of meaning amenable to semiotic analysis. In a semiotic analysis of the language used in the New York state appellate decision *In the Matter of Billie Boggs*, concerning the civil commitment of a homeless woman regarded as mentally ill, Bruce Arrigo demonstrates how the expressions used by the court, such as "hostile" and "engaging in magical thinking," communicated deeper meaning about its regard for the woman than the superficial meanings typically attached to these words. Bruce Arrigo, *Madness, Language and the Law* (Albany: Harrow & Heston, 1993). Arrigo's semiotic analysis of language the Court used in its decision reveals its prejudicial biomedical assumptions about mental illness that "provided it with 'interpretive resources' with which to understand Ms. Bogg's behavior" and to affirm her civil commitment order. Christopher R. Williams and Bruce A. Arrigo, *Law Psychology and Justice* (Albany: State University of New York Press, 2002) 198.

6.3(C) Summary of Section 6.3

A review of the literature on discourse analysis applied in legal and medical contexts illustrates concretely the interactional and ideational features of discourse in those settings, as well as highlighting the importance of identifying overarching institutional structures. In addition, this empirical research reveals the way participants exert or resist control through discourse as a social practice. Finally, this research shows the importance of identifying interpretive frames revolving around central metaphors and presumptions and how conversational parties contest meanings of these terms with repertoires drawn from medico-legal rationalities or lifeworld experiences.

6.4 Outline of Application of Steps in the Discourse Analysis to Review Panel Hearings

6.4(A) The Social Problem

The previous chapters have demonstrated that British Columbia's mental health law regime is discriminatory in its statutory texts and in its operation. The legislative scheme, which includes many health statutes and regulations, and legal procedures that flow from these laws, incorporate a reductionist biomedical way of understanding human nature. The legal regime, which has been shaped by biomedical assumptions, in turn reinforces medical practices in many ways, from the statement of committal criteria found in the legal forms that doctors, hospitals and police officers are statutorily required to complete, to the way in which social benefits are given for compliance with this regime.

6.4(B) Identifications of Crises within the Discourse

Transcripts of Review Panel hearings provide a valuable way to view the operation of British Columbia's mental health law regime. Each Review Panel hearing is a contested

struggle between the hospital that has detained the patient and imposed treatment and the patient who argues against the involuntary treatment. The core issue is whether the patient should have the right to make treatment decisions for him or herself; they therefore challenge the legitimacy of the mental health law regime in depriving them of liberty and defining them as being mentally incapable of making important decisions about their own life. The Review Panel hearings involve three panel members: a lawyer, a psychiatrist, and a community member. Since a number of the decisions involve one of the members giving a dissenting opinion, contested forms of discourse emerge within the Review Panel itself, problematizing the dominant discourse. The transcripts of Review Panel hearings are replete with moments of crisis within the discourse and are therefore ideal for seeing problematizations of the medico-legal discourse.

6.4(C) Interactional Aspects of Discourse

6.4(C)(i) Identification of Institutional Contexts

Before examining the conversational exchange found in the transcript data, I provide a description of the institutional contexts in which Review Panel hearings occur. This involves identifying the relevant legal framework that gives rise to the committal process and the opportunity for review of the committal order. I also describe the medical criteria for detention under the *Mental Health Act* and the interconnected provisions in the *Health Care Consent Act*. Since the Review Panel hearing is the most immediate context for understanding the patient's challenge to the hospital's committal order, I provide an account of how the Review Panel is constituted, what its powers are, and how members are chosen. A very important consideration at the stage of identifying institutional contexts is to keep in mind that these contexts are not rigid containers that shape all aspects of

behaviour and speech; rather there is an ongoing dialectical relationship between the contexts and the conversation that occurs within them. Thus, the initial assumptions concerning the nature and effects of these contexts will change with the analysis of the data.

6.4(C)(ii) Identification of Institutional Roles

Having made initial assumptions concerning the institutional contexts, I then identify the participants' institutional roles in the hearing, while again remaining open to changing these assumptions as the data are examined. The participants are the three panel members, the psychiatrist who appears on behalf of the hospital in which the patient is detained, the patient, and the patient's advocate. Although social workers and family members occasionally attend the hearing, they were not present in any of the samples I analyze in the next chapter.

6.4(C)(iii) Topical Agendas

As noted in the literature review, the power to establish a topical agenda is important and can strongly influence institutional discourse; therefore this is the first aspect of discourse I analyze in the transcript data. Throughout the analysis I show how participants at the hearings manoeuvre to maintain or challenge topical agendas and attempt to displace an established agenda and replace it with another. These manoeuvres are seen most clearly in question and answer sequences.

6.4(C)(iv) Question and Answer Types and Sequences

Since the type of discourse I analyze is from a hearing, which by its very nature consists mainly of interrogation and response, much of my analysis is on question and answer

sequences. I show how participants attempt to control ideational meanings of significant terms in the discursive exchange through question and answer exchanges. This involves identifying types of questions, such as leading questions and open questions. In addition, I identify other forms of resistance to questions, including interruptions and embedded requests, as illustrated in Drew's research, as well as forms of ideological resistance as found in Harris's research.

6.4(D) Ideational Meaning in Discourse

Ideational meaning and representational features of discourse are always woven together. For example, the topical agenda established by the psychiatrist appearing on behalf of the hospital invariably includes descriptions about the patient's "insight", "deterioration", and "risk". These terms are laden with connotations and implications that the psychiatrist then attempts to confirm through representations about the patient in clinical records and by controlling question and answer sequences. I therefore identify a number of key terms in the psychiatrist's presentation and in the law that governs the hearing process. I focus on contests between the various participants in the hearing concerning the meaning and relevancy of these terms to illustrate problematization of the discourse and how conclusions reached at the end of the hearing have consequences for the patient.

6.4(E) Construction of Identity and Social Reality

At the end of the analysis I show how both interactional and ideational features of the discourse have been used together to construct the identity of the patient. Most importantly, the Review Panel will either agree with the hospital presenter and order the continuing detention of the patient or will release the patient. The orders, found in Review

Panels' reasons for their decisions, apply findings of fact to the legal criteria set out in the *Mental Health Act*. Thus these orders always have descriptions of the patient, which purport to provide evidence supporting the order. These descriptions typically include characterizations of the patient's level of insight and risk to themselves and others, as well as descriptions about the patient's alleged illness. These descriptions have both immediate consequences for the patient – liberty or detention – and long-term psychological and physical implications related to, among other things, ongoing contact with psychiatric treatment providers, police authorities, and the use of powerful medications.

6.5 Chapter Conclusion

Foucault's writings on the nature of discourse, knowledge, and human agency have had a strong influence on the development of methodologies for conducting governmentality research and the critical analysis of discourse in modern society. Genealogies of legal and medical institutions are crucial for revealing the creation and mutations of discourses in both institutional settings, in ways that may not be apparent to current users of these discourses. Nevertheless, a more complete understanding of current discourses must also include a critical analysis of the way they are used in local contexts. Critical discourse analysis, especially when it incorporates methodologies from conversation analysis, is suitable for research on naturally occurring talk in institutional settings, particularly those involving the discourses of medicine and law. The literature review in this chapter concerning empirical research on discourse in medical and legal settings has provided a number of insights on discursive strategies and forms of resistance in those contexts.

The research on medical discourse shows how physicians in clinical interviews can discursively shape perceptions of patients' identities and illnesses. Research on discourse in legal settings demonstrates the value of paying close attention to power relationships between parties in legal proceedings and the way this affects the conversational exchanges between them. However, this research also highlights the importance of understanding the overarching effects of legal institutions in structuring legal and medical discourse, and the way that medicine and law are reciprocally shaped to create hybrid medico-legal discourses. The insights from the literature review in this chapter have helped me to create a model of critical discourse analysis that is appropriate for analyzing Review Panel proceedings. This model is applied in the next chapter to analyze transcripts of Review Panel hearings and disclose the operation of British Columbia's mental health law regime.

Chapter 7 Critical Discourse Analysis of Review Panel Hearings

7.0 Introduction

In this chapter I use the methodology for critical discourse analysis developed in the preceding chapter, as well as Foucault's articulation of *parrhesia*, to analyze five decisions of Review Panels assigned by the Mental Health Review Board of British Columbia, which included analysis of hearing transcripts for three of the decisions. I first summarize the nature of the social problem concerning British Columbia's mental health law system addressed in earlier chapters and explain why data from Review Panel hearings I selected are suitable for critical discourse analysis of this problem. Next, I describe the institutional and legal context in which the Review Panel hearings occur. I then conduct a critical discourse analysis of transcripts of hearings for three of the Review Panel decisions. I also analyze two other Review Panel decisions, for which transcripts are not available, to illustrate recurring themes seen in the three preceding transcripts. This critical discourse analysis reveals important aspects of British Columbia's mental health law system and, in the interdisciplinary context of this dissertation, provides a basis for making recommendations for changing the laws in this province.

7.1 The Social Problem

British Columbia's mental health law system is, on its face, in its operation, and in its far-reaching social consequences, pervasively discriminatory. The legislative scheme, which includes many health statutes and regulations, incorporates, to an extent unique in Canada, a reductionist biomedical way of understanding human beings. British Columbia's mental health law system, which has been shaped by biomedical assumptions, in turn reinforces

social discourses and practices in many ways, from the committal criteria found in the statutory forms that doctors, hospitals and police officers are required to complete, to the way social benefits are given for compliance with this regime. The institutional contexts created and supported by the legal regime, which include hospitals and police activity, involve forms of discourse which, even in their most concrete manifestations on the level of conversation, perpetuate and reinforce this discrimination. This medico-legal regime is implicated in the discursive construction of psychological incapacity, resulting in detrimental changes in the social status of persons caught up in this system. A form of critical discourse analysis can reveal the operation of this regime of power and thereby open the door to assertions of patients' rights, empowerment and reform.

7.2 Legal and Institutional Contexts

The Mental Health Review Board of British Columbia is a statutory body constituted pursuant to this province's *Mental Health Act*¹ and *Administrative Tribunals Act*.² The Review Board's purpose is to hear patient applications to challenge and reverse the involuntary treatment orders, confirmed in physicians' certifications, in Form 4 of the *Act*,³ that the patient's condition meets the four necessary and jointly sufficient criteria described in sections 1 and 22 of the *Mental Health Act*. Section 1 states that:

1 "person with a mental disorder" means a person who has a disorder of the mind that requires treatment and seriously impairs the person's ability:

¹ *Mental Health Act*, RSBC 1996, c 238.

² *Administrative Tribunals Act* RSBC 2004, c 45. The *Mental Health Act*, under s 24.2, referentially incorporates a number of sections of the *Administrative Tribunals Act* concerning the constitution and powers of the Mental Health Review Board. S 24.2 provides that "sections 1 to 10, 11, 13 to 15, 18 to 20, 26(5) to (7) and (9), 27, 30, 32, 35, 36, 38, 39, 40(1) and (2), 44, 48, 49, 55 to 57, 59 60(a) and (b) and 61 of the *Administrative Tribunals Act* apply to the board and members of the review panels."

³ A complete copy of Form 4 is attached to this dissertation as Appendix A.

- (c) to react appropriately to the person's environment, or
- (d) associate with others.

After a physician concludes that a patient's condition meets the first criterion set out in section 1, Section 22 allows the physician to detain a patient for 48 hours at a hospital if the physician who completes Form 4 of the *Mental Health Act* confirms that three further criteria are satisfied. These three criteria are set out in section 22(3)(c) and require confirmation that the patient:

- 22(3)(c)
 - (i) requires treatment in or through a designated facility;
 - (ii) requires care, supervision and control through a designated facility to prevent the person's substantial mental or physical deterioration or for the protection of the person or patient or the protection of others, and
 - (iii) cannot suitably be admitted as a voluntary patient.

The 48-hour detention may be extended if a physician completes another Form 4. People working within British Columbia's mental health law system frequently describe patients detained under a Form 4 certification order as "certified." The Review Panel refers to the four-part criteria (the "Four Criteria") in almost all of its written decisions, and it is reiterated verbatim in many forms in the *Mental Health Act*, including Form 4.

After a patient is certified, he or she may request a hearing, by completing and submitting an application under Form 7,⁴ for the Review Board to review and reverse the certification order, called "decertification" pursuant to section 25 of the *Act*.⁵ If the patient is

⁴ A copy of Form 7 is attached to this dissertation as Appendix C.

⁵ Hearing by review panel:

25 (1) A patient detained under section 22 is entitled, at the request of the patient or a person on the patient's behalf, to a hearing by a review panel.

(2) The purpose of a hearing under this section is to determine whether the detention of the patient should continue because section 22(3)(a)(ii) and (c) continues to describe the condition of the patient.

decertified, he or she is immediately released from detention and involuntary treatment. When the Review Board receives Form 7, it assembles a panel of three members, from a roster of 65, to hear the patient's application. The particular panel that hears the patient's application is called the Review Panel. The Review Panel hearings, which are not open to the public, involve three panel members: a lawyer, a psychiatrist, and a community member.⁶ The Chair of the panel is the lawyer, who supervises the order of the proceeding. The hearing typically occurs within two weeks of the patient's application and usually occurs at the hospital at which the patient was initially detained. The hearings, which are always recorded, generally last between one and four hours and the Review Panel must determine, on a balance of probabilities, whether the evidence presented at the hearing justifies the detention order. The Review Panel is legally obligated to render a written decision, in Form 8,⁷ within 48 hours of the conclusion of the hearing, but usually does so on the same day at the end of the hearing while the patient is present.

(2.1) A hearing by a review panel must include

consideration of all reasonably available evidence concerning the patient's history of mental disorder including
hospitalization for treatment, and
compliance with treatment plans following hospitalization, and
an assessment of whether there is a significant risk that the patient, if discharged, will as a result of mental disorder fail to follow the treatment plan the director or physician authorized by the director considers necessary to minimize the possibility that the patient will again be detained under section 22.

(2.2) Despite any defect or apparent defect in the authority for the initial or continued detention of a patient detained under section 22, a review panel must conduct a hearing and determine whether the detention should continue because of factors in section 22(3)(a)(ii) and (c) continue to describe the condition of the patient.

⁶ In other provinces in Canada, such as Ontario, these types of civil commitment review hearings are open to the public.

⁷ A copy of Form 8 is attached to this dissertation as Appendix D. Sections 1, 22 and 25 are reproduced verbatim in Form 8.

7.3 The Significance of Review Panel Hearings

7.3(A) Implied Presumption of Incapacity

There are two major features of British Columbia's mental health law regime that distinguish it from all other provincial health law systems in Canada. The first is that the presumption set out in section 4(a) of the *Health Care (Consent) and Care Facility (Admission) Act*⁸ (*HCCA*) that all adults are presumed to be capable of "giving, refusing, or revoking consent to health care" does not, by operation of section 2 of that *Act*, apply to patients detained under section 22 of the *Mental Health Act*. Moreover, there is nothing in the *Mental Health Act* that prevents psychiatric treatment from being imposed on patients who *actually* have the mental capacity that all adults in British Columbia are *presumed* to have. As such, even on first contact with a psychiatrist, a patient can be subjected to involuntary treatment under the *Mental Health Act*, regardless of whether the psychiatrist recognizes that the individual has the mental capacity to give, refuse, or revoke consent to health care.⁹ As I demonstrated in Chapter 5 on the *Charter*, the implied consequence of the joint operation of the *HCCA* and the *Mental Health Act* is that patients detained under section 22 of the latter *Act* are, in effect, *presumed* to lack the capacity to consent to or refuse psychiatric treatment.

7.3(B) Quantitative Data Concerning Review Panel Hearings

In British Columbia, there were approximately 8000 civil commitment orders issued in 2005.¹⁰ All patients detained under such orders are subject to involuntary medical

⁸ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181 [*HCCA*].

⁹ This is in marked contrast to other provinces such as Ontario where the presumption of capacity to consent to treatment applies to all adults, regardless of whether it is thought that they have a mental disorder. This is discussed at much greater length in the chapter on the *Charter*.

¹⁰ Gerard Clements, *Guide to the Mental Health Act* (British Columbia: Ministry of Health, 2005) at 1.

treatment.¹¹ Thus, “detention” may occur while patients are in the community on extended leave orders, under which they are required to submit to involuntary treatment with psychiatric medication. In 1994 there were 941 applications to the Review Panel. In that year 309 hearings were completed and 113 patients (36%) were discharged.¹² In 2006 there were 473 hearings completed and 96 patients (20%) were discharged.¹³ Approximately 5% of the written decisions from the Review Panel hearings involved a dissenting opinion.¹⁴

7.3(C) Deterioration Criterion

The second major feature of British Columbia’s mental health law regime is the emphasis, seen in section 22(3)(c)(ii) of the *Act*, on the psychiatrist’s assessment of the patient’s risk of physically or mentally deteriorating in the future. This subsection, enacted in 1996, increases psychiatrists’ level and range of discretion to certify a patient not only when they think that there is current evidence that the patient has a mental disorder, but also when the psychiatrist assumes that the patient will experience deterioration at some point in the future.¹⁵ My observation is that the deterioration criterion is the most frequently stated

¹¹ This is in contrast to mental health laws in Ontario in which patients who are found capable of making medical treatment decisions can withhold their consent to treatment while being detained on the grounds that they are mentally disordered and are a danger to themselves or others.

¹² Isabel Grant, James Ogloff & Kevin Douglas, “The British Columbia Review Panel: Factors Influencing Decision-Making” (2000) 23 *Int’l J L & Psychiatry* at 176.

¹³ Mental Health Act Review Panels Statistical Report from Allan Tuokko, former Board Chair of the Review Panel. The Review Panel does not publish statistical data related to annual rates of detention or discharge following hearings. In contrast, Ontario publishes annual reports of this type of data on its public website at www.ccboard.on.ca. For example, in 2007 there were 2619 capacity hearings before Ontario’s Consent and Capacity Review Board, which resulted in the board finding the patients capable in 35 cases, less than 2%. These percentages have been approximately consistent each year since.

¹⁴ Mental Health Act Review Panels Statistical Report from Allan Tuokko, Chair of the Review Panel. There are no more than one or two dissenting opinions in Ontario’s Consent and Capacity hearings each year.

¹⁵ As described at length in chapter 2, British Columbia’s mental health law regime incorporates a specific type of psychiatric thinking, which is rooted in neurobiological understanding of human nature, codified in the DSM, and geared toward pharmaceutical intervention. The DSM is a text that recommends categorical

rationale for certifying patients in this province, which I illustrate with numerous examples in the critical discourse analysis in this chapter.

These two major features of British Columbia's mental health law system together create the lowest threshold for the civil commitment of patients in Canada. These features are among the most salient institutional forces shaping both medical and legal discourse and practice in British Columbia, long before the patient appears for a Review Panel hearing. The reason is that they establish some of the core concepts and interpretive frames around which medico-legal discourse is organized in British Columbia's mental health law system. In particular, much discourse in physicians' clinical records and Review Panel hearings constellates around the term "deterioration" and includes repeated descriptions of the patient's *risk* of deterioration; the patient's *insight* into their mental condition and required treatment consonant with psychiatric assessments; and assertions about probability of *compliance* with medical treatment plans to prevent deterioration harm. Although the terms "deterioration", "risk", "insight", "compliance", and "harm" are found in other jurisdictions, they acquire special connotations and implications in the interpretive context of British Columbia's mental health law system.¹⁶ In their applications for Review Panel hearings, patients contest the legitimacy of the mental health law regime that deprives them

diagnosis; for each diagnostic category there is a checklist of symptoms and if a minimum number of criteria are met then the patient receives a diagnosis. Once they have crossed this threshold the psychiatric model assumes that patients who receive a diagnosis of a serious mental illness, such as schizophrenia, are at high risk of *deterioration* and worsening of mental illness. This requires biomedical forms of intervention, such as pharmaceutical treatment or electroshock therapy.

¹⁶ For example, there are criteria for involuntary psychiatric treatment with medication in Ontario when a psychiatrist concludes that a patient is at risk of mental deterioration, but only if the patient has a proven clinical history of being certified in the past, benefiting from the medication and deteriorating when discontinuing its use. In Ontario, the original certification could only occur after a complex assessment of the patient's capacity to consent to treatment in accordance with that province's *Health Care Consent Act*. Thus, the term *deterioration* has different connotations and implications in Ontario's medico-legal discourse than it does in British Columbia.

of liberty and defines them as being mentally incapable of making important decisions about their own lives. These contests concern the applicability of the Four Criteria to the patient's situation and frequently involve discursive strategies related to the use of the above-noted terms related to deterioration and insight. These terms are among the most important components in interpretive frames or repertoires¹⁷ found in British Columbia's mental health care system. Identifying these terms, interpretive frames and repertoires, therefore, is crucial for the critical discourse analysis in this chapter.¹⁸

7.4 Outline of the Methodology

As I demonstrated in the preceding chapter, the most suitable approach for my research on British Columbia's mental health law system is the integrated discourse analysis methodology developed by Janet Thornborrow. Thornborrow's methodology draws upon critical discourse analysis insights concerning the operation of power in institutional contexts in combination with the micro-analytic tools that conversation analysis provides. Recall the five steps used in my application of the methodology for clarifying the

¹⁷ Jonathan Potter describes interpretive frame and repertoires as "systematically related sets of terms that are often used with stylistic and grammatical coherence and often organized around one or more central metaphors." Jonathan Potter, "Discourse analysis and constructionist approaches: theoretical background" in James Richardson, ed, *Handbook of Qualitative Research Methods for Psychology and Social Sciences* (London: Sage, 1996) at 131.

¹⁸ As I stated in chapter 6 at page 232, the notion of interpretive frames and repertoires can be supplemented with Bruce Arrigo's semiotic analysis of the language used in American decisions concerning civil commitment. Semioticians regard words and phrases as signifiers that refer to "multiple and evolving meanings communicated in and through language" Christopher R. Williams and Bruce A. Arrigo, *Law Psychology and Justice* (Albany: State University of New York Press, 2002) at 38. In the first layer of semiotic analysis, metaphorical expressions used in discourse are identified. In the second layer of this analysis, the individual metaphorical expressions are read more closely to disclose their multiple meanings and connotations. In my discourse analysis of transcripts set out later in this chapter, I demonstrate how the terms "insight" and "deterioration" are riddled with metaphorical connotations and with further analysis I show how psychiatrists discursively link these terms to conceptions of "harm" and "risk." Similar to Arrigo's research on American court decisions, my analysis discloses how the use of these terms in Review Panel hearings has prejudicial and harmful consequences for the patients, particularly when viewed in the context of institutional regimes of power that my critical discourse analysis reveals beyond a semiotic level of examination.

interactional features of discourse: 1. identification of institutional context; 2. identification of institutional identities; 3. identification of topical agenda; 4. examination of question type and question sequences; and 5. revision of assumptions about institutional context and identity. I have provided the most general features of the legal institutional context above, but it is also germane to describe the institutional path by which patients arrive at Review Panel hearings, and I do so for each of the four patients, P1, P2, P3 and P4, described in this chapter. For example, P3 and P4 initially arrive at a hospital on a voluntary admission and are subsequently certified. P1 and P2, on the other hand, are arrested at their residences by the police and then brought to the hospital. Each type of institutional scenario may affect the hospital's perceptions of the patient and his or her subsequent treatment, as well as the way they are perceived at a Review Panel hearing. In addition, it is important to determine whether the patient has had prior hearings with the Review Panel and the reason they have appeared again for further review. A patient's second Review Panel hearing, as seen in P1's situation, is a significantly different institutional context than the initial hearing, with the patient bearing the stigma of having a certification order upheld by the first Review Panel.

A significant consideration at the stage of identifying institutional contexts is that the initial assumptions concerning the nature and effects of these contexts are seen as malleable rather than rigid containers that shape all aspects of behaviour and speech. An important part of Thornborrow's methodology is to always keep in mind that there is an ongoing dialectical relationship between the institutional contexts and the discursive activities that occur within them. Thus, the initial assumptions concerning the nature and effects of these contexts will change with the analysis of the data. Having made initial assumptions concerning the

institutional contexts, I then identify the particular institutional roles of the participants in the hearing, while again remaining open to changing these assumptions as the data are examined. For example, a reasonable initial assumption is that patients' advocates at the Review Panel hearings advance their clients' interests. However, as seen in P1's initial hearing, as described below, the patient advocates do not always behave in this manner and in fact sometimes act in ways that undermine the patient's position.

The analysis then focuses on the discourse found in the transcripts of two patients, described as P1 and P2, and Review Panel decisions without transcript data for P3 and P4. The power to establish a topical agenda is important and can strongly influence discourse in the institutional conversation; therefore this is the first feature that I examine in the transcripts, as well as challenges to topics the hearing focuses on. I then identify question types and sequences found in the transcripts, and the ways in which interruptions and resistance to questions are disclosed in the discursive exchanges. After making observations about the interactional features of the discourse I provide some comments on what the analysis reveals about the discursive construction of the patients and the operation of British Columbia's mental health law system.

7.5 Application of the Methodology

The data for this research was collected from my review of more than 2500 Review Panel decisions for the hearings that took place between 2008 and 2012 inclusive. Based upon reading these decisions, attending seven hearings as an observer, and listening to recordings of six other hearings, I selected five decisions (for four patients, one of whom had two hearings) that exhibit the types of issues that repeatedly appear in Review Panel hearings.

In particular, the decisions reflect recurring concerns that patients express related to issues of: 1. the perceived unfairness of the procedures used to initially detain them; 2. disagreements concerning psychiatric diagnosis; 3. the presence or absence of patient advocates and the quality of the advocacy; 4. health concerns regarding psychiatric medication; and 5. resources in the community to support them to live independently when they are not in hospital. The expression of these concerns discloses mechanisms within the apparatuses of biopower that both shape the medicalization of the patients and also provide them with opportunities to resist these influences through *parrhesiastic* confrontation afforded by the legal mechanisms of the Review Panel hearing process, which the patient initiates by filing an application under the *Mental Health Act*.

According to the facts recounted in each of the five decisions, the patients challenged the hospital's authority to detain them and force them to take medication. The questions the patients and their advocates raise in the hearings problematize the medico-legal discourse within which the patients are enmeshed. Moreover, the views of the Review Panel members, as reflected in their statements and questions, also highlight the problematic nature of the psychiatric labelling and legal status designations of the patients. This latter point is further illustrated in the critical discourse analysis of P3's and P4's Review Panel decisions, which included dissenting opinions from community members of the panels.

All of the empirical research for this dissertation was done in compliance with the research protocol approved by the University of Victoria's Human Research Ethics Board (the "Ethics Board"). The transcript material for this dissertation was collected with the consent of the Mental Health Review Board of British Columbia. In accordance with the Ethics

Board's requirements, I ensured that there was a thorough anonymization of all transcript material and written decisions to protect the privacy of all participants in Review Panel hearings.

7.5(A) Common Features of Review Panel Hearings

7.5(A)(i) Establishing the Institutional Roles of the Participants

Although there are features of each patient's life that make the institutional context and topical agenda of their situations unique, there are features common to all of the hearings. In addition to broad description of the legislative context described above, which plays an important role in constructing the institutional discourse, it is important to identify the institutional roles that the participants at the Review Panel hearings occupy. At the beginning of each hearing, before any evidence is heard, the chairperson (Chair) advises the patient of the role each Review Panel member occupies and also confirms the scope of the panel's authority. This establishes the authority that each member of the Review Panel has for using a particular form of institutional discourse related to the relevant sections of the *Mental Health Act*. The Chair's explanation also provides the broad legal framework for the proceeding that unfolds thereafter, as well as the order for hearing testimony and receiving evidence. In P1's hearing, the Chair gave an introduction that is typical of the explanations that Chairs give in other Review Panel hearings.¹⁹

CH1: This is the Mental Health Review Board hearing scheduled for 1 pm on +²⁰ in the case of P1 who likes to be referred to as P1. Good afternoon P1. P1 we are the panel that has been assembled under the provisions

¹⁹ The participants at P1's first hearing were: CH1, the lawyer designated as Chairperson for the panel; M1, the community member on the panel; Dr. R1, the physician member of the panel; Dr. H1, the psychiatrist who certified P1 and appeared at the Review Panel hearing on behalf of the hospital; and Adv1, P1's first patient advocate at the hearing.

²⁰ For the purpose of anonymization, any specific reference to a date is replaced with the symbol "+".

of the *Mental Health Act* to hear the evidence and review your certification under the Act this afternoon.

The purpose of the hearing is to determine whether you should continue to be under certification under the *Mental Health Act*. Essentially that means who has control over your treatment decisions, your residency, the medication you take and all that kind of thing. The only decision that this panel can make is whether you remain certified, in which case the hospital can continue to have control over your treatment decisions and place of residency and such. Or we can decertify you in which case you have control of those decisions yourself. We cannot make other treatment decisions for you. O.K.

My name is CH1. I am the Chair of the review panel. To my left is Dr. R1 who is the medical member of the panel. To my right is CM1, who is the community member of the panel. We are charged to hear all of the evidence today and then, considering everything, come up with a decision, hopefully today, which you will be informed of as to whether your certification under the *Act* should be confirmed or not.

We will first hear from the presenting facility Dr. H1, the psychiatrist who is going to tell us about you. The psychiatrist will then be questioned by your advocate, Adv1, and then we may have some questions of him. Following that you will have an opportunity to tell us about yourself and why you believe certification should not be continued. Then Dr. H1 may have some questions of you.

As noted, the three panel members are under a legal obligation to apply the statutory criteria, from both sections 22 and 25 of the *Act* and, like the magistrates in Harris' 1989 study are unlikely to challenge the legitimacy of their own institutional authority. The hospital presenter, who is often, but not always, the psychiatrist who is treating the patient in the hospital, is normally accorded equal respect. This is not to say that the Review Panel always agrees with the psychiatrist's diagnosis or recommendations for continued detention, but that the Review Panel usually does not question the authority of the psychiatrist's role as a person who represents a way of understanding patients in biomedical terms. Indeed the respect given for this type of authority is such that there is no requirement that the treating psychiatrist attend the hearing in person to answer for his or

her actions.²¹ The Review Panel will allow the hospital's evidence to be presented by persons who have never met the patient, as though the institutional entity, representing a form of discourse and reasoning, is so objectively authoritative that it does not have to be embodied by a human agent.

7.5(A)(ii) The Psychiatrist's Topical Agenda

Topical agendas have a powerful effect on the institutional discourse. An important component of the topical agenda that follows each patient to the Review Panel hearing is the Four Criteria in the *Mental Health Act*, which are set out in Form 4 and, by operation of section 25 of the Act, define the scope of the Review Panel's jurisdiction and discretion. On the face of it, there is nothing in the wording of the statute that requires the language of neurobiological psychiatry be used in the Review Panel's considerations. The force of the medico-legal culture in this province, however, is such that this type of discourse is almost always found in the Review Panel's deliberations and written decisions.

In addition to the way that the legal framework affects the topical agenda, the fact that the psychiatrist, as hospital presenter, commences the presentation of the evidence at the outset of the hearing by making an opening statement also establishes the topics that shape the unfolding discourse at the hearing. It should be borne in mind that there is no legal requirement that the hospital make the initial opening statement or that the patient or her advocate be given the opportunity to make an opening statement only after all of the hospital's evidence is heard. Even in courts of law, judges will allow, and sometimes even request, that both parties make opening statements at the beginning of the trial so that there

²¹ This is in contrast to Ontario's mental health law regime in which it is mandatory that the treating psychiatrist attends the hearing; otherwise, the patient is immediately discharged.

is at least some initial equality in the foundation of the topical agenda. The topical agenda that the hospital psychiatrist presents at the outset of the hearing influences the types of questions that are asked throughout the hearing, particularly because the Review Panel is an inquisitorial administrative tribunal and as such has wider discretion to ask questions and direct the inquiry related to the patient's application. The topical agendas therefore establish the initial settings for what Foucault described as the games of truth, in which authority is asserted and contested by the participants.

7.6 Critical Discourse Analysis of P1's Review Panel Proceedings

7.6(A) Background and Institutional Path

The first two Review Panel decisions involve a single male. The path that led to P1's first Review Panel hearing includes a history of being subjected to psychiatric treatment in a hospital and then many years later being brought back into the hospital by the police. P1's opposition to this last hospitalization led the first Review Panel hearing.²² P1's record of the journey along this institutional path is etched into his clinical records and police files, which then became part of the background for P1's entry into the hospital and encounter with Dr. H1.

Many years prior to his Review Board hearing P1 had been diagnosed with a specific psychiatric disorder. He took an anti-psychotic drug his physician prescribed, but it did not appear to have any beneficial effects for him. Several years prior to the first Review Panel hearing, P1 moved residence, ceased communication with the mental health team, and

²² The participants at P1's first hearing were: CH1, the lawyer designated as Chairperson for the panel; M1, the community member on the panel; Dr. R1, the physician member of the panel; Dr. H1, the psychiatrist who certified P1 and appeared at the Review Panel hearing on behalf of the hospital; and Adv1, P1's first patient advocate at the hearing.

stopped taking medication. During the next several years he lived in an apartment he owns. He took care of all of his personal needs, such as cooking, personal hygiene, cleaning, and paying bills. There was no evidence that he was socially disruptive or that he posed any danger to himself or others. His uneventful life changed when he called 911 and reported to the police that he believed that somebody had access to his private financial information. The police arrived at his residence and spoke to him about his complaint, and then left. The following day the police arrived at P1's residence, at which time he was placed in handcuffs, arrested, and delivered to the psychiatric ward of a hospital where two psychiatrists signed Form 4s certifying him for involuntary detention under section 22 of the *Act*. P1 applied for a hearing before the Review Panel, which occurred approximately two weeks after the committal; a second Review Panel hearing occurred four weeks after the first hearing. At the first Review Panel hearing, P1's application to be decertified was denied and he was placed on an extended leave program, which allows the patient to live in the community provided they return for regular injections of anti-psychotic medication and show up for appointments with psychiatrists, failing which the police will arrest the patient and bring them back for detention in the hospital. This is a fairly common practice.

P1 was decertified after his second Review Panel hearing,²³ even though the panel members decided that his condition had not changed since the first hearing. The difference between the two hearings is revealed not only in the panel's Form 8 written decision but also in how the discourse unfolded with different types of questions and answers between

²³ None of the Review Panel members from P1's first hearing appeared at the second hearing. The participants at P1's second hearing were: CH2, the lawyer designated as Chairperson for the panel; M2, the community member on the panel; Dr. R2, the physician member of the panel; Dr. H1, the psychiatrist who certified P1 and appeared at the first Review Panel hearing on behalf of the hospital and also appeared at the second hearing on behalf of the same hospital; and Adv2, P1's new patient advocate at the second hearing.

the parties. Critical discourse analysis of the two hearings shows how the use of medico-legal discourse, as reflected in the first hearing, constructed P1 as a disabled person who required involuntary medical treatment to prevent his deterioration, and in the second hearing as a person who did not require this intervention in his life.

7.6(B) Topic Agendas in P1's Hearings

In P1's first hearing, Dr. H1's opening statement summarizes the series of events that led to P1's committal at the hospital and includes a description of the diagnosis of each psychiatrist who examined P1. Dr. H1 then describes Dr. H1's own differential diagnosis of P1 from the DSM III-R, asserting that P1 suffers from a specific psychiatric disorder. Dr. H1 admits that this is not based on Dr. H1's observations of P1's behaviour but rather from historical reports, particularly those from P1's mental health team approximately five years prior to the hearing.

By the end of Dr. H1's opening statement, the topical agenda is established and will shape the types of questions asked during the hearing as well as the sequence of the questions. Dr. H1's conclusion, with which two other psychiatric colleagues who examined P1 concur, is that P1 is, pursuant to section 1 of the *Mental Health Act*, "a person with a mental disorder" who requires involuntary treatment with anti-psychotic medication. The manner with which P1's speech and actions are described in Dr. H1's opening statement also shows how the discourse of biomedical psychiatry displaces the form of life-world discourse that P1 apparently attempted to use when speaking with police and psychiatrists prior to his committal. Dr. H1's opening statement reference to a number of interviews between P1 and various psychiatrists is, no doubt, used in an attempt to show that there is

consensus among many physicians regarding P1's diagnosis and the need for medication.

Dr. H1 describes the result of the interview with the two psychiatrists in the hospital as follows:

Dr. H1: OK just for the purpose of clarifying things I started after P1 was admitted, so I didn't get a chance to write a detailed report. The other thing is that the other reason I am here is that I want to gain the trust of the patient so that he gets the best possible treatment and regains quality of life. So we start with Form 4, the first Form 4 completed by Dr. A, who is a hospitalist at the hospital and...has written that...

CH1: What is the date, Dr. H1?

Dr. H1: Date is +, this year. He writes "Patient brought in by Police under section 28. Paranoid about [criminal activity against him] and he has written that 'risk to self'", so that is what he has commented. Then another F4 was filled in the same day by Dr. B, who is a psychiatrist, and he was the on-call psychiatrist on that day. And he has written that P1 presents with persecutory delusions, agitation, disruptive behavior with poor insight, possible past history of psychosis, but P1 was uncooperative and poses potential risk to others if further deteriorates in his health. So that is what he has written.

By recounting all of this information in the opening statement, Dr. H1 creates a type of topical agenda that is difficult for P1 to resist or overcome, most obviously because Dr. H1 gives a chronology of H1's life suggesting that P1 has long-term unresolved mental health issues. Moreover, as Dr. H1 argues in the opening statement, there appears to be a current consensus among many professionals, including the police, two psychiatrists, and Dr. H1, that P1 has a serious mental illness. The presence of police involvement also tends to heighten the perception that P1 must have done or said something sufficiently alarming to warrant immediate use of handcuffs and detention in a police car.²⁴ To succeed in his

²⁴ In his study of police records from mental health apprehensions in Ontario, Robert Menzies shows how, in the creation of arrest documents, the police records significantly affected psychiatrists' later perception, diagnosis and documentation of mental illness in the apprehended patients. See Robert J. Menzies, "Psychiatrists in Blue: Police Apprehension of Mental Disorder and Dangerousness" (1987) 25:3 *Criminology* at 429. As Menzies states, "At the initial point of arrest, the police assisted in laying the groundwork for subsequent institutional careers of the medico-legal subjects" (*Ibid*).

application, P1 faces the daunting task of showing that all of these records are incorrect, that the numerous professionals who have dealt with him are mistaken in their assessment of his mental condition, and that the police were not justified in detaining him.

Note the interpretive frame Dr. H1 sets up with suggestions that P1 poses a *risk* to himself, but also a risk to others if he *deteriorates*. Dr. H1 repeatedly returns to the issues of P1's risk of deterioration throughout both hearings. This interpretive frame then shapes question and answer sequences during the hearing. The Review Panel's assumptions about P1's risk of harm and deterioration, established at least in part by Dr. H1's initial topical agenda, has a strong bearing on what the panel members regard as relevant evidence regarding P1's life and therefore how they frame questions during the hearing. As a participant in a *parrhesiastic* exchange with the Review Panel and Dr. H1, whose committal order is being challenged, P1 asserts rights in a contested confrontation in which dialogic exchange shapes the course of his life.

7.6(C) Question Types and Question Sequences

The control of the questioning process is one of the most important factors determining how conversation is shaped and how certain forms of discourse become dominant while others are suppressed. For example, the questions that Dr. R1, the psychiatrist member of the panel, asks do not challenge any of Dr. H1's assertions or assumptions regarding P1, but merely facilitate Dr. H1 in strengthening the case for P1's continuing certification.

This can be seen through the following questions and answers:

Dr. R1: Can we go over some of the nurses' notes?

Dr. H1: Yes.

Dr. R1: So we can get a better picture of...

Dr. H1: So first day for example?

Dr. R1: Yes, first couple of days?

Dr. H1: So this is the first day...Remains in intensive observation unit. Number 2: [Police car present]. Seen by Dr. A. OK...received on initial rounds. Brought patient in in a wheelchair to security staff in hospital in pajamas. Patient is escorted to Security Room #1 and nurse took all his belongings. Presented with irritability and pressured speech and was arguing with staff that he does not need to be in hospital. He refused to give vital signs. Provided with fluids and finger foods. Offer to use washroom. Patient refused same and patient was put in security room. Encouraged to knock on doors if he needs to use toilet. Patient appears to continue to be sleeping...will continue to monitor and patient remains asleep. Respiration visible.

Patient up to SR room banging loudly at approx. 6:30 am. Patient requesting to use washroom with 3 security guards. Let out of seclusion to use washroom. At Patient's request, additional blankets provided. Patient returns to seclusion room and settled.

And then next day...nurses say at 6 pm entered security room with security staff. Patient lying on bed and said...presented with disorganized thought at time...but pressured speech...was brought to hospital by police. I inject him...says someone was using his [financial information]. Allowed to vent and provided with reality feedback. Patient not receptive to same. Though he doesn't remember why he came into security room.

11:30 am, still somewhat disorganized thoughts. Requested Review Panel. Same explained.

Day 3 in hospital: Patient appears to have slept all night...P received into care at 10:30 am. Observed to be sleeping. Patient woken for a break. Speech rapid and pressured. Patient states mood is OK with reactive affect. Patient denies thoughts of suicide or self-harm.

Dr. R1: So what medication is he on right now?

Dr. H1: An atypical anti-psychotic medication.

Dr. R1: How much is he getting?

Dr. H1: [Amount stated.]

Dr. R1: That is only for upkeep.

Dr. H1: That was my thought.

Dr. R1's questions do not probe Dr. H1's diagnosis, treatment plan, or the historical adequacy of the clinical records on P1's file. Instead, the questions help Dr. H1 to offer

more information to fortify the topical agenda. The exchange between Dr. R1 and Dr. H1 in the last six lines of this sequence, which express a consensus about the appropriate dose of medication for P1, sound like a supportive dialogue between colleagues rather than a query as to whether P1 needs medication at all.

For the balance of the hearing, the Review Panel does not question Dr. H1's diagnosis or risk assessment of P1, but rather asks question that appear to reinforce Dr. H1's presumptions. For instance, the Chair, CH1, asks Dr. H1 the following:

CH1: Dr. H1, does he appreciate the diagnosis that he has?

Dr. H1: No.

CH1: Has he denied to you that he has a mental illness?

Dr. H1: Yes.

CH1: OK. Thank you...anything arising out of that?...No...OK, thank you Dr. H1 for attendance and all that. Now we are going to turn it over to Adv1 and P1.

CH1 does not ask whether P1 appreciates the diagnosis he has been *given*, but rather the diagnosis that he *has*, as though he owns it or it is an essential part of his being. Furthermore, even given CH1's assumption about P1 *having* a diagnosis, CH1 does not try to ascertain why Dr. H1 asserts that P1 does not appreciate the diagnosis or whether P1 has any degree of appreciation of the diagnosis. Similarly, CH1's question as to whether P1 had denied he has a mental illness is equally perfunctory, as though CH1 is running down a checklist or scorecard regarding P1's level of insight regarding his condition and making negative entries to tally at the end of the hearing. When CH1 says "anything arising from that" CH1 is using legal jargon to ask other panel members whether they have any questions arising from CH1's last two questions. Apparently they share CH1's view of P1's situation and have no further questions.

Having relieved Dr. H1 of the burden of elaborating on Dr. H1's answers to CH1's last two questions, the Panel then asks P1 whether he agrees with the diagnosis. This is seen in questions from the psychiatrist member of the Panel, Dr. R1:

Dr. R1: You don't believe you have this mental illness, this diagnosis?

P1: Mental illness. Those kinds of things I disagree with. The diagnosis.

Dr. R1: Why?

P1: What I can agree with is maybe depression.

Dr. R1: Right.

Again, Dr. R1 is dealing, in a perfunctory manner, with the issue of P1's insight into his condition. Dr. R1 asks P1 whether he agrees with the diagnosis he has been given. P1 disagrees, and Dr. R1 probes further with a one-word question of "Why?" P1's responds, not by denying that he has psychological problems he is grappling with, but by describing them as depression. One wonders why Dr. R1 does not ask P1 how he understands the difference between the psychiatric diagnosis and depression and how all of this applies to him. Instead, Dr. R1 simply takes P1's answer to be a categorical denial and Dr. R1 responds with the categorical conclusion, "Right," signalling Dr. R1's view that P1 has confirmed Dr. R1's assumption that P1 denies he has a psychiatric disease and does not have insight into his condition.

Despite P1's comment that he believes he may be depressed, Dr. R1 persists in asking him rhetorical questions that in effect assert that P1 denies that he is mentally ill. This is seen in the following question and answer sequence.

Dr. R1: You said you are on disability right?

P1: Yes.

Dr. R1: Why do you think you are on a disability? What kind of disability are you on?

P1: What kind of disability? I don't know. It's called mental illness.

Dr. R1: But you don't believe it?

P1: Mental illness, I suppose depression. If they give me anti-depression drug I take it.

The program that Dr. R1 is working through with these questions is in line with the agenda that Dr. H1 set up at the beginning of the hearing, namely that P1 has no insight and therefore that he is at risk of deteriorating and harming himself or others. Note P1's resistance to calling his condition *mental illness*. He says he has depression, but he does not say "it's mental illness" saying instead "it's *called* mental illness," suggesting that this is something that other people would say, but not what he would say.

7.6(D) The Conduct of P1's Patient Advocate in the First Hearing

During the time that P1's advocate, Adv1, questions P1, Adv1 tailors the questions to avoid giving P1 the opportunity to speak freely. Like the public defenders in Holstein's research on civil committal hearing in California in the 1980s, Adv1 tries to keep P1's answers to questions as brief as possible, perhaps to prevent P1 from speaking in a manner that Adv1 regards as crazy. Adv1 signals the intention to limit P1's speech when first asking him questions.

CH1: Now we are going to turn it over to Adv1 and P1.

P1: Is it my turn?

Adv1: No it's my turn. It's your turn after. I'm going to ask you some questions. A few things have come up in the presentation. So let's get them out of the way. Where do you live?

Yet, Adv1 never allows P1 to have his turn to speak freely at any time during the hearing. Instead, Adv1 constantly interjects the word “OK” to cut off P1’s questions and then changes subjects. For example:

P1: I also have a case number with the [financial agency]. I also reported to their compliance department. There is a case ID # (gives number)

Adv1: We don’t need that OK...In our discussions I asked you if you are prepared to follow up with the mental health team if you are discharged.

Adv1 does not permit P1 to explain his concerns regarding the theft of his financial information (which led to his arrest), a problem that troubled P1 because he thought that people did not believe him, as indeed they did not. He never gets a chance to tell his story and instead Adv1 redirects his attention to the issue of compliance with treatment plans. Like Dr. H1 and the panel members, Adv1 appears to believe that P1 has a mental illness and is in need of treatment with medication, but Adv1’s strategy is to have P1 show that he has enough insight into his life that he will comply with Dr. H1’s prescribed treatment in the community. This is seen in the following sequence of questions and answers:

Adv1: Do you have a mental illness?

P1: Mental illness is like something...this definition is too broad. The mental illness definition is too broad. Sometime in a medical situation they call you depressed. So sometime yes...in that kind of situation. So they give me [an anti-psychotic drug]. Finally many years ago they follow and give me [an anti-psychotic drug].

Adv1: Do you have a mental illness by a different meaning? You don’t like [the name of the diagnosis]. Do you have a mental illness?

P1: I try to point out. This psychiatrist is being misleading. What kind of delusion is it because that means...I try to find out what kind of delusion it is. What is called delusion is totally made up. Not truth or fact. They make up delusion, but delusion...what the psychiatrist said is not true.

Adv1: So you're asking the panel to today...correct me if I'm wrong...to decertify you and you are willing to be a voluntary patient...and seek treatment in the community...is that correct?

P1: Yes, yes, yes. The same as with the [previous community] mental health team.

Adv1: Thank you, I have no further questions.

Again Adv1 redirects P1 away from his criticism of the psychiatrist and back to an attempt to have P1 express a willingness to seek treatment in the community. Adv1 reveals skepticism about Adv1's own client's speech in the closing submissions as follows:

Adv1: At several years today without medication there has been no evidence presented that he has been a problem in the community either to himself or to others, aside from a couple of phone calls to the police. And probably ticking off phone tech support. He now says he will follow up in the community. He does not want to take depot medication, but he will take oral medication...*he says* [speaker emphasis]. So we are asking you to decertify him today.

Although it is difficult to detect in the written transcript, Adv1's intention regarding the comment at the end of the sentence "He does not want to take depot medication, but he will take oral medication...*he says*", sounds, in the audio recording, like a skeptical comment, made as an aside to the Review Panel, about P1's stated plan to take oral medication in the community. Like the public defenders in the research conducted by Warren in the 1970s²⁵ and Holstein in the 1980s,²⁶ it appears that Adv1 has a sense of working with the Review Panel and Dr. H1 to do what they collectively regard as best for P1, regardless of P1's wishes or beliefs. As seen below, this is very different from the approach taken by P1's new advocate in P1's second Review Panel hearing, Adv2, who insists that P1 speak freely

²⁵ Carol A.B. Warren, *The Court of Last Resort* (Chicago: Chicago University Press, 1982).

²⁶ James A. Holstein, *Court-Ordered Insanity: Interpretive Practice and Involuntary Commitment* (New York: Aldine De Gruyter, 1993).

and that P1 have the opportunity to tell his story, which Adv1 had prevented him from doing in the first hearing.

7.6(E) Ascriptions Regarding P1's Insight

Throughout the first hearing, Dr. H1 describes P1 in terms of diminished insight or a lack of insight into his condition. Dr. H1 does this on five occasions, stating that P1 has “poor insight” (twice), “limited insight”, “insight is quite compromised”, and “no insight”. These expressions concerning “no insight” do not refer to a person’s lack of introspective ability to examine personal thought processes; rather it is an ever-changing metaphorical expression²⁷ that is largely shaped by social and cultural context.²⁸ Psychiatrists, however, tend to describe the patient’s resistance to the psychiatric diagnosis and treatment as indications of a lack of insight and as further evidence of the patient’s illness.

7.6(E)(i) Insight and Deterioration

The use of the term “insight” takes on unique meaning in Review Panel hearings in British Columbia because, unlike other jurisdictions, such as Ontario, there are no criteria in British Columbia’s *Mental Health Act* to assess capacities to consent to health care. In British Columbia, the apparent assessment of cognitive abilities implied in ascriptions of

²⁷ Even in common speech, for example, the term insight, when taken in isolation, has no essential or universal meaning; it acquires its meaning in the context in which it is used. Consider the differences in connotations in the use of the term insightful between comments on an insightful proof of a mathematical theorem, an insightful literary critique of a work of poetry, or an insightful analysis of a dream. Similarly, while researchers in several jurisdictions around the world have commented on the way that psychiatrists and review tribunals use the term insight with little analysis, the term will have various meanings depending on whether it is related to patients’ reflection on their history, need for compliance with treatment plans, or whether they disagree with a diagnosis. See K. Diesfeld, “Insights on ‘Insight’: The Impact of Extra-Legislative Factors on Decisions to Discharge Detained Patients” in K. Diesfeld & I. Freckleton, eds, *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment* (Hampshire: Ashgate, 2003) 359.

²⁸ See Laurence J. Kirmayer, Ellen Corin & Eric Jarvis, “Inside Knowledge: Cultural Constructions of Insight in Psychosis” in Xavier Amador, ed, *Insight and Psychosis: Awareness of Illness in Schizophrenia and Related Disorders* (Oxford: Oxford University Press, 2012).

levels of insight to patients becomes associated with other factors such as the willingness to comply with treatment plans in order to prevent deterioration. This assessment demonstrates the social factors influencing assessments of patient insight. As some cultural anthropologists have noted,

The metaphor of insight implies that self-awareness is based on introspection. Social psychological studies, however, suggest that self-knowledge is largely the product of social processes involving observations of others and the acquisition of culture-specific modes of self-description. Insight, then, does not involve a transparent act of self-perception, but a cognitive and social construction or construal of the self. As such, it is profoundly shaped by cultural beliefs and practices.²⁹

Psychiatrists' association between ascriptions of insight to patients and assessments of their risk for deterioration is seen in a number of Dr. H1's comments during the first Review Panel hearing. For example, according to Dr. H1, and the other psychiatrists who saw P1 at the hospital, the consequence of P1's lack of insight is that he is a risk to himself. As Dr. H1 states on page 4:

Dr. H1: In terms of risk assessment, the reason I think he should be on involuntary is based on the fact that he has a serious mental illness. So [the diagnosis] is one of the serious mental illnesses. He has a poor response to treatment. This is another poor prognosticator. He has limited insight into his situation. He doesn't think he has...suffers from an illness...and he doesn't believe that he needs any treatment for it.

Dr. H1's assessment of P1's risk goes beyond an assumption that he is a risk to himself; Dr. H1 assumes that this lack of insight will put others at risk of danger. This is in part based on the comment on the first Form 4 completed when P1 was brought to the hospital during his last committal, in which another psychiatrist at the hospital states that: "P1 was

²⁹ *Ibid* at 197.

uncooperative and poses a potential risk to others if he deteriorates in his health.” In response to a question from P1’s advocate, Adv1, Dr. H1 gives the following response:

Adv1: OK, since one of the Form 4’s, one of the doctors said he was a risk to others. What did he mean by that?

Dr. H1: I’m not sure exactly what he was thinking, but that I can base it on the fact that he was quite agitated, he was quite...he thought that something is going on...he thought that he was not sure what it was...but he thought somebody was doing it. I think in a way being paranoid about somebody when you have no ideas in mind it could result in any kind of violence. You know delusional thoughts about somebody actually interfering with his affairs can eventually cause danger in terms of violence.

Dr. H1’s argument is not that P1 is *currently* a risk to others. Instead, the assumption is that presence of paranoid beliefs about others (if indeed that is what P1’s beliefs are) can *eventually* cause danger, violence and therefore harm to others. The implied assumption is that P1 is at risk of *deterioration*, which will result in personal and social harm. Dr. H1 therefore advances the argument that H1 must be an involuntary patient and remain on anti-psychotic medication permanently.

7.6(F) The Review Panel’s Decision

In the reasons for its Form 8 order that P1 remain detained, the Review Panel echoes Dr. H1’s assessment of P1, and the panel concludes that he does not appreciate his mental illness and does not believe in taking medication. However, as seen in the above questions and answers, P1 did not deny that he had problems and even went so far as to describe himself as depressed. Thus, the Review Panel’s conclusion that P1 has poor insight and does not appreciate his mental illness is based solely on his disagreement with the diagnosis. The Review Panel’s conclusion implies that, if decertified, P1 will not comply with Dr. H1’s treatment plan and, despite the fact that he has lived quietly and self-

sufficiently for many years, will deteriorate. The transcript of P1's Review Panel hearing shows how psychiatric concepts, legal presumptions and low certification thresholds in British Columbia's mental health law system worked together to construct P1's identity at the end of the hearing and put him on a further institutional path of involuntary treatment that could be even more difficult for him to exit. With the assistance of a new advocate, Adv2, however, P1 was released from the extended leave certification order in a second Review Panel hearing that occurred one month after the first hearing wherein P1's opportunities for open truthful speech were curtailed.

7.7 Patient 1's Second Review Panel Hearing

7.7(A) The Review Panel Psychiatrist's Cross-examination of Dr. H1

Dr. R1's facilitative questioning of Dr. H1 at P1's first hearing can be contrasted with the more aggressive questioning by Dr. R2, the psychiatrist member of the Review Panel in P1's second hearing. Dr. R2 repeatedly queries Dr. H1 on the issue of whether the diagnosis is appropriate and whether P1 is a risk to himself or anybody else. In the second hearing, Dr. H1 abandons the earlier contention that P1 is a risk to others or at risk of harming himself or others and instead argues that P1's risk is that his mental health condition will deteriorate if he does not take anti-psychotic medication.

Dr. R2: OK. You refer to the words "risk assessment". Do you use a structured risk assessment methodology or do you just review your own. It appeared that you have a structured system in mind. Most risk assessments are for aggression and violence kind of things.

Dr. H1: Which he has never been.

Dr. R2: Exactly.

Dr. H1: There's no point in using any of those things. I think my major point when I say risk assessment is that how much can he benefit from

certain treatment and what are the risks if treatment is not given here, like you know...

Dr. R2: O.K. So you're using the word risk, not in terms of risk of aggression, but in terms of risk of deterioration.

Dr. H1: Yeah.

Dr. H1's use of the term *deterioration* in this exchange is dramatically different from the way Dr. H1 used it in the first hearing where Dr. H1 linked the diagnosis of P1 with the risk of violence:

Dr. H1: You know delusional thoughts about somebody actually interfering with his affairs can eventually cause danger in terms of violence.

Dr. H1's and the first Review Panel's questionable assumptions concerning P1's risk of deterioration or harm are most clearly revealed in questions from Adv2 at the second Review Panel.

7.7(B) Patient Advocate's Cross-examination of Dr. H1

The difficulties P1 faced in his attempts to speak in the first Review Panel hearing were, to a degree, countered by the presence of an experienced legal advocate, Adv2, in the second hearing who helped P1 advance his own views. The ability to cross-examine effectively is a specialized skill that is acquired through legal training and honed with experience. Many of Adv2's questions were focused on revealing the fact that Dr. H1 and Dr. H1's colleagues ignored or discounted a large amount of evidence about P1's life, particularly the fact that P1 had never benefitted from psychiatric medication and did not appear to be a risk to himself or other people. This can be seen in the following sequence of questions and answers:

Adv2: To be clear, [there were multiple hospitalizations]. And he attended the mental health team from [several years ago] to when they closed the

file. So from [several years ago] to this year he had not had medications, right?

Dr. H1: No.

Adv2: He had no follow-up with the mental health team or psychiatrist *at all*?

Dr. H1: No.

Adv2: He owns his own [residence] right?

Dr. H2: Yes.

Adv2: So there have been no reported complaints..., correct?

Dr. H1: Yes, that's true.

Adv2: There's no police reports for poor behaviour or whatever?

Dr. H1: No.

Adv2: There's no history whatsoever of violence.

Dr. H1: None.

Adv2: No history of self-harm.

Dr. H1: No.

Adv2: There's no history of poor self-care?

Dr. H1: Um...I wouldn't say that 100%. True...but to some extent...yes...I would say yes.

Adv2: So...I mean...when the police went to his [residence], they didn't report the place as a mess that there was food lying around...

Dr. H1: No.

Adv2: And he looks after all his activities of daily living, cooking, cleaning, shopping, laundry, right.

Dr. H1: Right.

Adv2: There's no record in his history of any disturbance in or towards the public.

Dr. H1: That's correct.

Adv2: OK...so according to your report, one of the concerns is the decline in function. So you said he...received treatment [dates].

Dr. H1: That's correct.

Adv2: So [during this time]...I mean...you read the report from the Team...would you agree with the Team that with treatment there was no change in function, no improvement in function.

Dr. H1: Right.

Adv2: So the certification said agitation and disruptive behaviour. Would you agree that there was no evidence of agitative or disruptive behaviour in the community, it was only as a result of being forced to the hospital.

Dr. H1: That's true.

Adv2: And again...at the hospital, it was when he first got there that he was agitated and yelling at staff, only in relation to being detained.

Dr. H1: Right.

In this sequence of questions and answers, Adv2 dismantles an important part of Dr. H1's topical agenda, particularly that P1 had a history of uncooperative behaviour, disruption in the community, or any risky behaviour that would justify the police handcuffing him and detaining him. Indeed P1's agitated and loud behaviours in the hospital were situational responses to being forcefully detained. This diffuses some of the concern the Review Panel might have in hearing that the police were involved in P1's arrest and delivery to the hospital.

Adv2 asks other effective questions about the factual basis for Dr. H1's diagnosis of P1. According to Dr. H1, P1 showed negative signs of mental illness because he was socially withdrawn. In the following questions, Adv2 shows that this conclusion is unfounded:

Adv2: You said that the mental health team recommended extended leave in [name of] city, but he attended voluntarily...correct?

Dr. H1: Yes, that was in the discharge letter.

Adv2: OK, you said he has relationship instabilities. What evidence do you have of that?

Dr. H1: When you say relationships, it's not just girlfriend/boyfriend relationships...it means extended relationships...day to day contact with your neighbour. Contact with your friends...contact with family...all those things. When he was in hospital I asked him to give me some contracts so I could contact his family and he wasn't willing to, so I think that things may not be as good as he says, like you know...so just based on that...I don't think there are any friends, just once again based on assumptions, because he won't tell me.

Adv2: So he could have a large circle of friends and regular daily or weekly contact with his family.

Dr. H1: I doubt it, but it is possible.

Adv2: Have you asked him?

Dr. H1: I asked, but he won't tell.

Adv2: OK. You said one of your concerns is impulsivity. From the records you have available to you would you agree that the only act of possible impulsivity is the fact of leaving to [his new community] and not telling the [old community] city Team of his move to [his new community]?

Dr. H1: But I think it was a major incident...like...moving from one place to another, without informing anybody. I think it's major, but that's the only evidence I have...ya.

Adv2: Did you ask him about it?

Dr. H1: As I said my contact with him was in hospital and in hospital he thought any question I asked him was met with "This is personal information and I have no right to ask these questions."

Adv2: OK. You said the concern was that he called the police and was concerned about [a type of] theft, but again you said he was stressed by this and agitated. But there is no evidence that he was agitated when he was explaining to the police. The agitation occurred after being handcuffed and being forced to the hospital, correct?

Dr. H1: Yes, I think what I said was the agitation is not physical agitation, but psychological agitation where he was distressed by the things happening to him. It's not like he was just running around or hitting somebody. But he was not happy about what was happening. He was distressed by these symptoms which in reality...we thought were just only paranoid thoughts rather than...

Adv2: OK. I have no further questions. Thank you very much.

Adv2's questions force Dr. H1 to disclose that a number of the conclusions Dr. H1 reached concerning P1 were based on presumptions arising from Dr. H1's conclusion that P1 was mentally ill and not any evidence that Dr. H1 gathered through observation. P1's first Review Panel failed to ask these types of simple questions that Adv2 repeatedly put to Dr. H1.

7.7(C) P1's Cross-examination of Dr. H1

The presence of an effective patient's advocate at the second hearing also ensured that P1 had an opportunity to question Dr. H1 directly, which Adv1 prevented P1 from doing at the first hearing. P1's first question in the second hearing is:

P1: Yes...I want to ask Dr. H1. Dr. H1, may I know your first name?

Dr. H1: Yes...[gives first name].

By asking for Dr. H1's first name, P1 attempts to question the institutional role reflected in Dr. H1's honorific title before questioning Dr. H1 concerning the basis for diagnosing P1.

After three questions, the Chair, CH2, attempts to silence P1 by asking:

CH2: So, I'm wondering, are those all your questions for the doctor because we would like to have an opportunity to ask you questions as well?

P1 persists in asking Dr. H1 another question before CH2 interrupts again and asks P1:

CH2: Could the Panel ask you some questions please?

To which Adv2 responds by stating:

Adv2: I think we can have the panel's questions after; he wants to say something.

By insisting that P1 exercise his right to speak, Adv2, unlike Adv1, ensures that P1 has an opportunity to resist the passive and disempowered institutional role that was imposed on him as a psychiatric patient, which was reinforced at his first Review Panel hearing. The point of the set of questions P1 asks Dr. H1 is revealed when P1 yells:

P1: (yelling) Everything you presume...it's presumptions, your presentation always includes presumptions...

CH2: Can we just keep the volume down. Because the doctor is right there and...can hear you...

P1: OK.

What both Adv2's and P1's questions highlight is that Dr. H1 based the diagnosis and the treatment plan for P1 not on Dr. H1's own assessment of P1, but rather on presumptions based on scant evidence Dr. H1 found in historical clinical records, which Dr. H1 did not even present to the Review Panel at the second hearing.

7.7(D) Dr. H1's Intransigence on the Deterioration Criterion

Despite this lack of evidence, Dr. H1's assumption about the need for pharmaceutical solutions to mental illness are so entrenched that Dr. H1 refuses to change the assumption even when faced with strong evidence that it was not at all helpful for P1. This can be seen in the following question and answer sequence:

Dr. R2: And when you say he needs treatment, if he's not responding to treatment, why does he need treatment?

Dr. H1: I think the most important thing is that when we say treatment, it doesn't necessarily mean only tablets. Tablets are only part of it.

Dr. R2: OK.

Dr. H1: The treatment that we use in psychiatry is that you treat the symptoms with medication. Sometimes it works, sometimes it does not. In case it does not work, it doesn't mean that you don't use the medication. They may have some effect on him, like you know. Maybe not 100% as effective as...we won't...it's like exactly the same way as in dementia that most of the medication doesn't work, but you still use it because sometimes it helps you stay at home, rather than going to a nursing home....It may be that with the medication the progress is slower, we may not be in a position to stop it completely but we can slow up the progress so what is going to happen in five years may happen in 10 years....So if the disease is left on its own it may progress so quickly that what is going to happen without medication may happen in 10 years with medication. So we have saved five years in a way like you know that the disease progress has been slowed up. So that's one thing...

Number two is the psychological and social support which is very important to the person who is suffering from symptoms who is consistently being disturbed by it. They need somebody who can talk

about these things. So they have somebody who can listen to them and can appreciate it and can help them understand and get some insight. So while not being on medication some kind of support can be provided.

Dr. H1's assertions in this last answer are a remarkably clear – and common – statement of the assumptions about serious mental illness that inform both neurobiological psychiatry and British Columbia's mental health law system. Neurobiological psychiatry assumes that severe mental illness is chronic and progressive biological illness that inevitably leads to deterioration in psychological and social function. This is why psychiatric medication is prescribed even when it has little or no perceptible effect on the patient. As Dr. H1 states, "it may be that with the medication the progress is slower." These assumptions about the chronic and progressive nature of specific mental illnesses have been incorporated into section 22 of the *Mental Health Act*, which permits legally sanctioned medical intervention, even when a patient has the capacity to withhold consent to treatment and is functioning without current personal or social harm in the community. The psychiatrist can maintain the certification order for patients by working an explanation around the deterioration criterion. The Review Panel's decision in P1's first hearing is consistent with the logic of the Four Criteria set out in the *Act*. Following the second hearing, the Review Panel members, none of whom were at the first Review Panel hearing, decertify P1. Significantly, the second Review Panel questions whether P1 should be diagnosed as having the specific mental illness being diagnosed by the psychiatrist while Dr. H1 persists in this diagnosis.

7.7(E) The Second Review Panel's Cross-Examination of Dr. H1

At the second hearing there is more explicit contestation between P1 and Dr. H1, who persists in maintaining that P1 has a mental illness. Throughout the hearing, Dr. H1 continues to describe P1 as lacking insight or needing to develop insight. Dr. H1's assumptions concerning the relationship between insight and capacity to consent to treatment are most clearly seen in the following questions and answers:

CM2: The other question I was interested in...you might be able to tell us because of your interaction. Was...after he was admitted to the hospital was the problem of insight versus competence. Because we have an educated person and as far as I can tell the risk that we're talking about under the Mental Health Act. As an aside, the panel looks at all the evidence on a legal basis, not from a medical point of view. Is that what we're supposed to do?

Dr. H1: Yes.

CM2: So the question is, the risk is if he doesn't get treatment and assuming treatment has some effect, that his prognosis is worse than when he does get treatment. So what does he know about that? Does he know about the clinical studies that have shown that? And what the numbers are in those studies and the applicability of someone [older], compared to someone in the early psychosis program, for example.

Dr. H2: The most important thing to me is that he doesn't think that he has an illness, so I think that's a full stop to work on anything else. The most important thing is that if he thinks there is an illness, then we can work toward it. But when he thinks there is no illness he won't listen to what the benefits are of treatment.

CM2: So I guess if you can correct my impression if I'm wrong. If a person has a mental disorder and they don't have insight, they may or may not be competent to make treatment decisions around that disorder. Probably not competent if they don't have the insight to understand that they have it. Is that fair?

Dr. H1: Ya, the competency is not global, but in that particular area, yes.

CM2: So from what you know about this gentleman, you wouldn't feel that he is competent to make treatment decisions.

Dr. H1: Ya.

It is telling that in this exchange, the community member of the panel, CM1, asks Dr. H1 for guidance on how the Review Panel is supposed to function, which calls for an opinion that Dr. H1 has no special qualification to express. This shows the level of deference that some Review Panel members show toward physicians who appear at hearings.³⁰ The most significant aspect of this exchange, however, is the discourse that shows how easily Dr. H1 arrives at the conclusion that P1 is not competent to make treatment decisions for himself. Dr. H1 assumes that if P1 does not agree with the diagnosis, then he lacks insight. Dr. H1 further assumes that this alone means that he is not competent to make treatment decisions for himself and therefore treatment can be imposed on him involuntarily.³¹ Dr. H1's automatic link between assumptions about P1's alleged lack of insight and his mental incapacity to consent to treatment is not an anomaly. In my research on Review Panel decisions between 2008 and 2012, I found abundant evidence of this type of thinking in psychiatrists' presentations to Review Panels and in the panels' decisions.

7.7(F) Second Review Panel's Cross-examination of P1

P1 not only disagrees with Dr. H1's diagnosis of him but also argues that this labelling is itself the source of many of his problems in life. As in the first hearing, P1 does not deny that he has psychological problems and difficulties arising from depression and perhaps

³⁰ This is also found in other studies of mental health tribunals in England. See Elizabeth Perkins, *Decision-making in Mental Health Review Tribunals* (London: Policy Studies Institute, 2003). Perkins' findings on England's mental health system are not easily applied to British Columbia's system because of the difference in the legislative schemes and operation of the review tribunals. In England at the time of Perkins' research, the psychiatrist member of the panel met privately with the patient before the hearing to do an assessment and prepare a report with recommendations to present to the other panel members. Not surprisingly, the panel members tended to follow these recommendations regardless of the evidence that the patients adduced at the hearing.

³¹ This type of thinking discloses a discriminatory presumption concerning mental illness that is reinforced by the joint operation of the *Mental Health Act* and the *Health Care Consent Act*. However, as the Supreme Court of Canada held in the case of *Starson v. Swayze*, [2003] 1 S.C.R. 772, neither the presence of mental disorder nor the failure to agree with a diagnosis imply that a patient lacks the capacity to consent to psychiatric treatment.

other physical ailments; but he repeatedly resists the specific diagnosis being imposed on him. This is seen in the following series of questions and answers:

CM2: OK. So I understand from previous questions that you don't feel you have any mental problems or any kind of mental disorder, is that correct?

P1: Mental disorder is kind of...I don't think that I've got mental illness. At the time I tried to get some counselling in [previous community]. Because of...depression.

CM2: Um...you felt you had a...depression because of a [different issue]?

P1: yes....I was depressed...very weak...very weak condition

CM2: Ya...is that ongoing? Is that still a problem for you?

P1: Ongoing. It's because, I suppose my [health issue], my [health issue] is very weak....

In this exchange, P1 implies that the depression he believes he suffers from is not a *mental illness*, instead referring to a number of other causes of his emotional state, showing how he repeatedly resists psychiatric labelling of his condition in life. When Dr. R2 asks P1 whether he feels there would be any benefit in attending at the hospital for any kind of treatment, P replies as follows:

Dr. R2: OK, so you don't see any benefit from coming here? You said that.

P1: Benefit? I don't think that following...If under labelling of [the diagnosis] then follow the doctor's advice to treat [the diagnosis], then maybe...yes, it can be said that's not a positive for me.

Earlier in the second hearing, P1 asserted that it was because of the labelling of a particular diagnosis that he had a disadvantaged status in life:

P1: Of course, my future plan is my private business because your....Dr. H1 mentioned my situation it looks like some kind of...he tried to intervene with my personal life. Actually I have normal daily living things. Actually the psychiatric labelling has caused my life to become difficult. The psychiatric labelling. I'm in the status of an underdog. That's what I try to emphasize.

The analysis of the transcript evidence from P1's first and second hearings discloses that the label of mental illness was indeed not positive for him. Most recently it resulted in his arrest in his home, detention for weeks in the hospital and involuntary injection with anti-psychotic medication. He was released from detention because he persistently resisted this labelling and at the second hearing the Review Panel also questioned whether it was a legitimate diagnosis.³²

7.7(G) The Second Review Panel Decision for P1

In its decision, the Review Panel at the second hearing found that P1 suffers from a mental disorder without saying anything further about what the diagnosis might be. They also query whether the anti-psychotic medication was a safe and effective treatment for him. They note that P1 had no history of violence or disruption in the community and lived a self-sufficient life on his own. They decided that there was insufficient evidence that physical or mental deterioration would occur, and since all Four Criteria had not been met, they concluded that they had an obligation to discharge P1 from involuntary detention. In view of their queries throughout P1's second hearing, there are many strong indications that the Review Panel did not conclude that P1 has the specific mental illness attributed to him. This may be the reason for the conclusion that there is no evidence of P1 having

³² Discursive strategies that patients diagnosed with schizophrenia use to resist diagnostic labelling is explored in Ian Tucker, "'This is for Life': A Discursive Analysis of the Dilemmas of Constructing Diagnostic Identities" 2009 10(3) *Forum: Qualitative Social Research* 1-14. In this study, researchers interviewed patients diagnosed as having schizophrenia who used discursive manoeuvres to re-describe their situations, not in the negative terms of psychiatric labels, but in other ways that limit the threats to their sense of personal identity associated with these labels. Referring to Ian Hacking's writings on mental illness, for example, Tucker argues that "the term 'schizophrenia' is not solely defining an underlying illness, but is organized according to the relation between social knowledge and feedback of people's actions (influenced through their awareness of being classified) post-classification. The diagnostic category has been moulded through the interaction of altered actions of people classified through awareness of their diagnosis."

potential for physical or mental deterioration.³³ The questions they asked both P1 and Dr. H1 show that they were unwilling to be drawn into the topical agenda established by the operation of the *Mental Health Act* and Dr. H1's opening presentation. The second Review Panel's forceful questioning, however, highlights by contrast some of the pitfalls that other Review Panels can fall into when confronting medico-legal discourse reinforced by British Columbia's discriminatory mental health law system.

The transcripts and Review Panel decisions from P1's first and second hearings also demonstrate, in concrete detail, how British Columbia's mental health law regime violated his right to security of the person in a manner that was not in accordance with the principles of fundamental justice as expressed in the Ontario Court of Appeal case of *Fleming v. Reid*.³⁴ This violation occurred because detention and invasive medical treatment were imposed on him without any regard to his capacity to consent to this treatment. This forcible treatment also contravened the principles of fundamental justice as set out in the Supreme Court of Canada case of *Bedford v. Canada (Attorney General)*.³⁵ As noted in section 5.3(A) of chapter 5, the three principles of fundamental justice articulated in *Bedford* are that the impugned legislation must not be 1) arbitrary, 2) overbroad, or 3) involve social harms or rights violations that are grossly disproportionate to the purpose of the legislation.³⁶

³³ With time permitting it would have been informative to interview the panel members to discover further details regarding their reasons for decertifying P1.

³⁴ *Fleming v. Reid*, [1991] OJ 1083, 4 O.R. (3d) 74.

³⁵ [2010], OJ No. 4037, 102 OR (3d) 321.

³⁶ *Ibid* at para 105.

As I argued in chapter 5, while the *Mental Health Act* is a legislative expression of the Crown's *parens patriae* jurisdiction to care for patients who are incapable of caring for themselves, this is done without any legislative criteria for assessing the patient's mental capacity to consent to treatment. Rather, under section 31 of the *Mental Health Act*, the patient is *deemed* to consent to the hospital's invasive medical treatment. Section 31 is therefore arbitrarily disconnected from any consideration of the patient's mental capacities to consent to treatment. The consequences of the arbitrariness of the *Mental Health Act* and its application to patients is seen throughout the transcripts of P1's two hearings, when P1's desire to tell his story was ignored and when vague references were made to deterioration criteria and P1's alleged lack of insight, which R1 and the first Review Panel never made any attempt to connect with P1's mental capacity to consent to treatment.

The overbreadth of the *Mental Health Act* is also demonstrated well in P1's situation because it permitted the imposition of involuntary treatment on him, even in the face of evidence that he was capable of making treatment decisions for himself and had lived independently for many years, without posing a risk to himself or others. P1's situation shows how the *Mental Health Act* casts too broad a net and captures patients beyond the Crown's *parens patriae* jurisdiction.

Finally, P1's situation illustrates how the consequences of the application of the *Mental Health Act* were grossly disproportionate to the animating purpose of the legislation, which is to provide care for people who are incapable of caring for themselves. In the context of P1's situation, his handcuffing in the police car when he was arrested, his detention in the

hospital for many weeks and the injection of powerful psychiatric medication into his body greatly and unreasonably exceeded the fundamental purpose of the legislation.

The conclusions regarding the violations of principles of fundamental justice in P1's case are equally applicable to the situations of P2, P3 and P4, described below. In each of their situations, the treating psychiatrists make vague references to deterioration and insight criteria to justify their involuntary treatment and these criteria are arbitrarily disconnected from any consideration of their capacity to consent to treatment. Moreover, the *Mental Health Act* can be seen operating in a manner that is too broad in the contexts of their lives and the extended treatment they receive appears grossly disproportionate to any care required under the *Mental Health Act*.

7.8 Discourse Analysis of Patient P2's Review Board Hearing

7.8(A) Background and Institutional Path

The transcript of the third hearing analyzed in the chapter concerns a woman who was subjected to a mental health arrest at her own residence. She had spent a couple of weeks in a psychiatric ward of a hospital many years earlier, but had not been on any medication since that time and had held long-term employment. The police visited her residence on a query from someone she knew, and they commented that it was in a state of disarray. P2 was arrested pursuant to section 28 of the *Mental Health Act* and taken to the psychiatric ward of a hospital where she was diagnosed as suffering from an episode of mental illness,

placed under a certification order and subjected to involuntary treatment. Her Review Panel hearing occurred approximately two weeks after her committal.³⁷

7.8(B) The Review Panel's Decision and Chair's Dissent

Following the hearing, the majority of the Review Panel upholds the involuntary detention order and states that the patient was grandiose and irritable, and though her symptoms had abated while in the hospital, she had not yet stabilized. The Chair, CH3, dissents from this judgment and holds that that patient was adequately stabilized and that her presentation was clear and cogent.

7.8(C) Topical Agenda in P2's Hearing

As in the two hearings for P1, the topical agenda at P2's hearing is implicitly established by 1) the legal framework that allowed the civil committal; and 2) the summary of P2 clinical records provided by Dr. H3, the hospital presenter at the hearing who was also one of P2's treating physicians in the hospital. Dr. H2 attempts to establish a history of consensus regarding P2's psychiatric condition when Dr. H2 read the Form 4s that had been completed by the two physicians at the time of P2's committal as follows:

CH3: OK, Dr. H2 can you begin by reading into the record any Form 4 and the most recent Form 6's?³⁸

Dr. H2: So the first Form 4 was done by Dr. C and he certified that he examined P2 on + (date). She was brought by police officers under section 28. It reads: "Risk of harm to self. Paranoid delusions. No insight." Signed

³⁷ The participants at P2's hearing were: CH3, the lawyer designated as Chairperson for the panel; M3, the community member on the panel; R3, the physician member of the panel; H2, the psychiatrist who certified P1 and appeared at the Review Panel hearing on behalf of the hospital; H3, another psychiatrist at the hospital who was called to corroborate H2's testimony; and Adv13, P2's patient advocate at the hearing.

³⁸ Form 6 of the *Mental Health Act* is the form that physician must complete after the completion of a Form 4 if they intend to detain the patient beyond 30 days. CH3 was mistaken in assuming that at the time of the hearing there was a Form 6 for P2. A copy of Form 6, which reiterates the Four Criteria, is attached to this dissertation as Appendix B.

on (date and time) by Dr. C Second Form 4 signed by Dr. D, who examined P the next day at + (time). She was brought to the hospital by police under section 28....P2 requires hospitalization for assessment and treatment for her own protection.” Signed by Dr. D. [who] wrote she was brought to hospital by police on + (day 1).

As in P1’s situation, P2’s institutional path leading to the Review Panel hearing involved hospitalization years in the past and the most recent police arrest, possibly raising suspicions and alarms about the type of conduct that would require arrest, handcuffs and detention in a police car. While police officers have no special expertise in making psychological assessments, the weight that Review Panel members accord to the views of the police is seen in Dr. R3’s question to P2:

Dr. R3: What I want to know is how you account for the fact that so many doctors you had seen back in the beginning and the police think you have something wrong with you, but you don’t think so? How do you account for that difference?

The implication of Dr. R3’s statement is that the apparent beliefs of the police leading to arrest substantiate the consensus of the psychiatrist who examined P2. This shows the significance of the evidence regarding a mental health arrest in Dr. H2’s topical agenda.

7.8(D) Question Types and Sequences

It was Dr. H2’s view that P2 would require another ten days to two weeks of involuntary treatment in the hospital to get her symptoms under control, after which she could be released as a voluntary patient and may remain stable for months or years afterwards. According to Dr. H’s testimony, P2 has no insight into her illness because she denies that she has any type of mental illness and therefore does not require any psychiatric medication. It is clear throughout P2’s testimony that she does not agree with a psychiatric

approach to any of her health problems. During a cross-examination of Dr. H2, the patient's advocate asked:

Adv3: And her view of DSM diagnosis and medication, that she has right now. Is there any reason to think that her opinion now is any different from [before]?

Dr. H2: I don't know at what point she started to have these views. Um...I'm not sure.

CH3: What views are you talking about?

Adv3: Doesn't believe in meds and doesn't believe in the diagnosis. Do you anticipate that these views will change in the next 10 days?

Dr. H2: No.

In response to questions from the panel's psychiatrist, Dr. R3, regarding the length of time that P2 would require treatment for her symptoms to abate, Dr. H2 responds as follows:

Dr. R3: From what you know, what is the average length of time of an...episode?

Dr. H2: Treated or not?

Dr. R3: Both.

Dr. H2: I'm under the impression that this one, with treatment, should start to abate quite soon and should continue to do so.

Dr. R3: Untreated.

Dr. H2: Weeks, months. It can vary.

Dr. R3: Average.

Dr. H2: A month...you probably know more than I would.

Dr. R3: OK, thanks.

When we take the evidence from both lines of questioning together, it appears that Dr. H2 acknowledges that P2 will not agree with the diagnosis or the need for treatment during the two weeks that Dr. H2 intends to keep her as an involuntary patient in the hospital. Therefore, according to the logic of Dr. H2's assumptions, she will not gain any insight into her illness, even after psychiatric treatment. In addition, there is only a two-week

difference between the time that Dr. H2 believes he can bring her symptoms under control in the hospital and the one-month period that Dr. H2 believes they will probably abate on their own. The evidence presented at the hearing confirms that P2 was not at risk of harming herself or harming others and that she had a social support network consisting of several friends and relatives who lived close to her.

7.8(E) Dr. H2's Application of the Deterioration Criterion

Despite these considerations, Dr. H2's rationale for keeping P2 detained in the hospital is to prevent her deterioration. In Dr. H2's closing summation at the end of the hearing, Dr. H2 states that she needs to remain in hospital for a short period of time so as not to accelerate *deterioration* – a term used in the decision letter to demonstrate the need to stabilize symptoms.

This shows the way that psychiatrists in British Columbia use the term *deterioration* in certification decisions as a discursive strategy to justify detention and involuntary treatment in the face of current evidence of mental capacity to withhold consent to treatment and to live independently. Again, this shows how the recurring use of the term deterioration – along with conceptions of insight - strengthens the authority of psychiatrists to justify a low threshold for imposing involuntary treatment on patients in British Columbia.

7.8(F) Constitution of the Review Panel at P2's Hearing

Part of the explanation of the Review Panel's decision not to decertify P2 may lie in the constitution of the panel at that particular hearing. Unlike other community members in hearings I listened to, CM3, the community member of this Review Panel, appears to

repeatedly defer to Dr. R3, the psychiatrist on the Panel. Indeed, after listening to Dr. R3's questioning of the P2, CM3 states:

CH3: Thank you Dr. R3. Do you have any questions Dr. CM3 (community member)?

CM3: I have no questions. I think Dr. R3 has given a lot of questions and I've learned a lot from what...has [been] asked. I don't need to ask anything more.

It is rare that a community member does not ask any questions of the hospital psychiatrist at the hearing.³⁹ This response indicates that CM3 regards Dr. R3 as a guide whose medical orientation is so persuasive that there is no need to ask anything further. This has the effect of slanting this Review Panel strongly in the direction of a medical orientation, where minimal evidence of temporary medical benefit to P2 is enough to outweigh any concern about her right to autonomy.

7.8(G) Dr. H2's Sarcasm as a Discursive Strategy

Another reason that P2 might not have been released from detention is that there was evidence of personal conflict between her and Dr. H2. For example, P2 maintains throughout the hearing that her previous hospitalization had been based on a misunderstanding. When Dr. H2 asks P2 to talk about this earlier hospitalization, the following exchange ensues:

Dr. H2: Last question. You said nobody has heard the whole story about your [previous] admission.

P2: No, except you did. I told you.

Dr. H2: Can you entertain us?

P2: Don't be sarcastic. I hope you're not being sarcastic Dr. H2.

³⁹ This is based on my observations from attending Review Panel hearings, listening to records of hearing, and reviewing the Panel's decisions between 2008 and 2012 inclusive.

Dr. H2: I want the panel to hear the whole story...it sounds like something you wanted to talk about.

P2: Are you talking about when I was initially incarcerated for using a metaphor?

Dr. H2's response and P2's reaction to that response is as follows:

Dr. H2: So this was another misunderstanding (speaker emphasis with an audibly ironic and sarcastic tone).

P2: Yeah, as if those don't happen. Are you being sarcastic? I sure hope not Dr. H2, because I didn't like that tone. I didn't like that tone at all. "So this is another misunderstanding (speaker emphasis imitating Dr. H2's tone)." You think I'm lying about how I ended up in the mental hospital the first time. Were you being condescending and sarcastic?

Dr. H2: No, I wasn't. I was trying to make a point.

P2: Really. If you're trying to make a point make it in an intelligent way, not by using sarcasm and condescension.

Dr. H2: I'd also like to point out that one of the symptoms [of psychiatric diagnosis]...is irritability.

P2: Oh really, really.

Dr. H2: Yes, anyway, I think we can move on.

P2: Yeah. OK. That would make you irritable. You also get irritable when people are condescending with you.

Dr. H2: I was trying to make a point.

P2: I said make a point using intelligent dialogue, not condescension and sarcasm.

This exchange between Dr. H2 and P2 raises a couple of issues. The first is that by using a rhetorical question and asking P2 to "entertain" the Panel with her account of her earlier hospitalization, Dr. H2 was belittling and discounting the seriousness of her testimony even before she began speaking. Dr. H2 was thereby attempting to exercise control over the information P2 was about to present at the hearing. In addition, the comment that her description of her first hospitalization was another mistake was indeed said in a sarcastic and condescending tone to which P2 took umbrage because it also appeared to belittle her

experience and testimony. The level of politeness seen in the exchange between P2 and each of the Review Panel members is not evident in the communication between P2 and Dr. H2. Politeness has received considerable attention in Anglo-American pragmatics, in which politeness is “seen as sets of strategies on the part of discourse participants for mitigating speech acts which are potentially threatening to their own “face” or that of their interlocutor”.⁴⁰ Critical discourse analysts such as Fairclough have also examined politeness in verbal interactions but have expanded the analysis to include considerations of the variable uses of politeness among persons with unequal power. For example, in his examination of transcripts of interviews between doctors and patients I reviewed in the preceding chapter, Fairclough notes that while the traditional doctor in one interview shows no politeness toward the patient, asking questions that are baldly embarrassing and ignoring or dismissing the patient’s own explanation, in the transcript of a doctor with an alternative medical practice focused on the patient’s life-world, the doctor displays much more politeness in his speech. In contrast, Dr. H2 appears to have little concern for P2’s life-world account of her life.

7.8(H) Prejudicial Ascriptions Concerning P1’s Responses to Dr. H2

The second issue that is relevant to this discussion is that when P2 confronts Dr. H2 about this obvious and audible sarcasm, Dr. H2 denied P2’s observation and described it as “irritability” and a symptom of the specific mental illness. This, however, was the only instance of H2’s verbal behaviour during the hearing that was angry or irritable (if it could be described as such), and it was this irritability that the majority of the Review Panel accepted as evidence of ongoing symptoms warranting continuing detention in the hospital.

⁴⁰ Norman Fairclough, *Discourse and Social Change* (Cambridge: Polity Press, 1992) at 162.

Similar to Holstein's research on how district attorneys provoke patients to engage in crazy talk during committal hearings, Dr. H2 uses audible sarcasm to provoke P2 to anger. In both types of situations, the patients' responses are interactional outcomes. Yet, like the judges in Holstein's research,⁴¹ the majority of the Review Panel specifically regards P2's confrontational speech toward Dr. H2 as the product of her sole authorship and evidence of an endogenous mental illness.

The third issue raised in this confrontation between P2 and Dr. H2 is whether gender discrimination is a factor in the way that Dr. H2 characterized "irritability" as a symptom of her diagnosis. It was primarily because of this confrontation that the Review Board affirmed the committal certificate and refused to release P2. This characterization of P2's emotionality and audacity in being confrontational may be an indication of the type of gender bias that can function in a discriminatory manner toward women, particularly when they are further stigmatized because of other factors such as race, age and socio-economic status.⁴²

⁴¹ James A. Holstein, *Court Ordered Insanity: Interpretive Practice and Involuntary Commitment* (New York: Adline De Gruyter, 1993).

⁴² I also wonder whether P2's police arrest was the result of their tacit assumption that P2's untidy apartment was significant because a woman should be a good housekeeper and that, in her case, a disorderly apartment is a sign of a disorderly mind. Would the police have been as easily inclined to conclude that the messy apartment is evidence of mental disorder if P2 had been a man? Although it is unlikely that there is a greater degree of gender bias in British Columbia than elsewhere, there is empirical evidence that women are treated differently than men in this province's mental health law system. Research has confirmed that women are more likely than men to be unsuccessful in Review Panel hearings in which they apply to be released from involuntary treatment. See: Isabel Grant, James Ogloff & Kevin Douglas, "The British Columbia Review Panel: Factors Influencing Decision-Making" (2000) (23) *Int'l J L & Psychiatry* at 191.

7.8(I) P2's Challenge to the Legitimacy of Psychiatry

Although there is no other evidence of heated exchanges between P2 and other people at her hearing, the following exchange with Dr. R3 shows her questioning the professional legitimacy of the physicians who certified her and detained her in the hospital.

Dr. R3: What I want to know is how you account for the fact that so many doctors you had seen back in the beginning and the police think you have something wrong with you, but you don't think so? How do you account for that difference?

P2: Well, sometimes you see what you want to see because of your biases. I don't know. I said I told people the truth and then it was classified as [mental illness]. I told people the truth about my life and it was classified as ideas of grandeur. I'm getting upset and they say it's irritability...

A few moments later Dr. R3 asks:

Dr. R3: You used the work "delusion", or "delusional" before. I'm just wondering if you could define that. What does it mean?

P2: What I think you guys mean or what I think?

Dr. R3: What you think the word means.

P2: It's got two meanings to it. You can be delusional about your accomplishments right. Thinking you have expertise, but you don't.

In this exchange of questions and answers with Dr. R3, P2 challenges the impartiality of hospital physicians to diagnose and treat her and in her response to Dr. R3's question concerning delusions subtly implies that the physicians who claim to have expertise are themselves delusional. With these responses, P2 is challenging the institutional preconditions of the hospital's authority and is thereby exercising an ideological form of resistance as described in Harris' research.⁴³ This is also an example of P2 engaging in

⁴³ Sandra Harris, "Defendant Resistance to Power and Control in Court" in H. Coleman, ed, *Working with Language: Multidisciplinary Consideration of Language in Work Contexts* (Berlin: Walter de Gruyter, 1989) at 131.

parrhesiastic discourse, challenging Dr. H2's expertise and therefore the fundamental basis of Dr. H2's authority to exercise any control over her life. No doubt P2 believes she is speaking the truth in a situation that poses considerable risk to her. These risks include prolonged detention in the hospital, as well as more treatment with medication she believes is inimical to her health. She will also have to deal with the stigma of having a Review Panel uphold Dr. H2's certification order. P2 explicitly invites Dr. H2 to enter into a *parrhesiastic* pact with her, admonishing Dr. H2 for sarcasm and requesting respectful dialogue that may result in recognition of her rights as well as a transformation of the institutional game of truth in the Review Panel hearing. As I indicated in section 4.6 of chapter 4, this pact requires that participants recognize relational rights that Ivison says are "immanent in the discussion" and acknowledge reciprocity in the exchange.⁴⁴ The effect of British Columbia's discriminatory mental health laws militates against respectful dialogue that patients may expect or hope for in *parrhesiastic* encounters with psychiatric power at Review Panel hearings.

Although there was an indication in the Form 4s that Dr. H2 presented at the beginning of the hearing that P2 had a mental disorder, there was no evidence presented that she had ever suffered from any type of mental illness. All of the evidence both Dr. H2 and Dr. H2's colleague adduced at the hearing was oriented toward creating a picture of P2 as a person suffering from a psychiatric illness who had no insight into her condition, who would not comply with treatment recommendations and who, without medical

⁴⁴ Michel Foucault, "Polemic, Politics, Problematizations", translated by Robert Hurley and others in James D. Faubion, ed, *The Essential Works of Michel Foucault 1954-1984, Volume 1* (New York: New York Press, 1994) at 111.

interventions, would deteriorate. These descriptions of P2 reflect the creation of what it means to be a psychiatric subject in British Columbia's mental health law system. These descriptions imply that P2 lacks depth of knowledge about herself, has an inability to use acceptable language, and therefore has diminished status as an agent capable of making autonomous treatment decisions. Being certified as someone with mental illness has had, and may continue to have, repercussions in P2's life beyond the hospital, not the least of which will be the ease with which the police can arrest and detain her in the future for behaviour others might regard as eccentric or unusual. P2's hearing demonstrates how easily the legal presumptions of incapacity can be applied to a person labelled as having a mental disorder and the way that vague references to mental deterioration can be used in discursive strategies to maintain certification orders.

7.9 Discourse Analysis of P3's and P4's Review Panel Decisions

My critical discourse analysis of P1's and P2's transcripts indicates that the outcomes for patients can vary considerably depending on the members who sit on the Review Panels and the conduct of the patient advocates. The result in P1's second hearing might have been very different if he had not had an effective legal advocate or if there had been different members on the panel on the day of the hearing, members who were more deferential to medical authorities, as seen in his first hearing and P2's hearing. However, there are common discursive strategies revolving around the terms *insight*, *compliance*, *deterioration risk* and *harm* that are present throughout the hundreds of Review Panel hearings I reviewed that took place between 2008 and 2012, as are the presumptions of incapacity found in the medico-legal language employed by many participants in those hearings. In the following two sections I examine two other Review Panel decisions,

involving P3 and P4, to illustrate further issues related to the low threshold for certifying patients in British Columbia. The following discourse analysis will concern only the Form 8 decisions the Review Panels rendered at the end of the hearings and not transcripts of the hearings themselves, which are not available.

7.9(A) P3's Review Panel Hearing

7.9(A)(i) P3's Background and Institutional Path

In this case, the patient had herself admitted to the hospital seeking help for acute psychological distress, but the hospital psychiatrists subsequently certified her and refused to grant her request to leave the hospital. P3 applied for a Review Panel hearing to decertify her so that she could go home. The Review Panel noted that the patient had been certified on the grounds that, pursuant to section 1 of the *Mental Health Act*, she had a “bipolar disorder...which seriously impacts her ability to react appropriately to other persons or the environment.”

7.9(A)(ii) Review Panel's Decision for P3

In its decision, the Review Panel expressed disappointment that the treating psychiatrist from the hospital did not attend the hearing to be questioned directly about his report. They also expressed concern that no explanation was given for the smoking and clothing restrictions that were placed on the patient. Despite those reservations, the majority of the Review Panel upheld the hospital's decision to keep the patient detained in a hospital and concluded that P3 did not have judgment at a sufficient level to qualify her as a voluntary patient and required “supervision in a designated facility to prevent her mental deterioration.”

In a separate written decision, the dissenting community member of the Review Panel commented that the patient believed that she had a mental disorder and that medication helped her. She had been stable for many years until just before she checked herself into the hospital but was contesting the hospital's order to keep her in detention. The dissenting panel member commented that the doctor at the hearing had never met with the patient and had been asked by another doctor to present the case. The notes the presenting doctor read at the hearing were vague and lacking in detail. And while the patient had been at the hospital for a couple of weeks prior to the hearing, nobody had asked her about her history.

The dissenting panel member commented that the patient, who did not have legal representation at the hearing, was quiet during the first half of the hearing, apparently declining the opportunity to cross-examine the doctor. When she had a chance to speak in the second part of the hearing she was well organized and spoke in a clear manner about the issues that troubled her. The dissenting panel member noted that the Chair stated that the doctors had to be accepted as experts, despite the questionable quality of their reports. The dissenting opinion from the community member of the Review Panel discloses how *parrhesiastic* confrontation may not only be initiated by the patient, but also by other participants in the hearing, revealing the transformative potential of this form of dialogic engagement.⁴⁵

7.9(A)(iii) Deference to Medical Authorities

The Chair's comments reveal the remarkable deference often given to the medical authorities in British Columbia to impose involuntary treatment on people diagnosed as

⁴⁵ See Stuart Murray, Dave Holmes, Amelie Perron & Genevieve Rail, "Towards an Ethics of Authentic Practice" 2008 14 *Journal of Evaluation of Clinical Practice* 682-689 for a paper exploring the importance of *parrhesiastic* practices by nurses and other non-patient participants who work within health care systems.

having mental illnesses. Although the rules of evidence are not applied as stringently in administrative tribunal hearings as they are in courts of law, there must be some evidentiary foundation for the decision of the Review Panel, which is an administrative tribunal governed by the *Administrative Tribunals Act*.⁴⁶ The hospital presenter had never met P3 and therefore could not answer questions about her from personal knowledge, and there was no clinical history given in the report. The hospital's report on P3 was so deficient that it probably would not have been accepted as a report in court or most administrative tribunal hearings. The Review Panel deferred to the hospital presenter's *presumed* expertise and, without the presence of an effective patient's advocate or skilful cross-examination from the patient herself, this expertise was not challenged.

7.9(A)(iv) Consequences for P3

The dissenting panel member's comments about the patient's conduct during the hearing strongly suggest that the patient understood her situation, which appears to problematize the majority's conclusion that she did not have a sufficient level of judgment to be a voluntary patient. Even if we accept the patient's own belief that she had a mental disorder and was helped by medication, this does not imply that she was incapable of making decisions about her life. Yet the medico-legal discourse she unsuccessfully confronted constructed her as being incapable of making treatment decisions for herself. The Review Panel concluded that P3 must remain detained in a designated facility. This is the same facility that did not question her about her clinical history, did not explain clothing and cigarette restrictions imposed on her and did not send the psychiatrist who certified her to

⁴⁶ British Columbia's *Mental Health Act*, under s 24.2, referentially incorporates s 40(1) of the *Administrative Tribunals Act*, which provides that "the tribunal may receive and accept information that it considers relevant, necessary and appropriate, whether or not the information would be admissible in a court of law."

the Review Panel hearing to answer for the hospital's conduct. As a result, she was deprived of the right to make decisions as to whether she should be live in a hospital, what types of medication she wanted to take, or the doses of medication. The situation for P3 illustrates the domination and abrogation of rights that Foucault identified in the most coercive carceral settings.

7.9(B) P4's Review Panel Hearing

7.9(B)(i) P4's Background and Institutional Path

Another Review Panel decision illustrates how perceptions concerning risks to patients can be shaped by presumptions concerning mental incapacity viewed in complete isolation from the patients' disadvantaged social condition. P4's Review Panel decision concerns a woman. It seems that after losing her housing, she ended up on the street, where she became mentally unstable. Eventually a family member took her to the hospital where she was certified. She was later released from the hospital but remained certified on extended leave and was in transitional housing until she was placed in more permanent housing. The institutional contexts of social housing and the government policies that support or curtail it were significant aspects of the institutional path that led P4 to a Review Panel hearing.

7.9(B)(ii) P4's Complaint and the Review Panel Majority Decision

P4 challenged the hospital's order under the certification order and applied for a Review Panel hearing. Her primary complaint and her purpose in contesting the committal order was that she did not agree with the psychiatric medication, which she said affected her memory, her attention, made her feel sluggish, and caused muscle pain – common side

effects of the medication.⁴⁷ P4 was described in the majority decision as having a condition that met the criterion in section 1 of the *Mental Health Act* on the grounds that she suffers from a mental illness that “seriously impairs her ability to react appropriately to the environment.” In its decision, the majority of the Review Panel stated that P4 had “no insight into her illness” and therefore upheld the continued involuntary treatment with psychiatric medication. The majority of the panel concluded that until P4’s situation was more stable, she was at risk of *deterioration*.

7.9(B)(iii) The Dissenting Opinion

In a separate written decision, the dissenting community member of the Review Panel notes that before the most recent hospitalization the patient had not been in a hospital for many years and had lived independently since that time. According to the community member, at the time of the Review Panel hearing the patient was in transitional housing, which appeared to be stable, and she would be placed in more permanent housing in a month or two. She also had the support of her daughter, whom she saw regularly. Even with the little evidence provided in the Review Panel’s decision, it is difficult to see why this patient would be described as having “no insight”, other than the fact that she disagreed with the requirement to take medication, which she successfully avoided for many years prior to her recent hospitalization.

7.9(B)(iv) Deterioration Criterion and the Consequences for P4

The majority of the Review Panel based its decision primarily on the deterioration criteria in section 22 of the *Mental Health Act*. The evidence found in this decision and so many

⁴⁷ These are medically acknowledged side effects of these types of medication.

other Review Panel hearings again shows how easy it is for the mental health law system in British Columbia to find that a person lacks insight and that without medical intervention they will experience physical or mental deterioration. The consequences of P4's Review Panel decision are that she is on a pharmaceutical treatment regime which has serious side effects and which it will be very difficult for her to discontinue. The governmentality regime will monitor her conduct through multiple decentred agencies in the community, where her "recovery" will require compliance with a neoliberal medical system, with limited social support for her beyond that.⁴⁸

This decision also highlights the importance of identifying institutional resources and pressures, particularly related to insufficient housing, that lead to stress and instability in people's lives. In these situations patients' instability and distress may itself be an *interactional* outcome between individuals and social organizations, such as governments. The remedy may not be psychiatric medication, but rather a reallocation of social resources to support people in the community.

7.10 Chapter Conclusion

There are two major features of British Columbia's mental health law system that create the lowest threshold for subjecting patients to civil commitment in Canada. The first is that the joint operation of *Mental Health Act* and *Health Care Consent Act* is such that patients can be subjected to involuntary treatment even when they have the mental capacity to withhold consent to treatment. The second is that, even on a patient's first contact with a

⁴⁸ Marina Morrow, "Recovery: Progressive Paradigm or Neoliberal Smokescreen?" in Brenda LeFrancois, Robert Menzies & Geoffrey Reaume eds, *Mad Matters: A Critical Reader in Canadian Mad Studies* (Toronto: Canadian Scholars' Press, 2013).

psychiatrist, he or she may be certified if the psychiatrist concludes that the patient is at risk of mental or physical deterioration. These features contribute to forms of medico-legal discourse revolving around the terms *insight* and *deterioration*, and ancillary terms related to *compliance*, *risk*, and *harm*. This discourse is used and reinforced on many institutional levels and reflected in the statutory forms that psychiatrists, hospital administrators, police officers, and Review Panels are required to complete. British Columbia's legislative scheme and the medico-legal discourse in this province are implicated in shaping medical practices, hospital administration, police practices and therefore patients' identities long before they arrive at Review Panel hearings.⁴⁹ Participants in *parrhesiastic* exchanges at Review Panel hearings apply and challenge this same medico-legal discourse in ways that critical discourse analysis can disclose and problematize. Patients' resistance to diagnostic labelling and involuntary treatment reveals assertions of rights not found in American and Swedish research on committal hearings in the 1980s and 1990s, as described in chapter 6.

The critical discourse analysis of the records of the patients' Review Panel hearings in this chapter reveals the recurring ways that the presumptions and thresholds in British Columbia's mental health law systems are used in discursive strategies that are prejudicial to patients in ways that likely cause significant disadvantages for them. The primary discursive strategies centre on signifiers such as insight and deterioration, which define the threshold for permitting certification. Although research on these terms related to civil committal in other jurisdictions may be helpful and suggestive, it is limited because such

⁴⁹ Indeed, as Bruce Arrigo states, certain "conceptions of civil and criminal institutionalization are uniquely encoded with a logic that *linguistically* invalidates the "defendant/committee" even before the trial or forensic hearing unfolds. If this analysis is persuasive, then it therefore follows that the "defendant/committee" (the subject-in-law) is disciplined...first and foremost through the selected and privileged discourse of clinicolegal science." Bruce Arrigo, *The Contours of Psychiatric Justice: A Postmodern Critique of Mental Illness, Criminal Insanity, and the Law* (New York: Garland Publishing Inc., 1996) at xi.

terms acquire implications and connotations in the institutional and legal matrix in which they are used.

Detailed analysis is required to capture the nuances in the use of significant terms and discursive strategies in different mental health law systems. In this chapter, critical discourse analysis reveals how legal presumptions and criteria set out in British Columbia's *Mental Health Act* and the *HCCA* functioned to the detriment of four patients in their Review Panel hearings, but also how, through *parrhesiastic* confrontation, P1's agency was both asserted and transformed in his second hearing. The critical discourse analysis in this chapter revealed recurring patterns in the use of discourse I observed in the seven hearings I attended and the 2500 decisions I reviewed from Review Panels held between 2008 and 2012. Critical discourse analysis and the interdisciplinary perspectives developed in this research can help to generate critiques of these practices in order to effect social change and revisions to mental health laws and policies in this province.

Chapter 8 Conclusion

We have yet to write the history of that other form of madness, by which men, in an act of sovereign reason confine their neighbours...To explore it we must renounce the convenience of terminal truths, and never let ourselves be guided by what we know of madness. None of the concepts of psychopathology, even and especially in the implicit process of retrospections, can play an organizing role. What is constitutive is the action that divides madness, and not the science elaborated once this division is made and calm restored.

Michel Foucault, *Madness and Civilization*

8.0 Introduction

The motivation for this dissertation research arose from my observations of the harmful ways Canadian society treats people who are labelled as mentally ill and the role that the law plays in this treatment. I have been particularly troubled by British Columbia's mental health law regime because, while it is promoted as an advanced system for the benevolent care of people in need, on the face of its legal texts it appears to be one of the most coercive and discriminatory regimes in Canada. My research has shown that this province's mental health law regime not only appears discriminatory in its written laws, but also in the prejudicial and oppressive ways it affects the lives of the people who are subjected to these laws. My goal in this research, however, was not only to expose some of the flaws in British Columbia's current mental health legislation, but also to develop ways of thinking critically about mental health law that do not simply reproduce the concepts of psychopathology, segregation and divisions that Foucault invites us to question in the above quotation, practices he calls "that other form of madness." In pursuing that goal, my interdisciplinary methodology includes historical, theoretical, normative, and empirical dimensions, most of which is inspired by Foucault's philosophy. In this chapter I

summarize my findings concerning these dimensions of my research and the way that it has built upon and extended earlier research on mental health law. I also describe the limitations of my dissertation and conclude with my thoughts on future research.

8.1 Historical Dimension

There are many sources for the current ways of understanding, speaking about and treating people thought to have mental disorder in modern society. Histories of ideas and discourses can problematize “facts” we take to be uncontroversial, acceptable or necessary by showing how they are the product of contingent linguistic and social conventions. In Chapter 2, I gave an account of some of the social and historical sources of British Columbia’s current mental health law regime. I described developments in psychiatry since the end of the nineteenth century that eventually led to the rapid growth of medication-based psychiatric treatment and forms of medical discourse in the 1960s. I acknowledge that some people may have benefited from the use of psychiatric medication. Nevertheless, trends in psychiatric thinking, particularly since the mid-twentieth century, have resulted in a remarkable increase in the number and types of mental disease categories, as well as the treatment of these alleged diseases with psychiatric medications, aggressively marketed by multi-national pharmaceutical companies. These changes occurred in tandem with legal developments in British Columbia and many other jurisdictions around the world that have resulted in the production of medico-legal discourses that have had some significant negative effects in constructing human nature and the societies in which we live.

Despite common widespread trends of amalgamating neurobiological psychiatry with mental health law regimes in many countries and provinces, each jurisdiction differs in how discourses of human rights work to curtail psychiatric discretion. This makes it particularly important to explore the history of each jurisdiction to identify the discursive, institutional, and material forces that shape the jurisdiction's medico-legal discourse and mental health law regime. I therefore provided an account of the history of mental health laws and policies in British Columbia, which, to a degree unique in Canada today, render patients' capacity to withhold consent to treatment legally irrelevant and confer significant discretionary powers on psychiatrists to detain and impose treatment on them. Although there is considerable literature on aspects of the history of British Columbia's mental health law system, I have contributed to this research by providing details concerning the alignment of neurobiological thinking with law reform in British Columbia, particularly since the 1990s, and the effect of neo-liberal health policies on the recent and current status of British Columbia mental health system. The history I gave in Chapter 2 discloses some of the sources of the problematic nature of British Columbia's mental health laws that is reflected in, among other things, the growing concern among legal scholars that these laws, on their face, violate sections 7 and 15 of the *Charter*, as well as the *United Nations Convention of the Rights of Persons with Disabilities*.

The importance of the historical dimension of the research is that it exposes troubling features in the emergence of British Columbia's mental health laws, particularly since the 1990s when legislation was amended to increase physicians' discretion to impose treatment on patients according to assumptions of neurobiological psychiatry. An examination of these features can be used to problematize the current legal regime. This examination

provides an important element in a critique of these regimes and therefore forms part of the basis for making recommendations to change them.

It is possible, however, that systems of law in their textual form can appear discriminatory and harmful, while in practice people simply ignore them or manipulate them in a benevolent manner. Therefore, while historical accounts are valuable for showing the sources of mental health law systems, a critical theoretical perspective is required for understanding *how* systems of power and knowledge operate and whether they function in a harmful manner. A theoretical perspective suitable for this project is exemplified in the work of Michel Foucault.

8.2 Theoretical Dimension

In Chapter 3, I provided an interdisciplinary theoretical framework for understanding mental health law inspired by Foucault's later philosophy. I showed how, in his later writings, Foucault offers a vision of human nature that is contrary to the notion that he removed the human subject as an active agent in social and historical events. Instead, Foucault expresses a view in which human agents are shaped by power relations in society, but also have a role in constituting themselves through self-reflection and resistance. This is a theory of relational agency that Foucault conveys through his work on governmentality and the ethics of care of the self. Foucault's theory of governmentality in advanced liberal societies, such as British Columbia's, views government activity not as emanating from a central source of authority, but rather through regimes of power, in which governments exercise influence on human subjects through techniques and regulations embodied in de-

centred agencies such as mental health clinics and professional practices, both of which are informed by codes of conduct.

Foucault observes that in modern neo-liberal societies the primary purpose of government regulation is security and the minimization of risk that arises from social behaviour that is not under constant surveillance. Hence risk management becomes one of the central concerns related to security, around which these regulations are deployed. These regulations played significant roles in shaping the forms of deinstitutionalization and the community psychiatric treatment of those diagnosed as having mental disorders. Nevertheless, human agents, including psychiatric patients, involved in social activity shaped by governmentality are not passive but, through reflection and resistance, actively change the social institutions through which power is deployed. According to Foucault, human freedom has meaning only in the context of relations of power and resistance and therefore he advances a view of relational agency that has political, legal, and moral aspects.

The importance of the theoretical dimension of this research project is that it exposes how power operates in society through disciplinary activities that shape the law. The Foucauldian philosophical analysis is a particularly productive way of understanding law because it displaces the notion that the power of law simply is located juridically in the courts, in legal texts, or in the state apparatus. This analysis of law and Foucault's conception of relational agency are vital components in a normative critique of British Columbia's mental health law regime.

8.3 Normative Dimension

In Chapter 4, I explored further the normative dimensions of Foucault's later philosophy beginning with his work on the genealogy of Western law and later in his writings on *parrhesia*. Foucault's genealogies of Western law are not merely descriptive exercises; they also express a normative vision of human nature rooted in a conception of freedom. This is not a liberal view of the freedom of human subjects conceived as existing independently of social and historical contexts. Rather it is a form of freedom that exists in relational discursive activities between human agents and the communities in which they live, in which reflection upon and change in norms is an ongoing activity. Foucault's view is that power itself will produce persons who, by problematizing existing power relations, can challenge the workings of power, and thereby effect social change. His thoughts on *parrhesia* provide a way of understanding the relationship between people's self-understanding and their challenges, through risky, truthful, and confrontational speech, to the legitimacy of authoritative institutions in modern society, such as law and medicine. Just as human agents participate in creating a self from critical ethical reflection, so too is the legitimacy of social authority, including the authority of legal institutions, challenged, altered and endorsed through *parrhesiastic* exchanges.

Foucault's writings on Western law disclose how many legal concepts are based on a conception of sovereignty, first embodied in royal prerogative, then later in juridical legal forms. Although assumptions about sovereignty and the juridical understandings about power continue to shape the way law describes itself, including most human rights discourse, this does not necessarily describe the way the law *operates* in disciplinary societies. The operations of law can be demonstrated by exposing the *effects* of the

disciplines, such as medicine and education, through which normalization functions in modern societies and the way it is enforced through legal regulation.

As I described in Chapter 2, psychiatric disciplinary activities contributed to changes in British Columbia's mental health legislation, which expressed revisions to laws in juridical forms, such as the segregation of and the imposition of treatment on people thought to be mentally disordered. Mental health legislation that incorporates liberal human rights discourse also shows how juridical forms are used in an apparent attempt to place limits on disciplinary activity. The history of mental health legislation in various jurisdictions discloses the different ways that juridical forms of laws are joined with disciplinary practices. For instance, in some jurisdictions such as Ontario, patient consent is supposed to form the basis for treatment decisions while in others, such as British Columbia, discretion on the part of psychiatrists determines treatment.

Foucault's philosophy offers ways of understanding the relationship between the juridical forms of mental health laws and psychiatric treatment in Canadian Society. Moreover, as I explored in Chapter 4, his later writings provide a philosophically coherent way of talking about human rights. The risk in using the language of rights is that, historically, this language has been aligned with the liberal philosophical tradition that was the subject of much of Foucault's criticism. Foucault's concept of rights, however, is not so aligned. In contrast to liberal philosophy, Foucault's relational conception of human agency forms the basis for relational conceptions of human rights and law. In Chapter 5 I use these conceptions of relational rights and law as a way to assess the importance of *Charter* decisions in Canada in order to advance political, legal and moral claims for the

enhancement of rights for people diagnosed as having mental disorder and affected by mental health laws, concluding that *Charter* rights can be applied relationally for the benefit of these people.

One of the most important contributions from Foucault's philosophy is the idea that the legitimacy of authority is not an essential quality inhering in government entities or organizations and, in contrast to Kantian liberal theory, is not based on an unchanging and universal quality of human reason. Rather, the legitimacy of the authority of any mental health law system arises from the dialogic exchanges among patients, physicians, and legal agencies. Rights and obligations, which emerge from open and informed relations between people, will change and adapt to historical and cultural contexts. The importance of these types of relations highlights the fundamental normative role of informed consensual discourse in political, legal, and moral activity. Depriving people of the right to consent or withhold consent to informed health care decisions, as British Columbia's *Mental Health Act* does in a discriminatory manner, is politically, legally, and morally unacceptable. Any reform to British Columbia's mental health law system, therefore, must be based on a comprehensive recognition of the right to informed consent in all of its laws, including civil committal procedures, guardianship and patient property legislation, and the right of patients to have competent advocates advise them of their rights and help them to express their wishes in complex legal settings.

8.4 Empirical Dimension

For the analysis of the empirical component of my dissertation research, I adopted a critical discourse analysis methodology that identifies social problems and shows how they are

created by the operations of institutional power in social discourse. My methodology combines elements of Foucault's philosophy with Fairclough's discourse analysis methodology, and with key features of conversation analysis. The critical discourse analysis methodology I developed addresses limitations with earlier quantitative, qualitative and ethno-methodological research on civil commitment I described in Chapters 1 and 6. This earlier research is already two or three decades old and concerns many patients who had spent long periods of time in psychiatric hospitals. Since that time, the social changes caused by deinstitutionalization in Western industrial countries have taken root and have changed the identities of patients, most of whom were released from long-term care in asylums many years ago or have never stayed in this type of an institution. Some of the problems associated with deinstitutionalization may be more apparent for patients today than they were two or three decades ago, at an earlier stage of deinstitutionalization. Furthermore, the uncertainty and contestability of contemporary community psychiatry might mean that psychiatric patients, almost all of whom live in the community, are more inclined to question psychiatric diagnoses and treatment plans than patients were in the past. Almost all of the Review Panel decisions I read between 2008 and 2012 involved patients who had spent very little time in hospitals until they were detained under certification orders. Many of them were then released back into the community on extended leave orders. The transcripts I analyzed in Chapter 7 all involved patients who lived in the community and arrived at psychiatric wards of community hospitals along various institutional paths. Many of these patients confront and challenge psychiatric discourse in ways not seen in the earlier research. The critical discourse

analysis I applied to transcripts of confrontational testimony at hearings was particularly effective in revealing the nature and extent of these types of challenges.

Another limitation in the quantitative and qualitative research I cite in chapters 2 and 6 is that it does not describe in detail the way that the law influences psychiatric practices and therefore patients' identities long before they are certified or appear at civil commitment hearings. In contrast, my research addresses the way that law constructs discourse and institutional activity in mental health care. To quote Clive Unsworth again, "Law actually constitutes the mental health system, in the sense that it authoritatively constructs, empowers and regulates the relationships between the agents who perform mental health functions."¹ This observation has important implications for empirical research on medico-legal discourse in mental health law systems and should be used as a background assumption when exploring how patients challenge this system. The critical discourse analysis methodology I used allows me to expose how the mental health system in British Columbia "constructs, empowers and regulates the relationships between agents," while also revealing forms of resistance in patients' speech activity and how the human agency of all participants must be understood in relational terms. Patients' resistance to medico-legal discourse occurs in what Foucault calls "games of truth"², which I described in Chapter 7. Fairclough's and Thornborrow's methodologies for conducting critical discourse analysis shows how institutional contexts both restrain and provide opportunities for resistance for the participants in these games of truth.

¹ Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford: Clarendon Press, 1987) at 5.

² Michel Foucault, "The Ethics of the Concern for Self as a Practice of Freedom" in Robert Hurley, ed, *Ethics, Subjectivity and Truth* (New York: New Press, 1997) at 297.

Consistent with Foucault's views on relational agency, when doing critical discourse analysis I sought examples of the way that medico-legal concepts are defined in contested discursive confrontations between authorities, such as psychiatrists or Review Panels, and patients who resist their psychiatrists' ascriptions of mental disorder to them. The critical discourse analysis methodology I applied to transcripts of Review Panel hearings allows me to demonstrate how medico-legal claims are defined, reinforced and contested through *parrhesiastic* confrontations between psychiatrists, Review Panel members and patients. The analysis exposes the operation of British Columbia's mental health law regime in using medico-legal discourse centred on ascriptions of mental disorder and deterioration, as well as legal presumptions of patients' incapacity to make treatment decisions. My analysis shows how these forms of discourse, based on assumptions of neurobiological psychiatry, shape the identities of patients as medico-legal subjects and how these people use their own strategies to resist and negotiate their way through an institutional path that leads to detention, certification and their legal challenges to their civil commitment.

My critical discourse analysis of the transcripts of the people who had Review Panel hearings, described in Chapter 7, demonstrates how psychiatrists applied the legal tests in British Columbia's *Mental Health Act* to impose involuntary medical treatment on people in a discriminatory manner. The analysis of transcripts discloses, in detailed conversational exchanges, that the civil commitment criteria operate on presumptions that patients are incapable of making treatment decisions for themselves. In Chapter 7 I provided numerous examples of discursive exchanges to illustrate how psychiatrists frequently use the deterioration criterion found in section 22(1)(c) as an easy justification for certification, even when there is no evidence that the patients are likely to harm themselves or others,

and even in the face of evidence that they are mentally capable of making treatment decisions for themselves. Analysis of the transcripts reveals how difficult it is for patients to overcome presumptions regarding mental incapacity that are constantly reinforced through multiple discursive strategies in British Columbia's medico-legal system. Nevertheless, despite the strong influence that medico-legal institutions and discourse have in shaping the lives and identities of the patients, the transcripts reveal how patients asserted their agency through *parrhesiastic* confrontation: risky speech in which they questioned the legitimacy of institutional authorities that were attempting to define their identities and to restrict their freedom.

The importance of the empirical dimension of this research project is not only that it exposes the detailed workings of British Columbia's mental health law regime, but it also reveals human rights abuses in psychiatric practices in concrete detail. In particular, my critical discourse analysis of the data helps to explain how the *HCCA* and the *Mental Health Act* function in a discriminatory manner and structure medico-legal discourse in prejudicial and harmful ways for patients. The empirical dimension of the project, therefore, provides an essential component for making recommendations to change the law based on assertions of human rights violations.

8.5 Limitations and Future Direction for Research

There were limitations in my research related to the small number of transcripts I used; the restriction of the methodology to qualitative data without detailed quantitative statistical analysis; and the lack of data about what patients think about the legal processes in which they were enmeshed. I examine each of these limitations in turn.

My selection of Review Panel transcripts and decisions was based on my review of more than 2500 decisions and my attendance at seven hearings between 2008 and 2012. With this background experience, I chose three transcripts and two further Review Panel decisions that I believe exhibited patterns of evidence I observed over those years and depict mechanisms that support, reinforce, and sometimes challenge the existing mental health law regime. Due to time constraints, the sample size of transcripts and decisions for my empirical research was limited and small. Future research should include a larger variety of transcripts and decisions to investigate more thoroughly the workings of power and the nature of discrimination in British Columbia's mental health law system. This larger sample size could include, for example, a variety of people who are historically the victims of prejudicial treatment, such as racial minorities and elderly people, to assess whether they are subject to any special discrimination in the mental health law system. The presence of more women subjects in the research is important, particularly because researchers using statistical methodologies have found significant, though unexplained, differences in the way Review Panels treat women.³ My critical discourse analysis of the transcript of one woman revealed some suggestive patterns of gendered prejudicial presumptions about women, but I cannot say whether this was anything more than an isolated incident or anything less than a generalized sexist practice.

A greater variety of transcripts could also include samples of patients who are represented by legal advocates and those who are not. All of the transcripts I used in my research involved patients who had advocates at the hearings. The prejudicial effects of the British

³ See Isabel Grant, James Ogloff & Kevin Douglas, "The British Columbia Review Panel: Factors Influencing Decision-Making" (2000) (23) *Int'l J L & Psychiatry* at 191.

Columbia's mental health law might be even more pronounced at hearings when patients do not have advocates. Statistical research shows a consistent pattern of more favourable outcomes for patients who are assisted by advocates compared to those who do not have this assistance. Critical discourse analysis of hearings in which patients do not have advocates might help support arguments for the urgent need for legal aid funding for advocates, as well as providing examples of what is or is not effective advocacy in such hearings.

Although I used a qualitative research methodology in this dissertation, my conclusions on the prejudicial effects of the current certification process on patients could be supplemented with statistical research to show outcomes for populations of patients. Despite the limitations with the British Columbia statistical research from the 1980s and 1990s, it raised important questions about outcomes for patients who were released from detention by Review Panels as compared to those who were later released by their psychiatrists. This type of research should now be updated in view of the changes to the legislation that include the deterioration criterion in section 22(1)(c) of the *Mental Health Act* and changes in the demographics of the patient population in past three decades. Issues that could be addressed include questions of whether patients released from detention by Review Panels are at less risk of rehospitalisation compared to patients released by psychiatrists or who remain on extended leave orders with compulsory medications programs.

Another limitation in my research is that, although there are data about patients speaking at Review Panel hearings, there are no further data about what patients themselves think about the legal processes, the way they were treated at the hearings, the performance of

their advocates, or how they view the outcomes of the hearings. Further research could include these patient perspectives, which would add a layer of depth to the qualitative data. Certainly any comprehensive set of recommendations for changing British Columbia's mental health laws would need to include these patient perspectives.

8.6 Closing Reflections

When doing research for this dissertation I spent years meeting and speaking with many people who work in or are affected by British Columbia's mental health care system. These people include patients, psychiatrists, Review Panel members, social workers, lawyers, judges, patient advocates, and university professors. Many of these people acknowledge that comprehensive changes are urgently required for British Columbia's mental health law system and give anecdotal accounts of the harmful effects of this system. Indeed, a working paper for comprehensive changes to this province's adult guardianship laws was drafted in the early 1990s,⁴ and further proposals for changing these laws were made more recently in *Bill 29, The Adult Guardianship and Planning Statutes Amendment Act, 2007*. Unfortunately, these proposals for change, limited though they are, have never been instituted or proclaimed into law. More recently, scholars across Canada have published commentaries suggesting that British Columbia's mental health laws related to civil commitment are contrary to the *Charter* and the *United Nations Convention of the Rights of Persons with Disabilities*.

Despite the value of anecdotal accounts of harms caused by British Columbia's mental health laws, working papers for law reform, and scholars opining that the laws in this

⁴ Robert Gordon, "Out to Pasture: A Case for the Retirement of Canadian Mental Health Legislation" in Jill Peay, ed, *Seminal Issues in Mental Health Law* (Aldershot, 2005) at 37.

province violate human rights, research is required to show *how* this system operates and its *impact* on people. Allegations that British Columbia's mental health laws are discriminatory must be supported by admissible evidence, which is required to support recommendations for change. My research has provided examples of this evidence to support these claims and has offered suggestions for research to supplement it.

Effective mental health law reform further requires sensitivity to evidence of patients' situations as well as an adequate theoretical approach to human rights. In this dissertation I have offered an interdisciplinary theoretical framework, inspired Foucault's philosophy, for understanding relational agency and law that avoids the problems associated with traditional liberal rights discourse, while at the same time providing a basis for making political, legal and moral claims regarding human rights. Referring again to Foucault's quotation at the beginning of this chapter, the other form of madness our society must avoid is based on non-relational thinking that results in an impoverished sense of community in which we isolate, confine, and oppress some of our neighbours. The evidence and relational philosophical view I have presented in this dissertation offer a way out of this other form of madness.

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Appendices

Appendix A Form 4 of the *Mental Health Act Regulations*

FORM 4
MENTAL HEALTH ACT
[Sections 22, 28, 29 and 42,
R.S.B.C. 1996, c. 288]

MEDICAL CERTIFICATE
(INVOLUNTARY ADMISSION)

I, _____, M.D., certify that I examined
physician's name (please print)

_____ on _____ .
first and last name of person examined (please print) *dd / mm / yyyy*

In summary form, the reasons for my opinion are: (information may be obtained through interviews, observations and collateral sources)

1. In my opinion, this person:
 - has a disorder of the mind that requires treatment and which seriously impairs the person's ability to react appropriately to his/her environment or to associate with others (section 1 of the *Mental Health Act*);
2. In my opinion, this person:
 - (a) requires treatment in or through a designated facility; and
 - (b) requires care, supervision and control in or through a designated facility to prevent his/her substantial mental or physical deterioration or for the protection of the person or for the protection of others; and
 - (c) cannot suitably be admitted as a voluntary patient.

This person was was not
brought to me by a police officer or
constable under section 28 of the Act.

Note: if above space is insufficient, continue on back of form

Signed _____
physician's signature _____
date of signature (dd / mm / yyyy)

_____ _____
physician's address (please print) *telephone*

Note: This medical certificate, when duly signed, is authority for anyone to apprehend the person who is the subject of this certificate and to transport the person to a designated facility for admission and detention for a 48 hour period. If a second medical certificate is completed within that period, it provides authority to detain the person for one month from the date of admission under the first certificate.

If this is a first medical certificate, it becomes invalid on the 15th day after the date upon which the physician examined the person who is the subject of the certificate unless the person has been admitted on the basis of it.

Appendix B Form 6 of the *Mental Health Act Regulations*

FORM 6
MENTAL HEALTH ACT
 [Section 24, R.S.B.C. 1996, c. 288]

**MEDICAL REPORT ON EXAMINATION OF INVOLUNTARY PATIENT
 (RENEWAL CERTIFICATE)**

I, _____, M.D., being a physician and the
name of physician (please print)
 director of, **or** a physician authorized by the director of, _____
name of designated facility

certify that on _____ I examined _____
dd / mm / yyyy *first and last name of patient (please print)*

who on _____ was admitted as an involuntary patient to _____
dd / mm / yyyy *name of designated facility*

On the basis of my examination, and having taken into consideration the requirements of section 24 (2.1)* of the *Mental Health Act*, I have formed the opinion that: (1) sections 22 (3) (a) (ii) and (c)** of the Act continue to describe the condition of the patient; and (2) that this patient's status as an involuntary patient should be renewed.

The patient's status as an involuntary patient is renewed for a period of up to _____
number of month(s)

The patient must be examined again on or before _____, the date on which this renewal
dd / mm / yyyy

expires. The reasons that lead me to form the above opinion are:

Note: if above space is insufficient, continue on back of form

signature of physician _____
dd / mm / yyyy

Notes:

* Section 24 (2.1) requires that the physician's examination must include:

- (a) consideration of all reasonably available evidence concerning the patient's history of mental disorder including (i) hospitalization for treatment, and (ii) compliance with treatment plans following hospitalization, and
- (b) an assessment of whether there is significant risk that the patient, if discharged, will as a result of mental disorder fail to follow the treatment plan the director or physician considers necessary to minimize the possibility that the patient will again be detained under section 22.

** Section 22 (3) of the Act states the following involuntary admission criteria:

The patient is a person with a mental disorder who (i) requires treatment in or through a designated facility, (ii) requires care, supervision and control in or through a designated facility to prevent the patient's substantial mental or physical deterioration or for the protection of the patient or the protection of others, and (iii) cannot suitably be admitted as a voluntary patient.

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Appendix C Form 7 of the *Mental Health Act Regulations*

FORM 7
MENTAL HEALTH ACT
 [Section 25, R.S.B.C. 1996, c. 288]

APPLICATION FOR REVIEW PANEL HEARING

The information on this form is collected pursuant to section 25 of the *Mental Health Act*. It will be used to document and initiate your application for a review panel hearing. Any questions you have about this form may be addressed to the director or staff of this facility.

To the director of _____
name of designated facility

I, _____, request a hearing by a review panel, in the case of:
first and last name of applicant (please print)

_____, _____
first and last name of patient (please print) ward / unit

signature of applicant

date of signature (dd / mm / yyyy)

organization (if representing an organization when making the application)

relationship to patient

address of organization

Appendix D Form 8 of the *Mental Health Act Regulations*

FORM 8
MENTAL HEALTH ACT
 [Section 25, R.S.B.C. 1996, c. 288]

REVIEW PANEL DETERMINATION

I, _____, chair of the review panel, certify that the
chair's name (please print)

review panel has reviewed the case of _____
first and last name of patient (please print)

who was admitted to _____ on _____
name of designated facility *date (dd / mm / yyyy)*

*and whose status as an involuntary patient was last renewed effective _____
**Complete only if applicable* *date (dd / mm / yyyy)*

signature of chair *date (dd / mm / yyyy)*

We, the members, or a majority of the members, of the review panel, have determined that the patient named above

should continue to be detained in or through a designated facility because section 22 (3) (a) (ii) and (c) of the Act continues to describe the condition of the patient.

OR

should be discharged.

Our reasons are:

Note: If above space is insufficient, continue on back of form

Dated _____
dd / mm / yyyy

The panel, or a majority of the panel:

signature of panel member *name of panel member (please print)*

signature of panel member *name of panel member (please print)*

signature of panel member *name of panel member (please print)*