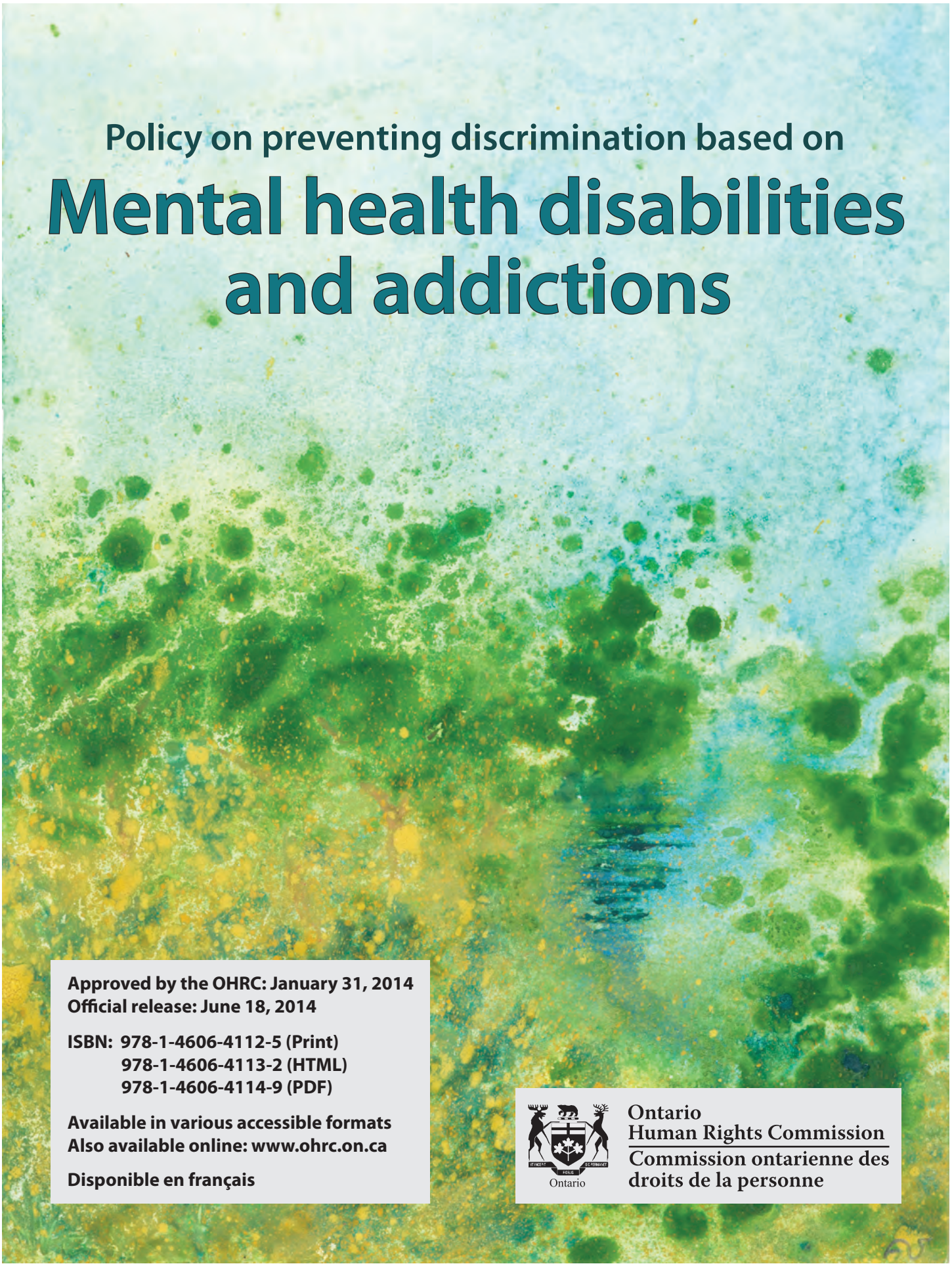

Policy on preventing discrimination based on

Mental health disabilities and addictions

Approved by the OHRC: January 31, 2014
Official release: June 18, 2014

ISBN: 978-1-4606-4112-5 (Print)
978-1-4606-4113-2 (HTML)
978-1-4606-4114-9 (PDF)

Available in various accessible formats
Also available online: www.ohrc.on.ca

Disponible en français

Ontario
Human Rights Commission
Commission ontarienne des droits de la personne

About the policy cover

The cover of this policy and related materials incorporate the watercolour painting *Arcadia I*, 2012 by A. Jay, a member of Workman Arts.

Introducing A. Jay

A. Jay is a Toronto-based artist, primarily working in paint. He is an active member of Workman Arts, and has participated in exhibitions across Toronto. He has an upcoming show in the CAMH Client Library from April 25 – July 31, 2014. He attended the Toronto School of the Arts and has taken art courses through the Toronto District School Board.

A. Jay artist statement

I am pleased to say that the New Year has brought with it a period of productivity. Painting is my preferred mode of expression and I actively seek out bucolic scenes to paint. While I have participated in workshops, studios and classroom activities, I remain largely self-taught. That is, I am still becoming more comfortable with various ways of mark-making. So I hope to make a bigger splash. If this seems senseless, know that when words fail pictures remain, and that reality is what you paint. A.

About Workman Arts

This art and mental health company is known internationally for its artistic collaborations, presentations, knowledge exchange, best practices, and research in the area of the impact of the arts on the quality of life of people living with mental illness and addictions.

Workman Arts (WA) facilitates aspiring, emerging and established artists with mental illness and addiction issues to develop and refine their art form through its arts training programs, public performance/exhibit opportunities and partnership with other art organizations. As well, WA promotes a greater public understanding of mental illness and addictions through creating, presenting and discussing artistic media.

Cover artwork © A. Jay, *Arcadia I*, 2012

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Executive summary

People with mental health disabilities or addictions have faced considerable and longstanding discrimination, stigmatization and social exclusion in Canada and across the world. In recognition of this, the Supreme Court of Canada has said:

> There is no question but that the mentally ill in our society have suffered from historical disadvantage, have been negatively stereotyped and are generally subject to social prejudice.[1]

Despite the prevalence of negative attitudes, prejudice, stereotyping, ignorance and misunderstanding about people with psychosocial disabilities,[2] the reality is that many people have a mental health or addiction disability, or will develop one at some point in their lives. Research estimates that almost one in five Canadian adults will experience a mental illness or addiction.[3]

Because of the extreme stigma[4] around certain types of mental health disabilities and addictions, many people may be afraid to disclose their disability to others. They may worry about being labelled, experiencing negative attitudes from others, losing their jobs or housing, or experiencing unequal treatment in services after disclosing a mental health issue or addiction. Fear of discrimination can also result in people not seeking support for a mental health issue or addiction.

A person's experience may be complicated further when discrimination based on a mental health disability or addiction intersects with discrimination based on other *Code* grounds, such as race, sex, sexual orientation, age or another type of disability, *etc*. People with psychosocial disabilities are also more likely to have low incomes than people without psychosocial disabilities, and many people live in chronic poverty.

The Ontario *Human Rights Code* (the *Code*) protects people in Ontario with mental health disabilities and addictions from discrimination and harassment under the ground of "disability." This protection extends to five "social areas."

- When **receiving goods, services and using facilities**. "Services" is a broad category and can include privately or publicly owned or operated services including insurance, schools, restaurants, policing, health care, shopping malls, *etc*.
- In **housing**, including private rental housing, co-operative housing, social housing and supportive or assisted housing.
- When entering into **contracts** with others, including the offer, acceptance, price or even rejection of a contract.
- In **employment**. Employment includes full-time and part-time work, volunteer work, student internships, special employment programs, probationary employment, and temporary or contract work.
- When joining or belonging to a **union, professional association or other vocational association**. This applies to membership in trade unions and self-governing professions, including the terms and conditions of membership, *etc.*

People with mental health issues and addictions are a diverse group, and experience disability, impairment and societal barriers in many different ways. Disabilities are often "invisible" and episodic, with people sometimes experiencing periods of wellness and periods of disability. All people with disabilities have the same rights to equal opportunities under the *Code*, whether their disabilities are visible or not.

Organizations and institutions operating in Ontario have a legal duty to take steps to prevent and respond to breaches of the *Code*. Employers, housing providers, service providers and other responsible parties must make sure they maintain accessible, inclusive, discrimination and harassment-free environments that respect human rights.

The Ontario Human Rights Commission (OHRC) is an independent statutory body whose mission is to promote, protect and advance human rights across the province as set out in the *Code*. To do this, the OHRC identifies and monitors systemic human rights trends, develops policies, provides public education, does research, conducts public interest inquiries, and uses its legal powers to pursue human rights remedies that are in the public interest.

The OHRC's policies reflect its interpretation of the *Code,* and set out standards, guidelines and best practice examples for how individuals, service providers, housing providers, employers and others should act to ensure equality for all Ontarians. The OHRC's *Policy on preventing discrimination based on mental health disabilities and addictions* provides practical guidance on the legal rights and responsibilities set out in the *Code* as they relate to mental health and addiction issues. In particular, the policy addresses:

- people's rights under the *Code*, particularly at work, in rental housing, and when receiving services
- the right to be free from reprisal ("payback") for exercising one's rights under the *Code*
- different forms of discrimination (*e.g.* profiling based on mental health, harassment, poisoned environment, systemic discrimination)
- the principles of accommodation (respect for dignity, individualization, integration and full participation)
- how the duty to accommodate applies to people with mental health or addiction disabilities
- duties and responsibilities in the accommodation process (*e.g.* the duty to inquire about accommodation needs, medical information to be provided, confidentiality, treatment)
- the considerations in assessing whether the test for undue hardship has been met (costs, outside sources of funding, health and safety considerations)
- other possible limits on the duty to accommodate
- how to balance the right of someone with a mental health issue or addiction to be free from discrimination where this may conflict with the rights of others
- people's rights to be free from discrimination within programs that are targeted to people with psychosocial disabilities

- how consent and capacity issues may relate to people's rights under the *Code*
- organizations' responsibilities to prevent and eliminate discrimination, and how they can create environments that are inclusive and free from discrimination.

The ultimate responsibility for maintaining an environment free from discrimination and harassment rests with employers, housing providers, service providers and other responsible parties covered by the *Code*. It is not acceptable to choose to stay unaware of discrimination or harassment of a person with a mental health disability or addiction, whether or not a human rights claim has been made.

The OHRC's *Policy on preventing discrimination based on mental health disabilities and addictions* is intended to provide clear, user-friendly guidance on how to assess, handle and resolve human rights matters related to mental health and/or addictions. All of society benefits when people with mental health or addiction disabilities are given equal opportunity to take part at all levels.

1. Introduction

From 2009 to 2011, the Ontario Human Rights Commission (OHRC) consulted on its mental health strategy with over 1,500 concerned individuals and groups, including approximately 1,000 people with mental health issues or addictions, as well as employers, service providers, housing providers, advocates, families and others. What the OHRC heard during this process can be found in *Minds that Matter: Report on the consultation on human rights, mental health and addictions.*[5] The OHRC relied extensively on this invaluable input when developing this policy.

People with mental health disabilities or addictions have faced considerable and long-standing discrimination, stigmatization and social exclusion in Canada and across the world. People with disabilities such as depression, bipolar disorder, schizophrenia, and alcohol and drug addiction often face ignorance, fear and a lack of understanding. This stigmatization has been widely recognized in research, public policy, and by human rights decision-makers. For example, the Supreme Court of Canada has said:

> There is no question but that the mentally ill in our society have suffered from historical disadvantage, have been negatively stereotyped and are generally subject to social prejudice.[6]

The stigma of mental health and addiction disabilities is prevalent in Canadian society. A public opinion poll conducted by the Canadian Medical Association indicated that one in four Canadians (27%) said they would be afraid to be around someone with a serious mental illness.[7] Research shows that the experience of being stigmatized affects people with mental health disabilities in several ways. For example, they may have concerns about being seen unfavourably or as incompetent, and they may avoid disclosing their disability.[8]

Despite the prevalence of negative attitudes, prejudice, stereotyping, ignorance and misunderstanding about people with psychosocial disabilities,[9] the reality is that many people have a mental health or addiction disability, or will develop one at some point in their lives. Research estimates that almost one in five Canadian adults will experience a mental illness or addiction.[10]

For many people, these disabilities are episodic, which means they may fluctuate and include periods and degrees of wellness and disability.[11] These periods of wellness and impairment may be unpredictable. They may be temporary or longer term over the course of a lifetime. Many mental health disabilities or addictions are described as “invisible” or “hidden” because they may not be obvious to others. They may exist on a spectrum from mild to severe. People with severe disabilities may experience a great degree of impairment, and society may create many barriers to full participation, compared to other people with less severe disabilities.

To understand the current context of discrimination, prejudice and exclusion that people with psychosocial disabilities experience, it is important to look at Canada’s past. Many of the barriers that exist in laws, policies, practices and attitudes today are a continuation of those from the distant and recent past. These tended to frame people with mental

health or addiction disabilities as less human or worthy than other people, or in paternalistic ways as people needing others to make decisions for them.[12] These attitudes are grounded in a belief system called "ableism," or attitudes in society that devalue and limit the potential of persons with disabilities.[13] Canada's history of negative attitudes towards and treatment of people with psychosocial disabilities may explain to some extent how our modern society finds itself so ill-equipped to deal with many of the issues that these communities continue to face.[14]

The Ontario *Human Rights Code* (the *Code*) protects people with mental health disabilities and addictions from discrimination and harassment under the ground of "disability." The *Code* makes it public policy in Ontario to recognize the inherent dignity and worth of every person and to provide for equal rights and opportunities without discrimination.

The Preamble to the *Code* emphasizes the importance of creating a climate of understanding and mutual respect for the dignity and worth of each person, so that each person can contribute fully to the development and well-being of the community.

Despite having a medical diagnosis of mental illness, people may not consider themselves "unhealthy" or "disabled." They may nevertheless experience discrimination based on disability. Even mental health disabilities that may be experienced as "minor" with no permanent manifestation could be entitled to protection under human rights legislation.[15] No matter the nature of the disability, all people with mental health or addiction disabilities have the same rights to be free from discrimination under the *Code.*

The human rights principles of dignity and autonomy, individualization, respect for differences and full participation are fundamental to advancing the rights of people with psychosocial disabilities. Dignity and respect are ultimately linked to self-determination – people's ability to have basic control over their lives. In its mental health consultation, the OHRC heard that the loss of self-determination, autonomy and dignity because of discrimination based on a psychosocial disability has a deep and significant impact on people's lives, and can prevent them from fully taking part in the life of the province.

2. Purpose of this policy

The OHRC's previous work on disability has addressed discrimination against persons with mental disabilities and/or addictions. The OHRC's *Policy and guidelines on disability and the duty to accommodate* (*Disability Policy*)[16] recognizes that people with mental disabilities face a high degree of stigmatization and significant barriers to employment opportunities. The present policy builds on the principles of the *Disability Policy* and other OHRC policies, and applies the same principles to scenarios involving people with mental health issues and/or addictions.[17]

Participants in the OHRC's mental health consultation described how people with psychosocial disabilities face many barriers that prevent equal opportunity and equitable treatment in rental housing, employment, and many different types of services. The OHRC heard that practical guidance is needed to help people with psychosocial disabilities understand their rights, and to help organizations understand how to meet their responsibilities under the *Code* to respect these rights.

Based on this input, this policy was developed to provide more information to individuals, employers, housing providers, service providers, government and others to address:

- people's rights under the *Code* at work, in rental housing, and when receiving services
- how the duty to accommodate applies to people with mental health or addiction disabilities
- how to balance the right of someone with a mental health issue or addiction to be free from discrimination where this may conflict with the rights of others
- people's rights to be free from discrimination within programs that are targeted to people with psychosocial disabilities
- how consent and capacity issues may relate to people's rights under the *Code*
- organizations' responsibilities to prevent and eliminate discrimination, and how they can create environments that are inclusive and free from discrimination.

The OHRC chose to focus on mental health and addictions as a subset of disability because of the unique issues that people from these groups face. For example, people often face specific stereotypes based on perceptions that they pose a risk and that they are responsible for their disabilities.[18] People are subject to unique laws that may restrict their rights and freedoms if they experience difficulty with decision-making ability or they are deemed to require psychiatric institutionalization. People with psychosocial disabilities are disproportionately represented among people with low incomes.[19] Because of these and other factors, people may experience particular social disadvantage and significant barriers in housing, employment and services.

At the same time, the information in this policy may apply to discrimination based on other types of disabilities (including learning disabilities, cognitive disabilities, intellectual disabilities and sensory disabilities). It can also be useful where these disabilities and other *Code* grounds (such as sex, race and gender identity) overlap with mental health disabilities or addictions.[20]

Section 30 of the *Code* authorizes the OHRC to prepare, approve and publish human rights policies to provide guidance on interpreting provisions of the *Code*. The OHRC's policies and guidelines set standards for how individuals, employers, service providers and policy-makers should act to ensure compliance with the *Code*. They are important because they represent the OHRC's interpretation of the *Code* at the time of publication.[21] Also, they advance a progressive understanding of the rights set out in the *Code.*

Section 45.5 of the *Code* states that the Human Rights Tribunal of Ontario (HRTO) may consider policies approved by the OHRC in a human rights proceeding before the HRTO. Where a party or an intervenor in a proceeding requests it, the HRTO *shall* consider an OHRC policy. Where an OHRC policy is relevant to the subject-matter of a human rights application, parties and intervenors are encouraged to bring the policy to the HRTO's attention for consideration.

Section 45.6 of the *Code* states that if a final decision or order of the HRTO is not consistent with an OHRC policy, in a case where the OHRC was either a party or an intervenor, the OHRC may apply to the HRTO to have the HRTO state a case to the Divisional Court to address this inconsistency.

OHRC policies are subject to decisions of the Superior Courts interpreting the *Code*. OHRC policies have been given great deference by the courts and the HRTO,[22] applied to the facts of the case before the court or the HRTO, and quoted in the decisions of these bodies.[23]

3. A note about terminology

There are inherent challenges in finding ways to best describe people. Because of the diversity of approaches to defining a mental health issue or an addiction, people may identify in many different ways. Terms that define groups and individuals with disabilities evolve as a result of the social and political climate and what is considered appropriate. Terms to describe people with mental health issues or addictions can reflect underlying negative views and stereotypes, and continued inequality, or they can promote acceptance, inclusion and human rights.

During its mental health consultation, the OHRC heard that any terms used to describe people with psychosocial disabilities should:

- reflect domestic and international human rights protections for people with disabilities
- be the ones used by the consumer/survivor movement
- reflect a social versus medical approach to disability
- reflect health (instead of emphasizing impairment)
- appeal to people who may or may not seek treatment.

As such, where it is necessary to identify individuals, allowing people to self-identify is always a preferred approach. When describing people, consider referring to the person before the disability. Avoid terms that are clearly considered inappropriate, and if an individual objects to a term, it should not be used. Some terms generally considered appropriate from a human rights perspective include:

- psychiatric disability
- mental health disability
- mental disability[24]
- consumer/survivor[25]

- mental health issue
- psychosocial disability (to refer to both mental health issues and addictions)
- substance abuse
- substance dependence
- addiction or addiction disability.

This policy will refer to people using these terms.

4. Recognizing mental health disabilities and addictions

4.1 Mental health disability

Defining disability is a complex, evolving matter.[26] Section 10(1) of the *Code* provides a broad definition of disability, which covers mental health disabilities under subsection (b) a "condition of mental impairment" and (d) "mental disorder." Past and perceived disabilities are also protected. The *Code* does not list all the conditions that could be considered a disability. It is a principle of human rights law that the *Code* be given a broad, purposive and contextual interpretation to advance the goal of eliminating discrimination. Because of this, the OHRC takes an expansive and flexible approach to defining psychiatric disabilities and addictions that are protected by the *Code*.

It is not possible or appropriate to provide an exhaustive list of mental health or addiction disabilities in this policy. Many impairments have been recognized as disabilities under the *Code*, including anxiety, panic attacks, depression, schizophrenia, alcohol dependence, and addictions to illegal drugs. Human rights law is constantly developing, and certain conditions, characteristics or experiences that are disputed as disabilities today may come to be commonly accepted due to changes in the law reflecting medical, social or ideological advancements.

The United Nations' *Convention on the Rights of Persons with Disabilities* (*CRPD*) recognizes that "disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others."[27] The definition includes, but is not limited to, people who have "mental impairments."[28]

This approach, often called the "social approach" to disability, is also reflected in Supreme Court of Canada decisions. In a landmark human rights case, the Court used an equality-based framework of disability that took into account evolving biomedical, social and technological developments, and emphasized human dignity, respect and the right to equality. The Court made it clear that disability must be interpreted to include its

subjective component, as discrimination may be based as much on perceptions, myths and stereotypes, as on the existence of actual functional limitations. The Court said:

> …[A] "handicap" may be the result of a physical limitation, an ailment, a social construct, a perceived limitation, or a combination of all these factors. Indeed, it is the combined effect of all these circumstances that determines whether the individual has a "handicap" for the purposes of the *Charter.*[29]

The focus should be on the effects of the distinction, preference or exclusion experienced by the person and not on proof of physical limitations or mental health status, the presence of an ailment, or the cause or origin of the disability.

Disabilities may be temporary, sporadic or permanent.[30] In many cases, they may not be visible to the average onlooker. People's experience of disability may result from bodily or mental impairments, or from limitations arising from impairments that affect people's ability to function in certain areas of living. From a functional or medical perspective, for example, mental health disabilities or addictions may be characterized by "alterations in thinking, mood or behaviour – or some combination thereof – associated with significant distress and impaired functioning."[31] However, people may not experience any limitations even when they have a medical diagnosis or experience impairment.[32]

Disabilities are also socially constructed.[33] Attitudes of society and its members often contribute to the idea or perception of a mental health or addiction disability; people may be treated as having a disability due to whatever impairment or limitation is perceived to exist. Some disabilities may actually result from the barriers that exist in society, such as attitudinal barriers like stigma or stereotypes, or the social, economic or cultural disadvantages resulting from discrimination and exclusion.[34]

> **Example:** A human rights tribunal found that a person with multiple physical disabilities was discriminated against when she was denied a first floor apartment that would have accommodated her. Her physical disability prevented her from cleaning and maintaining her apartment. Her landlord assumed that this was due to mental health issues and that the building was not appropriate for her because of her physical and perceived mental health issues. He thought that she should instead live in a long-term care home. The Human Rights Tribunal of Ontario (HRTO) rejected this assumption and said that the landlord imposed a "socially constructed" disability on her.[35]

A psychiatric or addiction disability may also be the result of combinations of impairments and environmental barriers, such as attitudinal barriers, inaccessible information, inaccessible communication or other barriers that affect people's full participation in society.

> **Example:** A person with a severe mental health issue who was homeless applied for supportive housing and went for an assessment. The application form was very technical and long. Due to factors relating to his disability and social situation, he didn't understand and couldn't answer the many questions. Because of this, the housing provider denied the housing, instead of offering to help him answer the questions. In this case, barriers in communication and lack of accommodation contributed to his experience of disability.

Human rights decision-makers and organizations should consider how people with mental health issues or addictions subjectively define their own experiences and related needs, as part of understanding someone's disability for the purposes of the *Code*.[36] At the same time, when determining if someone has had their rights violated under the *Code*, a human rights decision-maker may find it reasonable for an employer, service or housing provider to seek out some objective information about the person's disability or related needs. This could include information about their disability and limitations from a third party, such as a medical professional.

4.2 Addiction

Drug and alcohol addictions are disabilities under the *Code.*[37] There is often significant cross-over between addictions and mental health issues, with many people experiencing both.[38] People with addiction disabilities have the same right to be free from discrimination as other people under the *Code*.

People with addictions may face unique experiences of marginalization and disadvantage. These may be due to extreme stigma, lack of societal understanding, stereotyping and criminalization of their addictions – for example, where these involve illegal substances. The Ontario Appeal Court has endorsed the view that:

> Addiction is a disability that carries with it great social stigma and that this stigmatization is compounded where an addicted person is also part of another stigmatized group, such as those on social assistance.[39]

From a medical perspective, an addiction may be defined as:

> A primary, chronic disease, characterized by impaired control over the use of a psychoactive substance and/or behaviour. Clinically, the manifestations occur along biological, psychological, sociological and spiritual dimensions. Common features are change in mood, relief from negative emotions, provision of pleasure, pre-occupation with the use of substance(s) or ritualistic behaviour(s); and continued use of the substance(s) and/or engagement in behaviour(s) despite adverse physical, psychological and/or social consequences. Like other chronic diseases, it can be progressive, relapsing and fatal.[40]

Alcohol or drug addictions are well-recognized as disabilities within the meaning of human rights legislation.[41] Casual (or recreational) use of substances is not defined as a disability unless people are treated adversely because they are perceived to have addictions, or be "substance abusers."[42]

Some addictive behaviours are disputed as to whether they are "disabilities" protected by human rights law, or there is very little case law about them (for example, nicotine addiction/dependence, and problem or pathological gambling[43]). Disputes appear to be based on whether people can voluntarily overcome their addiction, and whether the person is subjected to stereotyping or is part of a group suffering disadvantage in society.[44] There is also debate about how best to accommodate certain addictions, particularly if engaging in the addiction causes a risk of harm to the person or to others.[45]

5. Ableism, negative attitudes, stereotypes and stigma

An "ableist" belief system often underlies negative attitudes, stereotypes and stigma toward people with psychosocial disabilities. "Ableism" refers to attitudes in society that devalue and limit the potential of persons with disabilities. Ableism is

> …analogous to racism, sexism or ageism, [and] sees persons with disabilities as being less worthy of respect and consideration, less able to contribute and participate, or of less inherent value than others. Ableism may be conscious or unconscious, and may be embedded in institutions, systems or the broader culture of a society. It can limit the opportunities of persons with disabilities and reduce their inclusion in the life of their communities.[46]

Discrimination against people with mental health or addiction issues is often linked to prejudicial attitudes,[47] negative stereotyping,[48] and the overall stigma[49] surrounding mental health and addictions. All of these concepts are interrelated. For example, stereotyping, prejudice and stigma can lead to discrimination. The stigma surrounding mental health and addictions can also be an effect of discrimination, ignorance, stereotyping and prejudice.

Where stigma, negative attitudes and stereotyping result in discrimination, they will contravene the *Code.* Organizations and individuals have a legal obligation under the *Code* to not discriminate against people with mental health or addiction issues, and to eliminate discrimination when it happens. These obligations apply in situations where discrimination is direct and the result of a person's internal stereotypes or prejudices. They also apply when discrimination is indirect and may exist within and across institutions because of laws, policies and unconscious practices.

Stigma, negative attitudes and stereotypes can lead to inaccurate assessments of people's personal characteristics. They may also lead institutions to develop policies, procedures and decision-making practices that exclude or marginalize people with mental health disabilities and addictions.

> **Example:** In one case, a human rights tribunal recognized that a decision not to investigate an alleged crime could be discriminatory if based on a belief that the allegation was "unfounded because it resulted from an assessment of the person's psychiatric condition rather than a genuine incident."[50]

> **Example:** In one case, a female bartender developed an anxiety disorder and began to experience panic attacks after she was seriously assaulted by two customers. Her employer accommodated her by allowing her to be absent when she was too ill to work. Then the complainant got a new manager who became impatient with her absences. A tribunal found that the manager discriminated against her when he reduced her shifts and made comments about her medical condition in front of others, including saying that she was "messed up" in her head, "needed drugs" and looked "pretty unstable."[51]

There are a number of prevalent stereotypes about people with mental health disabilities and addictions. For example, people with mental health disabilities are often characterized as being violent.

> **Example:** A man with a mental disability lived in a trailer park with his mother. The disability resulted in some "peculiar" but "harmless" behaviour. The owner began to be frightened of the man because of his perceived mental disability, and eventually warned other tenants to protect themselves and not provoke him. Otherwise harmless actions began to be interpreted as threatening. For example, the owner received a letter from the tenant asking her to repair a potential gas leak, and instead of investigating, she viewed him as "crazy" and dangerous, believing he might blow up his trailer. Eventually, he and his mother were evicted. A human rights tribunal concluded that there was "no reliable evidence" that the claimant posed a threat. The respondent sought the tenant's eviction because of her perceptions and misconceptions about his mental disability, and based on unfounded and stereotypical views, she concluded the tenant was a threat to the safety of herself and other residents. This was found to be discriminatory.[52]

Stereotypes related to violence persist even though studies show that most people with mental health disabilities are no more likely to engage in violent behaviour than the general population.[53] In fact, research shows that people with serious mental illnesses are more likely to be victims of violence themselves, than other members of the general population.[54]

People with mental health issues may also be perceived to lack the capacity to make decisions in their own best interests, even where this may not be the case. They are often seen as "childlike" and in need of help.[55] These perceptions may result in paternalistic attitudes and practices that can create barriers.

Certain types of disabilities are more stigmatized than others due to the stereotypes associated with them. People with schizophrenia or drug addictions may experience particularly negative attitudes from others based on beliefs about dangerousness, anti-social behaviour or risk. People with addictions may also experience particularly negative behaviour because of assumptions about how much they are personally responsible for their disability, and assumptions about their involvement with crime.[56]

Because of the extreme stigma around certain types of mental health disabilities and addictions, many people may be afraid to disclose their disability to others. They may worry about being labelled, experiencing negative attitudes from others, losing their jobs or housing, or experiencing unequal treatment in services after disclosing a mental health issue or addiction. Fear of discrimination can also result in people not seeking support for a mental health issue or addiction.[57]

Negative attitudes, stereotyping and stigma can also lead to harassment towards people with psychosocial disabilities in the form of negative comments, social isolation and unwanted conduct (including mental health profiling) from employers, landlords, co-workers or service providers. The Law Commission of Ontario's consultation on disability showed how negative attitudes and stereotypes can lead to actions that further marginalize people with mental health disabilities:

> [M]any persons with mental health disabilities, particularly those who have been homeless, shared experiences which demonstrated that they had been subject to heavy judgment and negative assumptions when dealing with legal systems. Lack of supportive services for persons with mental health disabilities, together with stigma and fear about these disabilities may lead to increased contact with police and may contribute to the criminalization of persons with mental health disabilities, an issue of great concern to many participants.[58]

Organizations must take steps to address negative attitudes, stereotypes and stigma and to make sure they do not lead to discriminatory behaviour toward or treatment of people with psychosocial disabilities.

6. Legal framework

6.1 Ontario *Human Rights Code*

6.1.1 Protections

Under the *Code*, people with mental health disabilities and addictions are protected from discrimination and harassment based on disability in five "social areas":

- When receiving goods, services and using facilities (section 1). "Services" is a broad category and can include privately or publicly owned or operated services such as insurance, schools, restaurants, policing, health care, shopping malls, *etc*. Harassment based on a mental health or addiction disability is a form of discrimination, and is therefore also prohibited in services.[59]
- In housing (section 2). This includes private rental housing, co-operative housing, social housing and supportive or assisted housing.
- When entering into a contract with others. This includes the offer, acceptance, price or even rejecting a contract (section 3)
- In employment (section 5). Employment includes full-time and part-time work, volunteer work, student internships, special employment programs, probationary employment,[60] and temporary or contract work.
- When joining or belonging to a union, professional association or other vocational association. This applies to membership in trade unions and self-governing professions, including the terms and conditions of membership, *etc.* (section 6).

It is well-established that people with mental health disabilities are entitled to the same level of protection as people with physical disabilities. To this end, the Ontario Court of Appeal said:

> Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, than that of competent persons suffering from physical ailments.[61]

In one case, the Supreme Court of Canada struck down an insurance plan for employees with disabilities that limited benefits for mental disabilities to a lower level than for physical disabilities.[62]

Section 9 of the *Code* prohibits both direct and indirect discrimination. Section 11 states that discrimination includes constructive or adverse effect discrimination, in which a requirement, policy, standard, qualification, rule or factor that appears neutral has the effect of excluding or disadvantaging a group protected under the *Code*.[63]

People with mental health issues or addictions are also covered by the *Code* under section 8 if they experience reprisal or are threatened with reprisal for trying to exercise their human rights.[64]

People are also protected from discrimination based on their association with someone with a mental health disability or addiction (Section 12). This could apply to friends, family or others – for example, someone advocating on behalf of someone with an addiction issue or mental health disability.[65]

A fundamental aspect of the *Code* is that it has primacy over all other provincial laws in Ontario, unless the law specifically states that it operates notwithstanding the *Code*. This means that where a law conflicts with the *Code*, the *Code* will prevail, unless the law says otherwise (section 47).

6.1.2 Defences and exceptions

The *Code* includes specific defences and exceptions that allow behaviour that would otherwise be discriminatory. An organization that wishes to rely on these defences and exceptions must show it meets all of the requirements of the relevant section.

Where discrimination results from requirements, qualifications or factors that may appear neutral, but that have an adverse effect on people identified by *Code* grounds, section 11 allows the person or organization responsible to show that the requirement, qualification or factor is reasonable and *bona fide.* They must also show that the needs of the person or group affected cannot be accommodated without undue hardship.

Section 14 of the *Code* protects "special programs" that are designed to address the historical disadvantage experienced by people identified by the *Code*. As a result, it is likely not discriminatory to implement programs designed specifically to assist people with psychosocial disabilities, as long as an organization can show that the program is:

- designed to relieve hardship or economic disadvantage
- designed to help the disadvantaged group to achieve or try to achieve equal opportunity, or
- likely to help eliminate discrimination.[66]

Section 17 sets out the duty to accommodate people with disabilities. It is not discriminatory to refuse a service, housing or a job because the person is incapable of fulfilling the essential requirements. However, a person will only be considered incapable if their disability-related needs cannot be accommodated without undue hardship.[67]

Under section 18 of the *Code*, organizations such as charities, schools, social clubs, sororities or fraternities that want to limit their right of membership and involvement to people with psychosocial disabilities can do this on the condition that they serve mostly people from this group.

> **Example:** Students at a university set up a club that provides social, networking and education opportunities for students with disabilities who experience severe anxiety and depression. They restrict their membership to people of this group under section 18 of the *Code*.

Section 24 states that a religious, philanthropic, educational, fraternal or social institution or organization that mostly serves the interests of people identified by certain *Code* grounds can give hiring preference to people from that group, as long as the qualification is reasonable and legitimate (*bona fide*), given the nature of the employment.

> **Example:** A community mental health organization hires peer support workers to help their clients navigate the mental health system. A core requirement of the job is for employees to have experienced a mental health disability.

6.2 *Charter of Rights and Freedoms*

The Canadian *Charter of Rights and Freedoms* guarantees people's civil, political and equality rights in the policies, practices and legislation of all levels of government. Certain rights may particularly apply to people with psychosocial disabilities in certain circumstances, due to legislation and policies that focus on these groups. Human rights legislation in Canada is subject to and must be considered in light of the *Charter*.[68]

Under section 7 of the *Charter*, all people have the right to life, liberty and security of the person.[69] Section 9 protects people against being detained or imprisoned arbitrarily, or with no good reason, and section 10 outlines a person's rights upon arrest or detention. These rights must be respected by organizations that carry out government policies, like police or hospitals, that may seek to detain people with mental health disabilities.[70]

Section 15 guarantees the right to equal protection under the law and equal benefit of the law, without discrimination based on mental or physical disability, among other grounds. This equality rights guarantee is similar to the purpose of the *Code*. Governments must not infringe *Charter* rights unless violations can be justified under section 1, which considers whether the *Charter* violation is reasonable in the circumstances.

6.3 *Accessibility for Ontarians with Disabilities Act*

The *Accessibility for Ontarians with Disabilities Act, 2005* (*AODA*)[71] addresses the right to equal opportunity and inclusion for people with disabilities, including mental health disabilities. The *AODA*'s goal is to make Ontario fully accessible by 2025. It introduces a series of standards (customer service, transportation, built environment, employment and information and communications) that public and private organizations must implement within certain timelines.

The *AODA* is an important piece of legislation for improving accessibility in the lives of people with disabilities. It complements the Ontario *Human Rights Code*, which has primacy over the *AODA*. The development and implementation of standards under the *AODA* must have regard for the *Code*, related human rights principles and case law, including issues faced by people with psychosocial disabilities.[72] Compliance with the *AODA* does not necessarily mean compliance with the *Code*. Responsible organizations must follow both.

6.4 Convention on the Rights of Persons with Disabilities

In 2010, Canada ratified the United Nations' *Convention on the Rights of Persons with Disabilities*, (*CRPD*), an international treaty designed to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity."[73]

The *CRPD* moves away from considering people with disabilities as recipients of charity towards being holders of rights. It emphasizes non-discrimination, legal equality and inclusion. Countries that have ratified or signed their acceptance to the *CRPD* are known as "States Parties."

International treaties and conventions are not part of Canadian law unless they have become part of legislation.[74] However, the Supreme Court of Canada has stated that international law helps give meaning and context to Canadian law. The Court said that domestic law (which includes the *Code* and the *Charter*) should be interpreted to be consistent with Canada's international commitments.[75] The *CRPD* is an important human rights tool that puts positive obligations on Canada to make sure that people with disabilities have equal opportunity in all areas of life. To meet the obligations under the *CRPD,* Canada and Ontario should make sure that adequate and appropriate community supports and accommodations are in place to allow for equal opportunities for people with disabilities, and should evaluate legislation, standards, programs and practices to make sure rights are respected.

All of the articles in the *CRPD* are relevant to the lives of people with psychosocial disabilities, but some apply particularly to the issues raised in the consultation. These include rights to:

- equality and non-discrimination (Article 5)
- accessibility (Article 9)
- equal recognition before the law (Article 12)
- liberty and security of the person (Article 14)
- live independently and be included in the community (Article 19)
- health, habilitation and rehabilitation (Articles 25 and 26)
- an adequate standard of living and social protection (Article 28).

Canada has not signed the Optional Protocol of the *CRPD*, which means that people cannot complain directly to the UN Committee on the Rights of Persons with Disabilities. However, there are reporting requirements for the *CRPD*. The Canadian Association of Statutory Human Rights Agencies (CASHRA) has called on all levels of government to fulfill their obligations. This includes consulting and involving persons with disabilities and representative organizations to monitor the *CRPD*'s implementation, identifying initiatives and developing plans to show how they will address *CRPD* rights and obligations.

7. Intersecting grounds

Discrimination may be unique or distinct when it occurs based on two or more *Code* grounds. Such discrimination can be said to be "intersectional." The concept of intersectional discrimination recognizes that people's lives involve multiple interrelated identities, and that marginalization and exclusion based on *Code* grounds may exist because of how these identities intersect.

The *CRPD* recognizes the "the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status."[76] It also recognizes that "women and girls with disabilities are often at greater risk, both within and outside the home of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation."[77]

People with a psychosocial disability who also identify with other *Code* grounds may be distinctly disadvantaged when they attempt to access housing, employment or services. Particular stereotypes may arise based on the intersections between these identities that place people at significant disadvantage.

> **Example:** In the OHRC's mental health consultation, it heard that young African-Canadian men with a mental health issue will experience specific barriers renting housing based on intersecting stereotypes that relate to sex, age, race and disability.

Discrimination based on a mental health disability or addiction could intersect with discrimination based on other *Code* grounds, including:

- race, colour or ethnic background
- creed
- ancestry (including Aboriginal ancestry)
- citizenship (including refugee or permanent resident status)
- gender identity and gender expression[78]
- sex (including pregnancy)
- family status
- marital status (including people with a same sex partner)
- disability, including physical, learning, cognitive and intellectual disabilities
- sexual orientation
- age
- receipt of public assistance (in housing)
- record of offences (in employment).

> **Example:** Women who are survivors of violence, trauma and/or abuse often face substance use and mental health issues. Some women with mental health issues may also experience disproportionate rates of gender-based abuse, harassment and violence, because of their increased vulnerability.

Stereotypes or treatment based on a person's socio-economic status may intersect with discrimination based on psychosocial disabilities. A person's experience with low income may be highly relevant to understanding the impact of discrimination on someone with a psychosocial disability or addiction, and this may result in specific experiences of discrimination.[79]

As part of the duty to maintain environments that are free from discrimination and harassment, service providers (*e.g.* health care professionals, police services, legal services), employers and housing providers must take steps to design their programs, policies and environments inclusively, to take into account the needs of people from diverse backgrounds, with a range of unique identities.

> **Example:** A supportive housing program for people with mental health disabilities makes sure that all of its units are accessible to people who also have physical disabilities, and a portion of its units are suitable for family living.

Organizations that provide services to the public should make sure their staff members have cultural competency skills.[80] The ability to interact comfortably with people from diverse cultural backgrounds may be key to recognizing and meeting the human rights-related needs of different populations, including people with mental health disabilities or addictions.

> **Example:** A police service trains its officers on de-escalation techniques to use when dealing with people who are in crisis, sometimes due to mental health issues. Part of this instruction includes sensitivity training to raise awareness about the negative associations and fearful reactions that many immigrants may have to police officers in uniform, particularly people who have come from countries governed by authoritarian regimes.

> **Example:** A hospital emergency department makes sure they have a roster of language interpreters available by telephone to provide efficient service to people whose first language is not English, and who may require attention related to a mental health disability.

When interacting with people, organizations should use an individualized approach that recognizes the unique identity of each person, and not rely on preconceived notions, assumptions or stereotypes.

8. Poverty, mental health and addiction

People with psychosocial disabilities are more likely to have low incomes than people without psychosocial disabilities, and many people live in chronic poverty. In the OHRC's mental health consultation, as well as in its housing policy consultation, it heard a great deal about the links between mental health, addictions and societal factors such as poverty, homelessness, lower levels of education, inadequate levels of public assistance and other social supports, and a lack of affordable housing. For example, many people who have psychosocial disabilities receive public assistance. Receiving public assistance may be inherently linked to experiencing a psychosocial disability; people who can only work intermittently due to disability-related factors may seek public assistance, such as Ontario Disability Support Program (ODSP) benefits, for additional income support.

Poverty has significant impacts on people with psychosocial disabilities, including on their personal dignity, ability to care for their families, their physical and mental health, and their ability to be fully included in their communities. At the most extreme end, poverty and a lack of affordable housing in Canada have created a crisis where people are left homeless. People with mental health issues and addictions experience high rates of homelessness.[81] Legal decision makers have recognized that people who are homeless are among the most vulnerable in society and often have mental health issues or addictions,[82] and have considered evidence that shows the impact of homelessness on physical and mental health.[83]

There are concerns that in Ontario, economic inequalities are increasing, leaving people from different *Code*-protected communities more vulnerable to discrimination and exclusion.[84] Because of factors associated with poverty and low income, people with psychosocial disabilities may be more likely to experience barriers to accessing housing, employment and services than people without psychosocial disabilities.

People receive only narrow protection under the *Code* for low socio-economic status. The *Code* protects people from discrimination and harassment in housing if they receive some form of public assistance, such as benefits from the Ontario Disability Support Program, Ontario Works, Canada Pension Plan, Old Age Security, Employment Insurance and the Ontario Student Assistance Program. As well, if people experience disadvantage because they are homeless or have low incomes, and this is linked to having a mental health issue or addiction, this could engage the protection of the *Code.*[85]

People with psychosocial disabilities may find themselves "marked" as having both low income and a disability if they receive ODSP benefits. In rental housing, they may face intrusive questions about their source of income or their disability, or stereotyping about being an unreliable tenant, because they receive social assistance and have a mental health issue or addiction.

> **Example:** A human rights tribunal found that a mobile home campsite refused repeatedly to rent to a person who received a disability pension and had psychiatric disabilities. The tribunal found that the campsite owner perceived incorrectly that the tenant was entirely dependent on his mother, despite reliable evidence to the contrary, and perceived he was not capable of paying his rent or addressing maintenance issues. The respondent was also concerned about the tenant's membership in Alcoholics Anonymous. Overall, the tribunal found that both the tenant's disability and his source of income were "inextricably linked" and both formed the reason why the campsite owner did not approve his rental application.[86]

Programs, policies and practices that negatively affect people based on low income will often disadvantage people with psychosocial disabilities.[87] Governments and organizations must make sure they remove barriers that result in people associated with *Code* grounds being denied equal access to services, housing or employment.

Not taking into account a person's actual circumstances related to receiving public assistance and his or her ability to meet the organization's rules or conditions has been found to be discriminatory.[88] When assessing the impact of seemingly neutral rules on people with psychosocial disabilities who have low incomes, organizations should take into account the real impact that these have on a person's experience. Where these rules or standards have an adverse impact, the duty to accommodate may apply.[89]

> **Example:** A service provider has an initial assessment process that takes place only by telephone. It recognizes that this has negative impact on people with low incomes, including people with psychosocial disabilities, because many people from this group do not own a telephone, and have difficulty accessing one. The organization changes the process to allow for in-person assessments as well.

> **Example:** An organization that oversees provincial elections works closely with a community mental health organization to ensure that people with mental health disabilities who are homeless can vote. People in this situation face barriers when voting because they may not have the required proof of identity and residence. The elections organization registers eligible mental health organizations to provide people with certificates that can be used at the poll as proof of identity and residence, enabling them to vote without additional identity documents.[90]

Showing cases of discrimination where neutral rules or policies negatively affect people based on low socio-economic status and disability may be supported by a systemic analysis. This may involve:

- showing evidence that people from the *Code*-protected group tend to be over-represented in the affected low-income population
- examining the impact of policies, practices, decision-making processes and organizational culture on people from this group, and
- establishing a link between the discriminatory actions being alleged and the disadvantaging impact on particular people from that *Code*-protected group.[91]

Governments at all levels in Canada must have regard for international treaties, such as the United Nations' *Covenant on Economic, Social and Cultural Rights*, and the *Convention on the Rights of Persons with Disabilities*. These human rights treaties recognize the interdependent nature of rights between adequate income, housing, education, work and equality. The *CRPD* recognizes, in particular, that people with disabilities tend to live in poverty. Article 28 outlines the right to an adequate standard of living and social protection, including food, clothing and housing, without discrimination because of disability. This includes people who have mental disabilities.

By ratifying these international treaties, Canada has made commitments to uphold and protect people's economic and social rights, including ensuring that people with mental health issues or addictions have an adequate standard of living, access to food security, and a right to housing. However, the United Nations has repeatedly expressed significant concern about Canada's record in implementing social and economic rights[92] and the failure of Canadian courts to provide remedies for violations of social and economic rights. The reluctance of courts and lawmakers to address social and economic issues as rights has real consequences for vulnerable groups, including people with psychosocial disabilities.

Even though the *Code* does not offer full protection against discrimination based on poverty, the OHRC and others have been successful in pursuing human rights complaints where low socio-economic status intersects with grounds such as disability, race, ethnic origin, citizenship, age and family status.[93] The main way that the OHRC has done this has been to show that a relationship exists between social and economic marginalization and a *Code* ground such as disability. Governments, policy-makers and organizations should make sure their programs, policies and practices do not have an adverse impact on people protected by *Code* grounds.

9. Establishing discrimination

The *Code* does not provide a definition of discrimination. Instead, the understanding of discrimination has evolved from case law. To establish *prima facie* discrimination (discrimination on its face) under the *Code*, a claimant must show that:

1) they have a characteristic protected from discrimination
2) they have experienced an adverse impact within a social area protected by the *Code*, and
3) the protected characteristic was a factor in the adverse impact.[94]

The claimant must show that discrimination occurred on a "balance of probabilities," that is, it is more reasonable and probable than not that discrimination took place. Once a *prima facie* case has been established, the burden shifts to the respondent to justify the conduct within the framework of the exemptions available under the *Code* (*e.g. bona fide* requirement defence). If it cannot be justified, discrimination will be found to have occurred.

As stated earlier, discrimination does not have to be intentional. Intent is irrelevant for establishing that discrimination occurred.

Discrimination is often hard to detect. Direct evidence pointing to discriminatory motives may not be available. Human rights decision-makers have recognized that cases may be shown through an analysis of all relevant factors, including evidence that is circumstantial. As well, human rights case law has established that a *Code* ground need only be one factor, of possibly several, in the decision or treatment for there to be a finding of discrimination.[95]

The analysis of whether substantive discrimination has taken place should be flexible and look at the full context of the impact of the distinction on the affected individual or group. The contextual factors and relevant considerations may vary slightly based on the type of discrimination claimed (direct, adverse effect, systemic, profiling, *etc.*), or the ground alleged. However, the legal test and threshold for discrimination do not change.

It is not necessary for language or comments related to a psychosocial disability to be present in the interactions between the parties to show that discrimination has occurred. However, where such comments have been made, they can be further evidence that the psychosocial disability was a factor in the person's treatment.

10. Forms of discrimination

Discrimination may take many different forms. For example, it may take place in a direct way. It can happen when individuals or organizations specifically exclude people in rental housing, employment or services, withhold benefits that are available to others, or impose extra burdens that are not imposed on others, without a legitimate or *bona fide* reason. This discrimination is often based on negative attitudes, stereotypes and bias about people with mental health or addiction disabilities.

Discrimination may also happen indirectly. It may be carried out through another person or organization. For example, an agent of a landlord may "indirectly" discriminate against people who she perceives to have psychosocial disabilities, because the landlord has told her to screen out anyone who has a disability. The organization or person that sets out discriminatory conditions, and the organization or person that carries out this discrimination, can both be named in a human rights claim and held responsible.

Discrimination is often subtle. It may be unlikely that discriminatory remarks will be made directly, or that someone will freely voice their stereotypical views as a rationale for their behaviour. Subtle forms of discrimination can usually only be detected after looking at all of the circumstances to determine if a pattern of behaviour exists. Individual acts themselves may be ambiguous or explained away, but when viewed as

part of a larger picture, may lead to an inference that discrimination based on a *Code* ground was a factor in the treatment a person received. An inexplicable departure from usual practices may establish a claim of discrimination.[96] Criteria that are applied to some people but not others may be evidence of discrimination, if it can be shown that people and groups identified by the *Code* are being singled out for different treatment.[97]

Sometimes seemingly neutral rules, standards, policies, practices or requirements have an "adverse effect" on people who have psychosocial disabilities.

> **Example:** A housing co-operative sought to evict a member because she did not perform volunteer duties (which were expected of all members), despite her doctor's note saying she could not do so for medical reasons. The co-op also sought further details of her medical condition which she refused to provide, and this also formed the basis for the eviction. The co-op's rule regarding volunteer service had an adverse effect on the complainant because of her mental disability. The Court found that the co-op had a duty to accommodate to the point of undue hardship before evicting. If the complainant could not do any of the volunteer activities for "valid medical reasons," the Court said that exempting her from this requirement would be unlikely to create undue hardship.[98]

Many laws, requirements or standards are put in place without considering the unique needs or circumstances of people with psychosocial disabilities. Organizations have a responsibility to understand where these may have a discriminatory effect, and to remove this effect where it occurs.

10.1 Profiling based on mental health

Mental health profiling may be defined as any action undertaken for reasons of safety, security or public protection that relies on stereotypes about a person's mental health or addiction rather than on reasonable grounds, to single out a person for greater scrutiny or different treatment.

> **Example:** Security staff at a hospital are routinely called to be present if a person's file reveals a mental health diagnosis, regardless of the person's behaviour.[99]

Mental health profiling is different from criminal profiling. Criminal profiling relies on actual behaviour or on information about suspected criminal activity by someone who meets the description of a specific individual.

"Profiling" as a human rights concept arises from the experiences of people from racialized communities and Aboriginal people who have been subjected to racial profiling. There is a wealth of jurisprudence establishing the phenomenon of racial profiling.[100] Although profiling based on mental health may look different, it can be just as damaging and alienating.

Profiling is based on preconceived ideas about a person's character. People with perceived or known mental health or addiction issues are commonly stereotyped as a risk to public security and safety even when there may be little objective evidence to support this perception.[101] Profiling based on mental health could happen in many different situations (for example, when receiving services, such as policing, education, in shops and restaurants,[102] and when accessing government, community and other services).

In the case of racial profiling, courts have accepted the widespread existence of racism. For example, in the case of anti-Black racism, they have accepted that pervasive negative societal views about Black men may wrongly connect Black men and acts of violence. This may lead to behaviour being unconsciously influenced by stereotypes, and overreactions to conduct where Black people are perceived as threatening, even where there is no real risk.[103]

It is the OHRC's view that longstanding and pervasive stereotypes can similarly influence actions against people with known or perceived mental health issues or addictions. Organizations and individuals must assess risk based on a person's individual circumstances, using objective evidence or criteria, and not on blanket assumptions or speculation based on a person's diagnosis or perceived mental health issue.

There may be situations where people with mental health issues or addictions engage in behaviour that is associated with their disability, which is not a risk to public safety, but is seen to be "different," unusual, or defies conventional norms. Because of this, they may be perceived to be a risk to public security and responded to in a disproportionate way.[104] It is the OHRC's position that this can be a form of profiling.

Even if there is some evidence of risk or wrongdoing, organizations are expected to respond in a way that is proportionate to the situation.[105] Where risk is presumed based on stereotypes, this can lead to unnecessary escalation of responses to people with mental health or addiction issues.

There will rarely be direct evidence of profiling and, therefore, it must be proven by inference drawn from circumstantial evidence.[106] The following factors are drawn from the case law on racial profiling. These factors may be relevant when considering whether profiling based on mental health was a reason for the alleged treatment:

- whether the respondent is aware of the person's mental health issue or addiction, or there is a perception that the person has a mental health issue or addiction
- statements were made that show the existence of stereotyping or prejudice against someone with a mental health issue or addiction (*e.g.* negative comments)
- no explanation, or a contradictory or changing explanation, is given for why someone was subjected to greater scrutiny or different treatment, or an explanation is offered that does not accord with common sense[107]
- there were deviations from the normal practice that are hard to explain[108]
- an unprofessional manner was used or the person was subjected to discourteous treatment (for example, through harsh questioning)[109]

- the person fit a certain profile[110]
- unfounded suspicion or action in the face of a possibly innocent explanation[111]
- misinterpreting innocent or ambiguous conduct as incriminatory (*e.g.* failure to make eye contact)
- overreaction to perceived challenging behaviour[112]
- events would have unfolded quite differently if the complainant were not known or perceived to have a mental health issue or addiction.[113]

People who believe they are being profiled can be expected to find the experience upsetting and might well react in an angry and verbally aggressive way. A person's negative reaction in these circumstances requires reasonable tolerance and tact and cannot form the basis for further differential treatment.

There are situations where observed behaviour arising from a person's mental health or addiction disability may justify a real or legal basis for scrutiny. For example, under the *Mental Health Act*, police can apprehend people and take them to see a doctor if police have "reasonable and probable grounds" to believe that the person is acting in a disorderly way and if there is reasonable cause to believe that the person has shown they are a risk to others (or themselves). Police must also believe that the person has a mental disorder that will result in serious bodily harm to others, or that the disorder will cause serious bodily harm or physical impairment to themselves.[114]

Also, under the *Criminal Code*, certain behaviour associated with substance use may form "reasonable suspicion" and may justify further scrutiny by police (for example, where there is evidence that someone is under the influence of alcohol or drugs while driving).

The HRTO has found that it is not discriminatory to respond to the actual behaviour of people with mental health disabilities that causes risk.[115]

Intersections of different *Code* grounds can contribute to people being perceived as a risk to public safety. For example, people with mental health issues who are Aboriginal or from racialized communities may be more likely to be profiled as a security risk than other people. Multiple stereotypes linked to a person's age, sex, disability, race, Aboriginal identity, or socio-economic status, *etc*., may result in people being more likely to be treated as a threat to public safety.

> **Example:** A Tribunal ruled that the owner of a shopping mall and the security company it employed engaged in a pattern of discriminatory treatment of Aboriginal people and people with disabilities. The Tribunal examined the "orders" that were used by the mall to direct the security officers on which people to watch for, and found that a number of elements discriminated against and stereotyped economically disadvantaged people. For example, the Tribunal noted that the direction to target people who have "a bad odour," are talking to themselves, *etc.* could have an adverse effect based on mental disability or addiction.[116]

If organizations scrutinize people with known or perceived psychosocial disabilities based on stereotypes and assumptions, rather than actual behaviour, this may be a violation of the *Code*.[117]

10.2 Harassment

Harassment is prohibited under the *Code* in employment and housing.[118] In employment, every employee has a right to be free from harassment in the workplace by the employer or agent of the employer or by another employee because of disability and other *Code* grounds. This right applies to the workplace, but also the "extended workplace," that is, events that occur outside of the physical workplace or regular work hours, but that have implications for the workplace, such as business trips, company parties or other company related functions. The issue is whether these events have work-related consequences for the person being harassed.[119]

In housing, people with psychosocial disabilities have the right to be free from harassment in accommodation by the landlord or an agent of the landlord or by an occupant of the same building, because of disability and other *Code* grounds.

> **Example:** A tenant, who identified as having learning disabilities and depression, decided to move from her apartment to a subsidized housing unit. The landlord was aware that she had a mental health issue. The landlord became angry that she was moving, and subjected her to slurs such as "mental," "crazy" and "sick" in the weeks before her move. The HRTO found that this was harassment because of her mental disability and that the applicant "suffered considerable humiliation and loss of dignity" as a result.[120]

People also have the right to be free from harassment in services, in making contracts, and in membership in unions, trade or vocational associations. Sections 1, 3 and 6 of the *Code* guarantee the right to equal treatment in these social areas, without discrimination based on disability, among other *Code* grounds. Harassment based on disability, as a form of discrimination, is therefore prohibited in these areas.[121]

The *Code* defines harassment as "engaging in a course of vexatious comment or conduct that is known or ought reasonably to be known to be unwelcome."[122] The reference to comment or conduct "that is known or ought reasonably to be known to be unwelcome" establishes both a subjective and an objective test for harassment.

The subjective part is the harasser's own knowledge of how his or her behaviour is being received. The objective component considers, from the point of view of a "reasonable" person, how such behaviour would generally be received. Determining the point of view of a "reasonable" person must take into account the perspective of the person who is harassed.[123] In other words, the HRTO can conclude based on the evidence before it that an individual knew, or should have known, that his or her actions were unwelcome.[124]

It should be understood that some types of comments or behaviour are unwelcome based on the response of the person subjected to the behaviour, even when the person does not explicitly object.[125] An example could be a person walking away in disgust after a co-worker has made derogatory comments about people with mental health or addiction disabilities.[126]

Some conduct or comments relating to a *Code*-protected ground (such as disability) may not, on their face, be offensive. However, they may still be "unwelcome" from the perspective of a particular person. If similar behaviour is repeated despite indications from the person that it is unwelcome, there may be a violation of the *Code*.

People may experience “a course of unwelcome conduct” based on a psychosocial disability, a past or perceived psychosocial disability, a person’s accommodation needs, the treatment they are receiving (*e.g.* medication or therapy), or the side-effects of treatment. Harassment could include:

- slurs, name-calling or pejorative nicknames based on psychosocial disability
- graffiti, images or cartoons depicting people with psychosocial disabilities in a negative light
- comments ridiculing people because of mental health or addiction-related characteristics
- intrusive questioning or remarks about someone’s disability, medication or accommodation needs
- singling out a person for teasing or jokes related to psychosocial disability
- inappropriately disclosing someone’s psychosocial disability to people who do not need to know
- repeatedly excluding people from the social environment, or “shunning”
- circulating offensive material about people with psychosocial disabilities at an organization by email, text, the Internet, *etc.*

Harassment based on *Code* grounds is occurring increasingly through cyber-technology, including cell phone text messaging, social networking sites, blogs and email.[127] While there are sometimes complex jurisdictional issues around the legal regulation of cyber-harassment, organizations may be liable for a poisoned environment caused when online communications containing comment or conduct that would amount to harassment are accessed through technology operated by the organization, or by private electronic devices used on the organization’s premises.[128]

Harassment may take different forms depending on whether the affected person identifies with more than one *Code* ground.

> **Example:** The HRTO found that an employer discriminated against an employee with bi-polar disorder when it made no efforts to respond to or investigate his concerns about harassment. The employee reported a number of incidents of inappropriate comment and conduct by his co-workers related to his disability

> and perceived sexual orientation. Nothing was done about the harassment and bullying. The man alleged that the harassment included homophobic taunts, being teased about taking medication and often being referred to as a "freak." As well, co-workers tried to interfere with his prospective customers by telling them that he was "crazy" and "busy with his new boyfriend."[129]

There is no requirement that a person must object to the harassment at the time for a violation of the *Code* to exist, or for a person to claim their rights under the *Code*.[130] A person with a mental health issue or an addiction who is the target of harassment may be in a vulnerable situation, and afraid of the consequences of speaking out. Housing providers, employers and service providers have an obligation to maintain an environment that is free of discrimination and harassment, whether or not anyone objects.[131]

10.3 Poisoned environment

A poisoned environment is a form of discrimination. In employment, tribunals have held that the atmosphere of a workplace is a condition of employment as much as hours of work or rate of pay. A "term or condition of employment" includes the emotional and psychological circumstances of the workplace.[132] A poisoned environment can also occur in housing and services.

A poisoned environment may be created when unwelcome conduct or comments are pervasive within the organization, which may result in a hostile or oppressive atmosphere for one or more people from a *Code*-protected group. This can happen when a person or group is exposed to ongoing harassment. However, a poisoned environment is based on the nature of the comments or conduct and the impact of these on an individual rather than just on the number of times the behaviour occurs. Although the definition of harassment refers to a "repeated" course of conduct or comment, sometimes a single remark or action can be so severe or substantial that it results in a poisoned environment.[133]

> **Example:** A woman, who had anxiety, was accommodated during surgery by having a person help her to relax before the procedure. After surgery, her surgeon told her, "Had I known you were crazy, I never would have operated on you." This type of comment could be seen as poisoning the service environment for this person.

A consequence of creating a poisoned environment is that certain people are subjected to terms and conditions of employment, tenancy, or services that are quite different from those experienced by people who are not subjected to those comments or conduct. This gives rise to a denial of equality under the *Code.*

> **Example:** In one case that dealt with a man who was battling an addiction to crack cocaine, the HRTO said: "I find that the personal respondent's use of the term 'crack head' both to and about the applicant was demeaning of the applicant because of his disability. The disclosure of his addiction in emails in the context of allegations of wrongdoing offended the applicant's dignity and stigmatized him

> because of his disability. I accept that this discrimination had a detrimental impact on the applicant's confidence within the work environment and on his ability to work with his business contacts, and that they did not respond to him as they had done previously.[134]
>
> …
>
> I accept that as a result of the discrimination, the applicant suffered humiliation, embarrassment, experienced a loss of self-respect, dignity, self-esteem and confidence and that he felt that he had been stigmatized in the context of his working environment. I find also that it resulted in him losing trust in the respondents and consequently to his resignation from this employment and that it resulted in a poisoned work environment."[135]

The comments or actions of any person, regardless of his or her position of authority or status, may create a poisoned environment. Therefore, a co-worker, a supervisor, a co-tenant, a member of the Board of Directors, a service provider, a fellow student, *etc*. can all engage in conduct that poisons the environment of a person with a psychosocial disability.

Behaviour need not be directed at any one person to create a poisoned environment. A person can experience a poisoned environment even if he or she is not a member of the group that is the target. Further, not addressing discrimination and harassment may in itself cause a poisoned environment.[136]

Organizations have a duty to maintain a non-discriminatory environment in services, housing and employment, to be aware of a poisoned environment that exists, and to take steps to respond and eliminate it.

> **Example:** A bartender at a club experienced depression after the death of her father, and took a medical leave. The HRTO found that, among other things, her employer publicly posted confidential details about her medical condition for club members and staff to see, and directed staff to give a copy of the posting to any member who requested one. The HRTO said that this was discriminatory because it stigmatized the employee and poisoned her work environment.[137]

Management personnel who are aware, or ought to be aware, of a poisoned environment but allow it to continue discriminate against the affected tenants, employees or service users even if they themselves are not involved in producing that atmosphere.[138]

10.4 Systemic discrimination

Discrimination based on psychosocial disabilities exists not just in individual behaviour, but can also be systemic or institutionalized. Systemic or institutional discrimination is one of the more complex ways that discrimination happens.[139] Organizations and institutions have a positive obligation to make sure that they are not engaging in systemic or institutional discrimination.

Systemic or institutional discrimination consists of patterns of behaviour, policies or practices that are part of the social or administrative structures of an organization or sector, and which create or perpetuate a position of relative disadvantage for people with psychosocial disabilities. The behaviour, *etc.* appears neutral on the surface but nevertheless has an "adverse effect" or exclusionary impact on people with psychosocial disabilities.

> **Example:** Barriers to employment for people with psychiatric disabilities may be created when non-criminal contact with police is recorded and disclosed as part of a police record check. This can be a form of systemic discrimination.[140]

Systemic discrimination can also overlap with other types of discrimination that are not neutral. For example, a policy that has an adverse discriminatory effect can be compounded by the discriminatory attitudes of the person who is administering it.

> **Example:** A municipality developed a bylaw restricting the location of group homes for people with disabilities as a response to the concerns of neighbours who don't want tenants with mental health issues or addictions living in their neighbourhood. The municipality also continues to enforce its longstanding bylaws that make rooming houses illegal, and restrict many renters from sharing a house. These rules and bylaws, whether intentionally or not, will have an adverse impact on people with psychosocial disabilities, who are more likely to use these types of housing. The actions of the municipality may be evidence of systemic discrimination.[141]

Systemic discrimination is often embedded in an institution or sector, and may be invisible to the people who do not experience it. It may be "reinforced by the very exclusion of the disadvantaged group" because the exclusion fosters the false belief that it is the result of "natural" forces (for example, that people with psychosocial disabilities are just not as capable of others of being employed).[142] To combat systemic discrimination, it is essential for organizations to create a climate where negative practices and attitudes can be challenged and discouraged.

In some situations, the existence of historical disadvantage is a factor that gives rise to or contributes to systemic discrimination. It is therefore necessary to consider an individual or group's already disadvantaged position in Canadian society as part of any analysis of whether systemic or institutional discrimination is taking place. In the case

of people with psychosocial disabilities, the broader context of societal stigma, privacy concerns of disclosing one's disability, pervasive negative stereotyping, and experiences of historical, economic and social marginalization may all be relevant to someone's personal experience of discrimination within an institution or sector.

> **Example:** To apply for articling positions through a law society, a law student filled out an application that contained the question: "Have you ever been treated for schizophrenia, paranoia, or a mood disorder described as a major affective illness, bipolar mood disorder, or manic depressive illness?" He answered "yes," because previously he had experienced a couple of episodes of depression, for which he sought treatment. Once he answered "yes," conditions were placed on him so that each time he needed to re-apply to the law society for activities to advance his career, the issue of his mental competence was re-visited. Despite not having had further episodes of depression, after being admitted to the Bar, he was asked for multiple medical reports and required to see a psychiatrist, he was investigated by two private investigators; and he experienced delays not imposed on others. A human rights tribunal concluded that the question was discriminatory, and caused systemic discrimination against people with the named mental conditions. This was in part because the process following a "yes" answer to the question exposed applicants to a more intensive (and intrusive) evaluation than others. The tribunal also heard evidence that 77% of people who answered "yes" to the question had conditions put on their membership. The tribunal noted that the factors in the case were "sufficient to constitute an adverse impact, especially when viewed against the historical disadvantage and present-day social stigma experienced by people diagnosed with mental disabilities."[143]

It may not be necessary for multiple people to make complaints about an institution's policies or practices for their impact to be understood as causing systemic discrimination. Often, it can be inferred from the evidence in one person's case that many people from a *Code*-protected group will be negatively affected.

To show systemic discrimination, a link between the institution's policies or practices and the impact on the individual or the group must be established.[144] For detailed information on how to identify systemic discrimination, see section 4.1 of the OHRC's *Policy and guidelines on racism and racial discrimination*.[145]

11. Reprisal

Section 8 of the *Code* protects people from reprisal or threats of reprisal.[146] A reprisal is an action, or threat, that is intended as retaliation for claiming or enforcing a right under the *Code*.

People with psychosocial disabilities may try to enforce their *Code* rights by filing a grievance against an employer, making an application at the HRTO, or making an internal discrimination complaint to a service provider, housing provider, or to their employer. However, there is no strict requirement that someone who alleges reprisal must have already made an official complaint or application under the *Code*.[147] Also, to claim reprisal, a person does not have to show that their rights were actually infringed.[148]

The following will establish that someone experienced reprisal based on a *Code* ground:

- an action was taken against, or a threat was made to, the claimant
- the alleged action or threat was related to the claimant having claimed, or trying to enforce a *Code* right, and
- there was an intention on the part of the respondent to retaliate for the claim or the attempt to enforce the right.[149]

Example: A bartender, who had depression and had experienced various allegedly discriminatory acts at her workplace, complained to her employer that she had been discriminated against. Shortly thereafter, the bartender received notice that her employer wanted to talk to her about complaints made against her (most of which could not be substantiated) and concerns about missing money (which she had never been suspected of being responsible for before). The HRTO found that the "respondents' demand for a meeting was an intentional threat of retaliation because [the applicant] had claimed and enforced her rights under the *Code.*"[150]

People associated with persons who have complained about discrimination are also protected from discrimination and reprisal.[151]

12. Mental health and addictions programs, laws and policies

There are different types of programs, laws and policies that target, serve or benefit people with disabilities, including mental health disabilities or addictions. These include programs, laws and policies that:

- promote equality and remove barriers (*e.g.* the *AODA*, special programs under s. 14 of the *Code*)
- provide particular supports, accommodations or benefits (*e.g.* Ontario Disability Support Program benefits, special interest organizations)
- restrict people's activities or participation in society (*e.g.* laws relating to legal capacity or competency may restrict the activities of persons with psychiatric disabilities in society).[152]

All of these different programs, laws and policies are subject to the *Code*. Even if limiting a program, membership or employment to only people with psychosocial disabilities is intended to address inequality or hardship, the organization still has a legal responsibility to prevent, respond to and eliminate discrimination.

Measures that apply distinctly to people with psychosocial disabilities must ensure equality, respond to people's individualized needs and uphold people's dignity. They should never be used as a way to continue inequality, segregation or exploitation.

Specific issues have arisen around assessments and care within the health care system. Health care services, just like any other service, are covered by the *Code*. Actions and conduct by medical professionals, and legislation that applies to health care for people with mental health or addiction disabilities, must uphold people's rights to be free from discrimination.

Both the selection process of a service and the criteria used to select service users are open to scrutiny under human rights legislation.[153] Criteria that are under-inclusive, and that deny benefits to people with specific disabilities, while they are available to other people with disabilities or people without disabilities, have been found to be discriminatory in certain circumstances. This has been shown in challenges to large-scale government benefit programs.[154] In these cases, a human rights decision-maker may consider whether the exclusion of the claimants was based on *Code*-related grounds or whether the grounds factored into the government's decision.[155]

Organizations should carefully consider selection criteria to make sure these reflect the underlying purpose of the program or service and are not unjustifiably screening out people based on a mental health issue or addiction, or other *Code* grounds.[156]

> **Example:** The Ontario Disability Support Program is a social assistance program designed to assist people with a disability who have low socio-economic status. It is distinct from Ontario Works, the Ontario government's general social assistance program, in that recipients must also have a disability to qualify. If a person meets the required criteria, they are then eligible for specific financial and employment support benefits offered by ODSP. The program was successfully challenged because it specifically excluded people whose impairments resulted solely from drug and alcohol addiction. The Ontario Court of Appeal found that it was well-known that addicts and welfare recipients are subject to stigma and prejudice, and that there was no obvious explanation for why this group was left ineligible for benefits under the legislation. This was sufficient to create an inference that the legislation discriminated by "perpetuating prejudice and disadvantage and by stereotyping through depriving the respondents of benefits available to other people because of their specific disability."[157]

Disagreements may occur about medical decisions, including medical diagnoses, the administering (or lack of administering) of a particular drug, inclusion in a particular medical program, or making decisions to apprehend people under the *Mental Health Act*. These decisions are made by doctors, other health care providers and, in the case of mental health apprehensions, police acting under mental health legislation. General allegations about whether a person has received an appropriate standard of medical care for a disability or has been properly assessed have been found not to fall under human rights legislation. Instead, there must be some basis to support an allegation that proper treatment was not provided *because of* a person's psychosocial disability or medical condition or that the person was not accommodated in receiving medical services to the point of undue hardship.[158] Tribunals have held that disagreeing with a medical decision or an apprehension under the *Mental Health Act* is not enough, even if the decision is proven to be wrong. There must be an additional indicator of discrimination to support an allegation.[159]

However, where there is different treatment that has an adverse effect based on a real or perceived psychosocial disability, a health care provider fails to accommodate the patient's disability-related needs up to the point of undue hardship, or the conduct or practice has a disproportionate impact on people with psychosocial disabilities, this may fall within the jurisdiction of the *Code*.[160]

When people with psychiatric disabilities are unwell and subject to restrictions on their autonomy, they are in a very vulnerable position. People may not feel they can object to behaviour or actions that may be discriminatory. To comply with legislation such as the C*ode* and the *AODA*, health care service providers and others serving people with mental health issues or addictions (such as police) should develop human rights policies and complaint procedures to make sure people understand their rights and responsibilities.

12.1 Special programs

Section 14 of the *Code* allows for programs to be set up that are designed to help people who experience hardship, economic disadvantage, inequality or discrimination, and protects these programs from challenge by people who do not experience the same disadvantage.[161]

Programs with well-designed criteria that assist people with mental health issues or addictions can be a good way to ensure substantive equality. The OHRC encourages organizations to develop and use special programs where hardship or disadvantage exist. Some examples of the types of special programs that can alleviate historical disadvantage for people with psychosocial disabilities include:

- hiring and training – special programs that address under-representation of persons with psychosocial disabilities in an organization, profession or job category
- housing – programs that help people with psychosocial disabilities who have historically had difficulty finding housing

- health – special strategies to improve health outcomes for people with psychiatric and addiction disabilities
- education – initiatives that support people with psychosocial disabilities in school, vocational training or support in gaining admittance to programs they have been historically excluded from
- consumer/survivor initiatives – businesses and support services that are run for and by consumer/survivors, often with government funding
- advocacy – initiatives that help people with psychosocial disabilities to access their legal rights and entitlements.

To meet the requirements of a special program, any restrictions or exclusions within the program must be rationally connected to the purpose of the program, and should be supported by objective evidence. Eligibility criteria that are not clearly related to the purpose of the program and that adversely affect people based on *Code* grounds will likely violate people's human rights.

Therefore, if a program excludes someone with a psychosocial disability who has needs that the program was designed to benefit, the program provider would have to show that this is justified because it relates to the underlying purpose of the program.[162]

> **Example:** Based on a wealth of research showing the high rates of homelessness for people with "severe mental health issues," the government decides to provide funding to agencies to set up affordable housing programs that provide housing and support for people in this group. One housing agency decides to exclude people who have substance addictions (either as their sole disability, or along with another mental health issue). If this exclusion was challenged, the housing provider would have to justify why this restriction is relevant to the purpose of the program. Otherwise, the program could be found to violate the *Code*.

Special programs cannot internally discriminate against the people they are meant to serve. Special programs must meet the same non-discrimination standard as other services that are not special programs. If someone has a disadvantage that a program was designed to benefit, but is excluded from the program, the program could be found to be discriminatory.[163]

13. Duty to accommodate

Under the *Code*, employers and unions, housing providers and service providers have a duty to accommodate the needs of people with psychosocial disabilities to make sure they have equal opportunities, equal access and can enjoy equal benefits. Employment, housing, services and facilities must be designed inclusively or adapted to accommodate people with psychosocial disabilities in a way that promotes integration and full participation.

The OHRC's *Policy and guidelines on disability and the duty to accommodate*, *Human Rights at Work* and the *Policy on human rights and rental housing*[164] provide in-depth guidance on accommodating the needs of people with disabilities and other *Code*-protected groups in employment, housing and other areas. The purpose of this policy is to apply these principles specifically to people with mental health and/or addiction disabilities.

The duty to accommodate has both a substantive and a procedural component. The procedure to assess an accommodation is as important as the substantive content of the accommodation.[165] In a case involving the accommodation of a mental health disability in the workplace, the Court said: "a failure to give any thought or consideration to the issue of accommodation, including what, if any, steps could be taken constitutes a failure to satisfy the 'procedural' duty to accommodate."[166]

The duty to accommodate mental health disabilities is no less rigorous than the duty to accommodate physical disabilities.

> **Example:** In one case, a tribunal found that an organization had discriminated when it failed to provide a stress leave to an employee with anxiety and depression, and instead required him to either retire or transfer to another province (despite the negative impact that the transfer would have had on his family situation and possibly on his mental health). In its decision, the tribunal pointed to the organization's generous sick leave policy for people with physical disabilities, such as cancer, and contrasted this with how differently the organization treated stress leaves.[167]

Human rights law establishes that there cannot be a "double standard" for how mental health disabilities are treated versus how physical disabilities are treated.[168]

13.1 Principles of accommodation

The duty to accommodate is informed by three principles: respect for dignity, individualization, and integration and full participation.

13.1.1. Respect for dignity

The duty to accommodate people with disabilities means accommodation must be provided in a way that most respects the dignity of the person, if doing so does not cause undue hardship. Human dignity encompasses individual self-respect, self-worth and inherent worth as a human being. It is concerned with physical and psychological integrity and empowerment. It is harmed when people are marginalized, stigmatized, ignored or devalued. Privacy, confidentiality, comfort, individuality and self-esteem are all important factors.

Autonomy is also an important aspect of dignity. It reflects a person's right to self-determination, and means subjecting people to minimal interference in their choices. Dignity will include considering how accommodation is provided and the person's own participation in the process.

Respect for dignity includes being considered as a whole person, not merely in relation to one's disability or the psychiatric system. It includes respecting and valuing the perspectives of consumer/survivors and people with addictions, particularly when people speak about their own experiences.

Housing providers, service providers and employers should consider different ways of accommodating people with mental health or addiction disabilities along a continuum, ranging from ways that most respect dignity and other human rights values, to those that least respect those values.

> **Example:** A woman asks for flexible work hours on Thursdays so she can attend a therapy appointment related to a mental health issue. Instead of taking her request in good faith and working with her confidentially to understand how best she can be successful at work, the employer tells the woman's colleagues about her request and asks them whether, based on their own impressions, they believe that the woman has a mental health issue. This approach is inappropriate and does not respect the employee's dignity or her privacy.

13.1.2. Individualization

There is no set formula for accommodating people identified by *Code* grounds. Each person's needs are unique and must be considered afresh when an accommodation request is made. What might work for one person may not work for others. A solution may meet one person's requirements, but not another's.

> **Example:** In employment, a policy that mandates a set return to work plan for people with disabilities may be discriminatory if the particular circumstances of a person making an accommodation request are not considered.[169]

Accommodations may need to be re-visited over time to make sure that they continue to meet a person's needs appropriately.

13.1.3. Integration and full participation

Accommodations should be developed and implemented with a view to maximizing a person's integration and full participation. Achieving integration and full participation requires barrier-free and inclusive design and removing existing barriers. Where barriers continue to exist because it is impossible to remove them at a given point in time, then accommodations should be provided, unless this causes undue hardship.

It is well-established in human rights law that equality may sometimes require different treatment that does not offend the person's dignity. In some circumstances, the best way to ensure the equality of people with disabilities may be to provide separate or specialized services. However, employment, housing, services and facilities must be built or adapted to accommodate people with disabilities in a way that promotes their integration and full participation.[170]

> **Example:** A co-op housing provider ensures that several of its one-bedroom units throughout the co-op are available to people who, due to a mental health disability, need to live in quiet, private spaces on their own.

Segregated treatment in services, employment or housing for people with disabilities is less dignified and is unacceptable, unless it can be shown that integrated treatment would pose undue hardship or that segregation is the only way to achieve equality.[171]

13.2 Inclusive design

Ensuring integration and full participation means designing society and structures for inclusiveness. Inclusive or "universal" design emphasizes barrier-free environments and equal participation of persons with psychosocial disabilities with varying levels of ability. It is a preferred approach to removing barriers or making "one-off" accommodations, which assume that existing structures may only need slight modifications to make them acceptable.

Effective inclusive design will minimize the need for people to ask for individualized accommodation. As the Law Commission of Ontario has said:

> The concept of universal design, which requires those who develop or provide laws, policies, programs or services to take into account diversity from the outset, is connected to the principle of autonomy and independence in that, when properly implemented, universal design removes from persons with disabilities the burden of navigating onerous accommodation processes and negotiating the accommodations and supports that they need in order to live autonomously and independently. In this way, the principle of autonomy and independence is closely linked to that of participation and inclusion.[172]

The Supreme Court has noted the need to "fine-tune" society so that structures and assumptions do not exclude persons with disabilities from taking part in society.[173] It has affirmed that standards should be designed to reflect all members of society, to the extent that this is reasonably possible.[174] Housing providers, service providers, employers and others have an obligation to be aware of differences between individuals and groups and must build in conceptions of equality to standards or requirements.[175] This proactive approach is more effective because it emphasizes accessibility and inclusion from the start.

Organizations, including government, should use the principles of inclusive design when they are developing and building policies, programs, procedures, standards, requirements and facilities. New barriers should never be created when designing new structures or revising old ones. Instead, design plans should incorporate current accessibility standards such as the Principles of Universal Design.[176] This type of planning decreases the need to remove barriers and provide accommodations at a later date.

> **Example:** A municipality passes a bylaw that requires 10% of the units offered through all new rental housing developments to be affordable housing. It does this because it recognizes that many groups protected by the *Code*, including people with psychosocial disabilities, need affordable housing.

The *Accessibility for Ontarians with Disabilities Act*[177] provides a mechanism for developing, implementing and enforcing accessibility standards with the goal of a fully accessible province by 2025. Standards have already been passed into regulation for customer service, employment, information and communication, transportation and public spaces. Changes have also been made to the accessibility provisions of the *Building Code Regulation*. Under the *AODA*, government public and private sector employers, service providers and landlords are required to comply with accessibility standards in varying degrees over time relative to an organization's size and sector. If accessibility standards under the *AODA* fall short of requirements under the *Code* in a given situation, the requirements of the *Code* will prevail.

Along with the expectation to prevent barriers at the design stage through inclusive design, organizations should be aware of systemic barriers in systems and structures that already exist. They should actively identify and seek to remove these existing barriers.

> **Example:** A workplace designs a performance management procedure. It builds in flexible processes to make sure it adequately responds to people who may be experiencing difficulty performing their work due to factors related to a *Code* ground, including a mental health or addiction issue, by offering accommodation, short of undue hardship. In its approach to assessing and accommodating employees who are experiencing difficulty doing their work, it focuses on the employee's behaviours at work, and asks "What can I do to make sure you are successful at work?" It also identifies that accommodation is available, if needed. This approach allows employees to focus on their needs, decide if they want to disclose that they have a disability or other *Code*-related issue (for example, family status obligations) that is affecting their work, and allows them to begin a conversation about accommodation, if necessary.[178]

Organizations will likely find that inclusive design choices and removing barriers, as well as individual accommodations, will benefit large numbers of people.

13.3 Appropriate accommodation

In addition to designing inclusively and removing barriers, organizations must also respond to individual requests for accommodation. In some situations involving people with psychosocial disabilities, organizations may also have to respond to situations where they perceive that there may be a need for accommodation, even if a specific request has not been made.[179]

The duty to accommodate requires that the most appropriate accommodation be determined and provided, unless this causes undue hardship. Accommodation is considered appropriate if it results in equal opportunity to enjoy the same level of benefits and privileges experienced by others or if it is proposed or adopted for the purpose of achieving equal opportunity, and meets the individual's disability-related needs. The most appropriate accommodation is one that most:

- respects dignity (including autonomy, comfort and confidentiality)
- responds to a person's individualized needs
- allows for integration and full participation.

Accommodation is a process and is a matter of degree, rather than an all-or-nothing proposition, and can be seen as a continuum. The highest point in the continuum of accommodation must be achieved, short of undue hardship.[180] At one end of this continuum is full accommodation that most respects the person's dignity and promotes confidentiality. Alternative accommodation (that which would be less than "ideal") might be next on the continuum when the most appropriate accommodation is not feasible. An alternative (or "next-best") accommodation may be implemented in the interim while the most appropriate accommodation is being phased in or put in place at a later date when resources have been put aside.

Determining the "most appropriate" accommodation is a separate analysis from determining whether the accommodation would result in undue hardship. If a particular accommodation measure would cause undue hardship, the next-best accommodation must be sought.

If there is a choice between two accommodations that equally respond to the person's needs in a dignified way, then the accommodation provider is entitled to select the one that is less expensive or less disruptive to the organization.

13.4 The legal test

Section 11 of the *Code* prohibits discrimination that results from requirements, qualifications or factors that may appear neutral but that have an adverse effect on people identified by *Code* grounds. Section 11 allows an organization to show that a requirement, qualification or factor that results in discrimination is nevertheless reasonable and *bona fide* (legitimate). However, to do this, the organization must show that the needs of the person cannot be accommodated without undue hardship.[181]

The Supreme Court of Canada has set out a framework for examining whether the duty to accommodate has been met.[182] If *prima facie* discrimination (or discrimination on its face) is found to exist, a respondent must establish on a balance of probabilities that the standard, factor, requirement or rule

1. was adopted for a purpose or goal that is rationally connected to the function being performed (such as a job, being a tenant, or participating in the service)
2. was adopted in good faith, in the belief that it is necessary for the fulfilment of the purpose or goal, and
3. is reasonably necessary to accomplish its purpose or goal, in the sense that it is impossible to accommodate the claimant without undue hardship.[183]

As a result of this test, the rule or standard itself must be inclusive of as many people as possible and must accommodate individual differences up to the point of undue hardship. This makes sure that each person is assessed according to their own personal abilities instead of being judged against presumed group characteristics.[184] The ultimate issue is whether the organization or individual providing accommodation has shown that they have done so up to the point of undue hardship.

The following non-exhaustive factors should be considered during the analysis:[185]

- whether the accommodation provider investigated alternative approaches that do not have a discriminatory effect
- reasons why viable alternatives were not put in place
- ability to have differing standards that reflect group or individual differences and capabilities
- whether the accommodation provider can meet their legitimate objectives in a less discriminatory way
- whether the standard is properly designed to make sure the desired qualification is met without placing undue burden on the people it applies to
- whether other parties who are obliged to assist in the search for accommodation have fulfilled their roles.

Similarly, section 17 of the *Code* also creates an obligation to accommodate, specifically under the ground of disability. Section 17 says that the right to be free from discrimination is not infringed if the person with a disability is incapable of performing or fulfilling the essential duties or requirements of attending to the exercise of the right. However, this defence is not available unless it can be shown that the needs of the person cannot be accommodated without undue hardship.

In employment, essential duties are the “vital” or “indispensable” aspects of someone’s job. In housing, the essential duties or requirements of being a tenant may include paying rent, maintaining one’s unit so it does not violate health and safety laws, and allowing other people to reasonably enjoy their premises. In the case of services, the “essential duties or requirements” of using a service will vary depending on the circumstances.

Section 17 means that someone cannot be judged incapable of performing the essential duties or requirements of a job, of being a tenant, or taking part in a service, without efforts to accommodate the person to point of undue hardship. Conclusions about a person's inability to perform the essential duties should not be reached without actually testing the person's ability.

> **Example:** An employee experienced depression and anxiety. After coming back from a disability-related leave, he returned to modified duties. Even though his doctor cleared him to go back to work full-time, his employer placed him in a lower, part-time position at a lower pay rate. He was eventually terminated from his employment. The HRTO found that the employer failed to meet both its procedural and substantive duty to accommodate. The employer violated the *Code* when it based its decision to place the employee in a lower-paying position on its belief about the applicant's ability to perform in the workplace, and continued to refuse to provide full-time work, even though this was supported by the employee's doctor. The employer relied on its "non-expert opinion" and "stereotypes." It incorrectly relied on assumptions that the employee could not handle the job pressures, and that his "performance would be unreliable" because of his past medical condition.[186]

It is not enough for the organization to assume that a person cannot perform an essential requirement of a job, tenancy, service, *etc.* Rather, there must be an objective determination of that fact.[187]

13.5 Forms of accommodation

Many different methods and techniques will respond to the unique needs of people with psychosocial disabilities. Accommodations may include modifying an organization's:

- buildings and facilities
- policies and processes
- performance goals, conditions and requirements
- decision-making practices
- work, housing or service culture
- methods of communication.

Most accommodations are not expensive to provide, and if instituted widely, will benefit more than the person requesting the accommodation. Accommodation should be a non-coercive, co-operative process that both parties take part in. Accommodating someone because of their mental health disability or addiction may also mean accommodating the side-effects associated with the person receiving treatment, such as medication for their disability, or accommodating symptoms of withdrawal.

Depending on a person's individual needs, examples of accommodation may include:

Employment

- modifying job duties
- making changes to the building (for example, building partitions in an open office space to increase someone's ability to concentrate)
- providing job coaching
- referring someone to an employee assistance program
- providing alternative supervision arrangements
- providing alternative ways of communicating with the employee
- allowing for more training, or training that is delivered in a different way
- modifying break policies (for example, to allow people to take medication on a more frequent basis)
- allowing short-term and long-term disability leave
- allowing a flexible work schedule
- job bundling[188]
- alternative work.[189]

Services

- providing multiple ways of contacting a service including by phone, in person and by regular and electronic mail
- providing extra time to a service user
- providing more breaks to a service user, where appropriate
- providing support for decision-making[190]
- making attendance requirements flexible, where possible, if non-attendance can be shown to be linked to a disability
- modifying rules around non-compliance with deadlines, if non-compliance can be shown to be linked to a disability[191]
- ensuring that service users have a quiet, comfortable space to sit
- considering someone's disability as a mitigating factor when addressing behaviour that would otherwise warrant imposing sanctions.

Housing

- helping someone fill out application forms (for example, for social or supportive housing)
- adjusting tenant selection criteria (such as using a guarantor when other information, such as credit history or rental history, is not available)
- modifying deadlines (such as deadlines to report income changes in social and supportive housing)
- modifying ways that information is communicated to tenants
- establishing a list of contact supports to call in emergency situations
- making structural modifications to units (such as sound-proofing)
- working with outside professionals to address someone's needs, if agreed to by the tenant.

A person's co-workers, as well as other tenants and service users, may have a role to play in helping with an accommodation. In these cases, it may be necessary for others to know that a person requires an accommodation to facilitate the accommodation. However, care must be taken to protect the person's privacy, to not reveal any more information than is necessary, to make sure that they are not "singled out," and that their dignity is respected.[192]

An accommodation provider should take steps to resolve any tension or conflict that may occur as a result of resentment on the part of others who are expected to help implement an accommodation. In some situations, tension may be linked to a lack of awareness about the nature of the person's disability or needs.

Keeping in mind that everyone experiences disability differently, accommodation providers are also required to educate themselves about the nature of disabilities as part of the procedural duty to accommodate,[193] and to dispel any misperceptions or stereotypes that employees, other tenants or service staff or users may have about people with disabilities[194] that could lead to inequitable treatment. Resolving these issues must be done in a way that most respects the person's dignity and privacy. One key approach to doing this is to implement anti-harassment and accommodation training. Otherwise, tension and conflict could lead to harassment or a poisoned environment for the person with the psychosocial disability.

13.6 Duties and responsibilities in the accommodation process

The accommodation process is a shared responsibility. Everyone involved should co-operatively engage in the process, share information and consider potential accommodation solutions. The person with a disability is required to:

- make accommodation needs known to the best of their ability, preferably in writing, so that the person responsible for accommodation can make the requested accommodation[195]
- answer questions or provide information about relevant restrictions or limitations, including information from health care professionals, where appropriate and as needed[196]
- take part in discussions about possible accommodation solutions
- co-operate with any experts whose assistance is required to manage the accommodation process or when information is needed that is unavailable to the person with a disability
- meet agreed-upon performance standards and requirements, such as job standards, once accommodation is provided
- work with the accommodation provider on an ongoing basis to manage the accommodation process
- discuss his or her disability only with persons who need to know.[197]

The accommodation provider is required to:

- be alert to the possibility that a person may need an accommodation even if they have not made a specific or formal request[198]
- accept the person's request for accommodation in good faith, unless there are legitimate reasons for acting otherwise
- get expert opinion or advice where needed (but not as a routine matter)
- take an active role in ensuring that alternative approaches and possible accommodation solutions are investigated,[199]and canvass various forms of possible accommodation and alternative solutions[200]
- keep a record of the accommodation request and action taken
- maintain confidentiality
- limit requests for information to those reasonably related to the nature of the limitation or restriction, to be able to respond to the accommodation request
- implement accommodations in a timely way, to the point of undue hardship
- bear the cost of any required medical information or documentation (for example, the accommodation provider should pay for doctors' notes, psychological assessments, letters setting out accommodation needs, *etc*.).

Although the person seeking accommodation has a duty to assist in securing appropriate accommodation that will meet their needs, they are not responsible for originating a solution[201] or leading the accommodation process. It is ultimately the accommodation provider's responsibility to implement solutions, with the co-operation of the person seeking accommodation. After accommodation is provided, the person receiving the accommodation is expected to fulfil the essential duties or requirements of the job, tenancy, or taking part in a service.

Contracting with a disability management company does not absolve an employer of responsibilities or liability if the accommodation process is not managed properly.[202]

In employment, unions and professional associations are required to take an active role as partners in the accommodation process, share joint responsibility with the employer to facilitate accommodation, and support accommodation measures regardless of collective agreements, unless to do so would create undue hardship.[203]

Generally, if the accommodation is required to allow the person to be able to take part in the organization without impediment due to disability, the organization must arrange and cover the cost of the accommodation needed,[204] unless this would cause undue hardship.[205]

Where a person requires assistance for their disability beyond what is required to access housing, employment or services equally, such as an assistive device for daily living, the organization would not generally be required to arrange or pay for it, but is expected to allow the person to access this type of accommodation without impediment.

Accommodating someone with a psychosocial disability may be hindered by a lack of appropriate mental health services in the community to identify someone's disability-related needs and limitations, or to assist with an accommodation. Waiting lists for psychiatrists' assessments, for example, can be extremely long. In these cases, accommodation providers should use the best information they have available to make the accommodation, or provide interim accommodation, taking into consideration how the person identifies their own needs, pending the assessment. Otherwise, people with mental health disabilities or addictions may be denied equal opportunity to housing, services or employment.

Requirements under the *Convention on the Rights of Persons with Disabilities* state that States Parties, including Canada, must take steps to make sure that people with disabilities are provided with accommodation (for example, to ensure equal access to justice, education and employment).[206]

13.6.1 Duty to inquire about accommodation needs

In general, the duty to accommodate a disability exists for needs that are known. Organizations and persons responsible for accommodation are not, as a rule, expected to accommodate disabilities they are unaware of. However, in some circumstances, the nature of a psychosocial disability may leave people unable to identify that they have a disability, or that they have accommodation needs.[207]

Accommodation providers should also be aware that people with psychosocial disabilities may be reluctant to disclose their disabilities, due to the considerable stigma surrounding mental health issues and addictions.[208]

Accommodation providers must attempt to help a person who is clearly unwell or perceived to have a mental health disability or addiction by inquiring further to see if the person has needs related to a disability and offering assistance and accommodation.[209]

Mental health disabilities and addictions should be addressed and accommodated in the workplace like any other disability. In some cases, an employer may be required to pay special attention to situations that could be linked to mental disability. Even if an employer has not been formally advised of a mental disability, the perception of such a disability will engage the protection of the *Code*.

> **Example:** An employer is unaware of an employee's drug addiction but perceives that a disability might exist due to noticeable changes in his behaviour. The employer sees that the employee is having difficulty performing, and is showing obvious signs of distress that include repeated bouts of crying at his desk. If the employer imposes serious sanctions or terminates the employee for poor performance, without any progressive performance management and attempts to accommodate, these actions may be found to have violated the *Code*.[210]

> **Example:** A new police constable was involved in a traumatic incident and started experiencing symptoms of post-traumatic stress disorder (PTSD). His symptoms led to a second incident, in which he over-reacted to a patron at a restaurant, whom he incorrectly perceived to be a threat. He acted in a way that led his supervisors to believe he could be experiencing PTSD. However, his supervisors did not appropriately accommodate him by offering assistance or suggesting that he seek help or take time off. Instead, he was eventually fired for misconduct. The HRTO ruled the police service's actions were discriminatory, and affirmed that an employer has both a procedural and substantive duty to accommodate a person's mental health disability, even when that person is not capable of recognizing that they have a disability, or expressing that they need help or accommodation.[211]

Where an organization is aware, or reasonably ought to be aware, that there may be a relationship between a disability and someone's job performance, or their abilities to fulfil their duties as a tenant or service user, the organization has a "duty to inquire" into that possible relationship before making a decision that would affect the person adversely.[212] This includes providing a meaningful opportunity to the employee, tenant or service user to identify a mental health disability or addiction as the reason for the inappropriate behaviour and to request accommodation. A severe change in a person's behaviour could signal that the situation warrants further examination.

> **Example:** John has bipolar disorder. He has chosen not to disclose this information to his employer because he is concerned about how he would be treated at work if it were known that he had a mental disability. He experiences a crisis at work, followed by a failure to appear at work for several days. The employer is concerned about John's absence and recognizes that termination for failure to report to work may be premature. The employer offers John an opportunity to explain the situation after treatment has been received and the situation has stabilized. Upon learning that a medical issue exists, the employer offers assistance and accommodation.

Where a person exhibits inappropriate behaviour due to a psychosocial disability, employers, housing providers or service providers have a duty to assess each person individually before imposing measures that may affect the person negatively. Such measures might include starting eviction proceedings, revoking subsidies, withdrawing services or imposing discipline in employment. Before sanctioning a person for misconduct or "unacceptable behaviour," an organization must first consider whether the actions of the person are caused by a disability, especially where the organization is aware or perceives that the person has a disability.[213] The person's disability must be a factor that is considered in determining what, if any, sanctions are appropriate, unless this causes undue hardship. Where the behaviour is not related to a disability, sanctions or discipline will generally apply, as usual.[214]

Accommodation providers should always inform employees, service users and tenants that a disability-related assessment (such as a medical assessment) or accommodation can be provided as an option to address job performance issues or issues relating to fulfilling one's duties as a tenant or a service user.

In employment, for example, an accommodation provider may be able to ask for medical documentation to clear fitness to work, if there is sufficient objective evidence that there are legitimate reasons to be concerned.

> **Example:** A receptionist has multiple crying spells at work, which is interfering with his ability to answer the phone. The manager expresses concern about his performance and behaviour, asks what he needs to do well at work, and offers accommodation in the form of an employee assistance program. The person does not disclose any disability-related needs, refuses offers of assistance, and continues to have crying spells that compromise his work. The manager then asks the person to seek a medical assessment to document any accommodation needs. The person declines. The manager starts a process of progressive performance management, meeting with the employee at points during the process to continue to offer accommodation and support.

The use of progressive performance management and progressive discipline as well as outside supports, such as employee assistance programs, makes sure that people with psychosocial disabilities have a range of opportunities to address concerns on an individualized basis before termination, removing a service or eviction is considered.

Once disability-related needs are known, the legal onus shifts to those with the duty to accommodate.[215] For example, counselling or referral through employee assistance programs (EAPs) could be the solution for an underlying disability that might be aggravated by workplace or personal stress.

13.7 Medical information to be provided

In the OHRC's mental health consultation, questions were raised about the kind of information an accommodation provider can ask for from a person with a mental health issue or addiction. Many of these issues have been raised in the context of employment, but the issue may also arise in housing and services, depending on the circumstances. These issues have implications for the privacy of employees, tenants and service users. At the same time, organizations must have enough information to allow them to meet their duty to accommodate.

As stated above, the person seeking accommodation is generally required to advise the accommodation provider that they have a disability, and the accommodation provider is required to take requests for accommodation in good faith.[216] In employment, a person

with a mental health disability does not have to meet an onerous standard for initially communicating that a disability exists to trigger the organization's duty to accommodate. Organizations should limit requests for information to those reasonably related to the nature of the limitation or restriction, to assess needs and make the accommodation.

The type of information that accommodation seekers may generally be expected to provide to support an accommodation includes:

- that the person has a disability or a medical condition
- the limitations or needs associated with the disability
- whether the person can perform the essential duties or requirements of the job, of being a tenant, or of being a service user, with or without accommodation (this is more likely to be relevant in employment)
- the type of accommodation(s) that may be needed to allow the person to fulfill the essential duties or requirements of the job, of being a tenant, or of being a service user, *etc.*
- in employment, regular updates about when the person expects to come back to work, if they are on leave.

Example: An employee tells her employer that because of her disability, she needs to attend medical appointments every Wednesday morning for the next month. The employer accepts this information in good faith and provides flexible hours on those days as an accommodation.

Example: A tenant tells his landlord that he has been hospitalized due to a disability and cannot make his rent payment on time. Knowing that the person is in hospital, the landlord does not require confirmation that the tenant has a disability, but asks for information to indicate that his need is temporary in nature, and that he will be able to pay his rent once released in a few weeks' time. The person provides this information, and the landlord makes an allowance for the late payment.

There may be rare instances where there is a reasonable basis to question the legitimacy of a person's request for accommodation or the adequacy of the information provided. In such cases, the accommodation provider may request confirmation or additional information from a qualified health care professional to get the needed information.

Example: A large employer establishes a disability management program, because it finds that a significant number of employees experience mental health disabilities at some point in their working lives. Instead of expecting an employee to provide medical documentation to support a request for accommodation, it focuses on the person's own assessment of their needs and strengths. Only if the person's needs are complex, or the person is not taking part in the process, will additional information from a doctor be sought. Using this approach, the employer maintains good employee/employer relations, and employees come back to work sooner from disability leave.[217]

Where more information about a person's disability is needed, the information requested must be the least intrusive of the person's privacy while still giving the accommodation provider enough information to make the accommodation.

> **Example:** A person (who has anxiety) enters a grocery store with a dog. For health and safety reasons, the store normally does not allow animals, but makes an exception for service animals. The store owner asks the person to leave, and the person states that his dog is a service animal. The store owner needs further verification, because the dog does not have any identifying markings to indicate that it is a service animal. The person is asked to provide medical documentation that he has a disability and that the disability is related to his need to use a service animal.[218]

In the rare case where an accommodation provider can show that it legitimately needs more information about the person's disability (as opposed to just the needs related to the disability) to make the accommodation, it could ask for the nature of the person's illness, condition, or disability[219] (for example, is it a mental disability, a learning disability or an addiction?), as opposed to a medical diagnosis.

Organizations are not expected to diagnose illness or "second-guess" the health status of an employee. An accommodation provider is not entitled to substitute its own opinion for that of medical documentation provided by a doctor.[220] Similarly, an organization must not ask for more confidential medical information than necessary because it doubts the person's disclosure of their disability based on its own impressionistic view of what a mental health disability or addiction disability should "look like."[221]

> **Example:** A woman discloses to her co-workers that she experiences depression. Later, she presents a doctor's note verifying that she is being treated for a "medical condition" and indicating she requires a week off work. While the employer knows that the woman has said she is depressed, it is his view that she doesn't appear to be sad or distressed. As a result, he refuses to provide the accommodation unless she provides more information about her diagnosis. This could be a violation of her rights under the *Code.*

An accommodation provider should be able to explain why it is requesting particular information about a person's disability and how this relates to accommodating the person.

Generally, the accommodation provider does not have the right to know a person's confidential medical information, such as the cause of the disability, diagnosis, symptoms, or treatment,[222] unless these clearly relate to the accommodation being sought, or the person's needs are complex, challenging or unclear and more information is needed. In rare situations where a person's accommodation needs are complex, challenging or unclear, the person may be asked to co-operate by providing more information, up to and including a diagnosis.[223] In such situations, the accommodation provider must be able to clearly justify why the information is needed.

> **Example:** A person is employed as an addictions counsellor for an abstinence-based drug treatment program. She requests an accommodation based on a "disability" to take time off work each week to attend "treatment." Based on recent observations of the person, and concerns about the person coming to work while inebriated, the employer wants to know from the employee's doctor if she has a substance dependence related to alcohol or drugs. The employer could argue that this request is legitimate, because of the potential negative impact of someone who appears inebriated working with clients with addictions. Knowledge of the employee's diagnosis will inform how the employer accommodates her (for example, by providing her temporarily with a different position, or offering her time off to address her addiction).

However, wherever possible, an accommodation provider must make genuine efforts to provide needed accommodations without requiring a person to disclose a diagnosis, or otherwise provide medical information that is not absolutely necessary.

Where someone's needs are unclear, they may be asked to attend an independent medical examination (IME). However, there must be an objective basis for concluding that the initial medical evidence provided is inaccurate or inadequate. The IME should not be used to "second-guess" a person's request for accommodation.[224] Requests for medical examinations must be warranted and take into account people's particular disability-related needs.[225]

> **Example:** A person with bipolar disorder is employed as a lifeguard, which is a "safety sensitive" position. He is hospitalized for a period of time and upon being released, his doctors indicate that he is fit to return to work. However, upon returning, he is evaluated and his supervisor notices that he cannot focus well, his reaction time is slow, and he makes repeated mistakes. In this case, the employer may be justified in asking the employee to attend an independent medical examination.[226]

No one can be made to attend an independent medical examination, but failure to respond to reasonable requests may delay the accommodation until such information is provided, and may ultimately frustrate the accommodation process.

Mere assertions of symptoms, such as statements that the person experiences "stress," "psychological problems," "anxiety," "pain" or "feels depressed" – things that many people commonly experience – may not be enough to establish a mental disability within the meaning and protection of human rights legislation.[227] If choosing to disclose such information in writing, individuals and doctors should make it clear that these symptoms relate to a disability.

> **Example:** A person provides a doctor's note to their employer stating that they are experiencing "stress" and need a leave of absence. The employer may be entitled to ask for more information about whether the stress is linked to an underlying disability. If it is, the employer may ask about the person's restrictions, the expected date of return to work, and whether or not the person could still be present at work with an accommodation.

However, where these types of assertions exist alongside other indicators that the person is distressed or unwell, and where an employer, housing provider or service provider perceives that a person may have a disability, the *Code*'s protection will be triggered.

Where a person provides disability-related information that an accommodation provider deems "insufficient" to enable it to provide accommodation, the accommodation provider cannot use its own failure to ask for additional information to deny the accommodation or to otherwise subject a person to negative treatment (for example, termination of employment, denial of service, *etc.*).[228]

If the person does not agree to provide additional medical information, and the accommodation provider can show that this information is needed, it may be the case that the person seeking accommodation could be found to not have taken part in the accommodation process and the accommodation provider would likely be relieved of further responsibility.[229]

13.8 Confidentiality

Maintaining confidentiality for people with mental health disabilities or addictions may be especially important because of the strong social stigmas and stereotyping that persist about such disabilities.

> **Example:** In one case, an employer publicized confidential medical information when it posted private medical details about the applicant (including details of her depression) on the club's bulletin board. The tribunal found that this was discriminatory because it stigmatized her and poisoned her work environment.[230]

Documentation supporting the need for a particular accommodation should be provided only to the people who need to be aware of the information. For example, in employment, it may be preferable in some circumstances for information to be provided to the company's health department or human resources staff rather than directly to a supervisor, to further protect confidentiality.

> **Example:** A person needs flexible scheduling due to a mental health issue when attending court. Documentation to support the accommodation is given only to the Court's accessibility co-ordinator. It may be sufficient for other court staff to know only that they need to provide the person with the accommodation.

A person's medical information should be kept separately from their personnel file, or any file associated with their tenancy or use of a service.

In cases where there are compelling circumstances affecting the health and safety of an individual, it may be necessary to disclose information about a person's health to others.[231] This should be done in accordance with privacy laws. More information about privacy laws and how they apply to public and private housing providers, employers and service providers can be found at the Office of the Information and Privacy Commissioner of Ontario and the Office of the Privacy Commissioner of Canada.[232]

> **Example:** A health care practitioner at a university health centre or a college academic advisor would be allowed to disclose personal health information to a client's family or physician if there were reasonable grounds to believe it was necessary to do so to reduce the risk of suicide.[233]

13.9 Treatment

Seeking treatment,[234] such as medication or therapy, is a very personal issue, and speaks to the fundamental rights of people to decide what to do with their own bodies. All capable adults have the right to consent or refuse to consent to treatment.[235] This is protected under section 7 of the Canadian *Charter of Rights and Freedoms*.[236] A substitute-decision maker must consent to treatment for people who have been deemed incapable.[237]

13.9.1 Requiring treatment

Employers, housing providers and service providers should be aware that it may be a violation of a person's human rights to impose blanket conditions or requirements to:

- get treatment
- get a particular kind of treatment (*e.g.* medication, see a psychiatrist)
- monitor someone's treatment

as a condition of getting or maintaining housing, services, or employment, where this is not a *bona fide* or legitimate requirement of taking part in the organization. Housing providers, service providers and employers should be aware of imposing extra conditions on people with psychosocial disabilities that are not imposed on people with other types of disabilities, or people without disabilities, where these are not legitimate requirements.

> **Example:** A university student seeks testing accommodation to accommodate her mental health issue. She is told that she must see her counsellor regularly as a condition of receiving this accommodation. Unless this condition can be shown to be a *bona fide* requirement of providing testing accommodation, this likely infringes her rights under the *Code.*

> **Example:** A person with schizophrenia lived in shared accommodation, provided by a mental health agency. It offered onsite rehabilitative services, including in-house counselling. The housing agreement required him to, among other things, comply with his treatment regime, refrain from drug or alcohol abuse, and not engage in violent behaviour. The tenant stopped taking his medication, but continued to see his medical professional team regularly. Without warning to him and with no consultation with his medical professionals, the agency told him to leave the housing because he no longer fit the program criteria. During a legal hearing, the agency said that it had asked him to leave because he was no longer on medication, had a history of violence (from 10 years earlier), was deteriorating emotionally (*e.g.* hearing voices and talking in computer language) and had told the staff he was an alcoholic. Although the case was not analyzed according to the *Code*, the Court found that the housing provider had breached the housing agreement, and that there was no real urgency to remove the person from his home, given that there was no indication that he posed a risk to anyone.[238]

To show that a requirement to take part in treatment is reasonable and *bona fide*, an organization must meet the three-step legal test set out in the *Meiorin* decision. This includes showing that it would cause the organization undue hardship to accommodate the person using alternative methods.[239]

People must be assessed based on their individual needs. Requirements should not be based on blanket assumptions that just because someone has a psychosocial disability, he or she must seek treatment, or a particular kind of treatment. Imposing such requirements, where they are not *bona fide*, can contribute to the disadvantage that people with psychosocial disabilities face as a group that has historically faced lack of informed consent with respect to treatment.

At the same time, while a person has the right to refuse treatment for their psychosocial disability, there may be repercussions flowing from this decision.[240]

A person's refusal to get treatment, where the requirement to take part in treatment is reasonable and *bona fide*, may affect an organization's ability to provide appropriate accommodation, and it may interfere with a person's ability to perform the essential duties of the job or the essential requirements attending the exercise of a right.

In some cases, an employer may require treatment as part of a "last chance agreement" where an employee has engaged in behaviour that has warranted termination. In such cases, these agreements are used as a condition of reinstatement.[241] Where last chance agreements are put in place, they must be designed to take into account a person's individual circumstances.[242] And, they should not contain provisions that impose penalties or higher standards for the person with a mental health or addiction disability (such as greater expectations for work performance) than those required of other similarly situated people.[243]

13.9.2 Treatment and the duty to accommodate

Accommodating a person's mental health issue or addiction by modifying processes, procedures, requirements or facilities to allow equal access, is not the same as treating someone's mental health issue or addiction. An employer, housing provider or service provider is generally not expected (or qualified) to give counselling, treatment or medication to a person. For example, a landlord would not be expected to "counsel" their tenant with a mental health issue or provide social work services as part of their duty to accommodate.[244]

In some circumstances, someone might choose to seek treatment and must be accommodated while doing so in housing, services or employment.

> **Example:** A housing provider may be expected to allow building access, or provide information to third-party agencies (with the tenant's consent) that help a tenant with hoarding behaviours if these are affecting the organization.

> **Example:** An employee starts a methadone treatment program. He works out an accommodation plan with his employer that allows him to collect his dose every day at a pharmacy during work hours and visit his doctor several times a week, provided he makes up the time at work. His employer is aware that he may have difficulty waking up during the acclimation stage of the program. His employer provides him with flexible work hours in the mornings to help him adjust.[245] With these accommodations, the employee is able to fulfil the essential duties of his job.

There may be greater expectations on organizations that have a care-taking responsibility to a person (compared to other organizations that are more peripheral to people's lives) to arrange treatment for the person as a form of accommodation, providing the person agrees to this.

> **Example:** Where mental disability-related behaviours are perceived to be interfering with a student's ability to take part in education, part of the school's duty to accommodate could be to seek consent to arrange for counselling through an available service, such as a school social worker, or make a referral to an outside agency. However, a fitness facility would not likely have this same duty.

14. Undue hardship

Organizations covered by the *Code* have a duty to accommodate to the point of undue hardship. Accommodation need not be provided if it causes undue or excessive hardship. However, some degree of hardship is acceptable.

The *Code* prescribes only three considerations when assessing whether an accommodation would cause undue hardship:

- cost
- outside sources of funding, if any
- health and safety requirements, if any.

No other considerations can be properly considered. For example, business inconvenience, employee morale, third-party preferences, *etc.* are not valid considerations in assessing whether an accommodation causes undue hardship.[246]

In many cases, it will not be costly to accommodate someone's mental health issue or addiction. Accommodation may simply involve making policies, rules and requirements more flexible. While doing this may involve some administrative inconvenience, inconvenience by itself is not a factor for assessing undue hardship.

To claim the undue hardship defence, the organization responsible for making the accommodation has the onus of proof.[247] It is not up to the person with a disability to prove that the accommodation can be accomplished without undue hardship.

The nature of the evidence required to prove undue hardship must be objective, real, direct and, in the case of cost, quantifiable. The organization responsible for accommodation must provide facts, figures and scientific data or opinion to support a claim that the proposed accommodation in fact causes undue hardship. A mere statement, without supporting evidence, that the cost or risk is "too high" based on impressionistic views or stereotypes will not be sufficient.[248]

Objective evidence includes, but is not limited to:

- financial statements and budgets
- scientific data, information and data resulting from empirical studies
- expert opinion
- detailed information about the activity and the requested accommodation
- information about the conditions surrounding the activity and their effects on the person or group with a disability.

14.1 Costs

The Supreme Court of Canada has said that, "one must be wary of putting too low a value on accommodating the disabled. It is all too easy to cite increased cost as a reason for refusing to accord the disabled equal treatment."[249] The cost standard is therefore a high one.

Costs will amount to undue hardship if they are:

- quantifiable
- shown to be related to the accommodation, and
- so substantial that they would alter the essential nature of the enterprise, or so significant that they would substantially affect its viability

The costs that remain after all costs, benefits, deductions and other factors have been considered will determine undue hardship. All projected costs that can be quantified and shown to be related to the proposed accommodation will be taken into account. However, mere speculation (for example, about financial losses that may follow the accommodation of a person with a mental health disability or addiction) will not generally be persuasive.

If an accommodation exceeds an organization's pre-determined accommodation budget, the accommodation provider must look to its global budget, unless to do so would cause undue hardship. The costs of accommodation should be distributed as widely as possible within the operation so that no division disproportionately assumes the costs of accommodation. [250]

Where an accommodation would cause undue hardship, the accommodation provider is required to find the next-best solution. For example, interim accommodation could be provided while the organization establishes a reserve fund to phase in the accommodation that is the most appropriate.

14.2 Outside sources of funding

To offset costs, an organization has an obligation to consider any outside sources of funding it can obtain to make the accommodation. A person seeking accommodation is also expected to avail themselves of any available outside sources of funding to help cover expenses related to their own accommodation.

> **Example:** A tenant in a supportive housing building in a street-level unit has post-traumatic stress disorder, which is exacerbated by exposure to noise. The person requires sound-proofing of his apartment to accommodate his disability. To make the accommodation, the supportive housing provider applies for funds through its funder and the tenant accesses a government-funded accessibility grant for people with disabilities to help alleviate the costs.

Before being able to claim that it would be an undue hardship based on costs to accommodate someone with a psychosocial disability, an organization would have to show that they took advantage of any available government funding (or other) program to help with such costs.

14.3 Health and safety

If an accommodation is likely to cause significant health and safety risks, this could be considered "undue hardship." Employers, housing providers and service organizations have an obligation to protect the health and safety of all their employees, clients and tenants, including people with mental health issues or addictions, as part of doing business safely, and as part of fulfilling their legal requirements of the *Occupational Health and Safety Act*. The *Code* recognizes that the right to be free from discrimination must be balanced with health and safety considerations.

An employer, housing provider or service provider can determine whether modifying or waiving a health or safety requirement or otherwise providing an accommodation will create a significant risk by considering:

- Is the person seeking accommodation willing to assume the risk in circumstances where the risk is solely to their own health or safety?
- Would changing or waiving a requirement or providing any other type of accommodation be reasonably likely to result in a serious risk to the health or safety of other employees, tenants, staff or other service users?
- What other types of risks are assumed within the organization, and what types of risks are tolerated within society as a whole?

Accommodation could involve addressing a health and safety risk arising from behaviour caused by someone's disability. Assessment of whether an accommodation would cause undue hardship based on health and safety must reflect an accurate understanding of risk based on objective evidence rather than stereotypical views. Undue hardship cannot be established by relying on impressionistic or anecdotal evidence, or after-the-fact justifications.[251] Anticipated hardships caused by proposed accommodations should not be sustained if based only on speculative or unsubstantiated concern that certain adverse consequences "might" or "could" result if the person is accommodated.[252]

In evaluating the seriousness or significance of risk, the following factors may be considered:

- The nature of the risk: what could happen that would be harmful?
- The severity of the risk: how serious would the harm be if it occurred?
- The probability of the risk: how likely is it that the potential harm will actually occur?
- Is it a real risk, or merely hypothetical or speculative? Could it occur often?
- The scope of the risk: who will be affected if it occurs?

If the potential harm is minor and not very likely to occur, the risk should not be considered serious. If there is a risk to public safety, consideration will be given to the increased numbers of people potentially affected and the likelihood that a harmful event may happen.

Organizations must try to mitigate risks where they exist. The amount of risk that exists *after* accommodations have been made and precautions have been taken to reduce the risk (short of undue hardship based on cost) will determine whether there is undue hardship.

Wherever possible, organizations should train their staff on effective and appropriate de-escalation strategies that can be used to defuse situations where a person's disability-related behaviour may present challenges. In many situations, effective intervention can mean the difference between peaceful conflict resolution and a full-blown crisis.

> **Example:** A police service trains all of its officers on de-escalation techniques with a specific focus on how to interact effectively with people who may be experiencing a mental health crisis. In addition, the service liaises with organizations that have expertise in mental health advocacy and support. In response to a call that a man in a public library was in distress and appeared to have a knife, police were called to the scene, and a mobile mental health crisis unit was put on standby. Using de-escalation techniques, the police were able to convince the man to drop his weapon. Then, the police and psychiatric nurses were able to speak to the man, reassure him, and calm him down.

Where policies or procedures implemented in the name of minimizing risk intrude on the dignity and equality of people with psychosocial disabilities, the responsible organization will need to show that the policy, procedure, *etc.* is a *bona fide* and reasonable requirement.[253]

"Zero tolerance" policies will often have a disproportionate impact on people with mental health disabilities or addictions, and do not negate an organization's obligation to accommodate to the point of undue hardship by assessing and reducing risk.

> **Example:** A service user attends a mental health service, is upset and starts yelling and making intimidating gestures at front counter staff. Security staff speak to the person, but the person continues yelling, and is ejected from the office. The service has a strict policy to prevent abuse of staff and bans people who are perceived as threatening from using the service. However, staff believe that the incident relates to the person's mental health issue. Instead of banning the person from using the service, the service provider contacts the person and explains their concerns and what led to them becoming upset, identifies any accommodations needed, and works with the person to identify how the person can continue taking part without repeating the incident.

Where a person's conduct is objectively disruptive, employers, housing providers and service providers must consider a range of strategies to address behaviour.

> **Example:** The behaviour of a woman with schizophrenia had the potential to endanger the safety of other tenants in her building. For example, on several occasions, she screamed loudly in the halls and other common areas, and once she left food on her stove unattended. By working with the woman and members of her family, a housing provider developed a crisis response plan, which included the woman's brother and mother being available by phone and being willing to intervene when her behaviour was disruptive.[254]

Strategies will include assessing, and where necessary, reassessing and modifying any accommodations that are already in place for the person, and/or providing or arranging for additional supports.

High probability of substantial harm to anyone will constitute an undue hardship. In some cases, it may be undue hardship to attempt to mitigate risk, such as where the risk is imminent and severe.[255]

The dignity of the person must be considered when addressing health and safety risks. Even where people are correctly assessed to pose a risk, organizations should apply a proportionate response. If a real risk exists, the least intrusive means to address the risk must be used.

15. Other limits on the duty to accommodate[256]

While the *Code* specifies that there are only three factors that will be considered when determining whether the test for undue hardship has been met (cost, outside sources of funding and health and safety issues), in some cases, courts and tribunals have recognized that even where these three factors are not at issue, there is not a limitless right to accommodation.[257] There may be other narrow circumstances where it may not be possible to accommodate a person's addiction or mental health disability.

However, an organization must not jump to the conclusion that accommodation is not possible or required. It must still meet its procedural duty to accommodate by examining issues on a case-by-case basis, and seeking out next-best solutions, such as phased-in or interim accommodation. The onus will be on an organization to show the steps they have taken and the concrete reasons why accommodation is not possible. Situations where the duty to accommodate might be limited may include:

1. *No accommodation is available that allows the person to fulfil the essential requirements of the job, tenancy, service, etc.*

There may be limited circumstances where a measure identified as a potential accommodation, that would not otherwise constitute an undue hardship based on cost and health and safety, is still not required. This is because the measure would fundamentally alter the nature of the employment, housing, service, contract, *etc*.,

or because it would still not allow the person to "fulfill the essential duties attending the exercise of the right."[258] This may be the case even after the organization has been inclusively designed, barriers to participation have been removed, and accommodation options examined. Or, after accommodation has been tried and exhausted, there may be no further accommodation available that will help the person to complete the essential requirements of the housing, services, employment, *etc*. In such instances, the organization may have fulfilled its duty to accommodate.

> **Example:** A person who has a drug addiction seeks treatment through a voluntary residential abstinence-based program. Due to his disability, the person leaves the program part way through and relapses on three different occasions. The program attempts to accommodate the person's disability and offers counselling and support to help him stay and complete the program. This has no effect. After he has left multiple times, the program identifies that it cannot continue to keep a space open for him until he can rejoin the program and meet the essential requirements (attendance) with or without accommodation.[259]

In extreme situations – for example, where disability-related absences have spanned several years or more – human rights case law has established limits on the duty to accommodate. In such situations, it has been held that "the duty to accommodate is neither absolute nor unlimited,"[260] and does not guarantee an indefinite leave of absence.[261]

In employment, the purpose of the duty to accommodate is not to completely alter the essence of the contract of employment, that is, the employee's duty to perform work in exchange for remuneration. Although the employer does not have a duty to change working conditions in a fundamental way, it does have a duty, if it can do so without undue hardship, to arrange the employee's workplace or duties to enable the employee to do his or her work. This can include alternative work, a flexible work schedule, lightened duties or even staff transfers.[262]

Human rights case law establishes that potential accommodations that would fundamentally alter the nature of the employment relationship need not be provided.

> **Example:** In one case, an employee argued that the duty to accommodate requires an employer to refrain from collecting an overpayment of wages, in circumstances where attempts to collect have a negative impact on the employee by reason of his/her disability. The HRTO said that the duty to accommodate does not require this as it "flies in the face of the well-established principle that the duty to accommodate does not require pay for no work in exchange."[263]

> **Example:** In another case, the HRTO considered whether the employer's decision not to continue allowing an injured worker to remain in a modified position on a part-time basis, instead placing her on an unpaid medical leave, was discriminatory. The respondent argued that its obligation to the applicant did not extend to permanently creating or bundling a set of tasks that did not

> result in a job that was useful to the respondent's operations. Without finding undue hardship, HRTO agreed that this was not a necessary accommodation as the duty to accommodate does not require the employer to allow the employee to perform only some of the essential duties of the job. It stated that the duty to accommodate does not require an employer to permanently assign the essential duties of an employee with a disability to other employees or to hire another employee to perform them in the employee's place.[264]

There may be cases where the characteristics of an illness – for example, very lengthy absences or a very poor prognosis – are such that the proper operation of the business is hampered excessively, or where an employee remains unable to work for the reasonably foreseeable future, even though the employer has tried to accommodate him or her. The employer's duty to accommodate may end where the employee is no longer able to fulfill the basic obligations associated with the employment relationship for the foreseeable future, even with accommodation.[265]

Therefore, not every accommodation will be required even where providing it might not constitute an undue hardship in terms of cost and health and safety.[266] While the cases above were decided in the context of employment, it is likely that the same legal principles would apply in the social areas of housing, services, *etc.* if the accommodation would fundamentally alter the nature of the housing or service.

> **Example:** Under the *Code*, a landlord may be required to install full-spectrum lights as an accommodation to help a tenant manage his mental health disability, unless it would pose an undue hardship. However, if the tenant were to ask the landlord to arrange and pay for home care services, this would likely not be required because home care services alter the essential nature of the landlord's obligation which is to provide housing and not services.

2. Where a person does not participate in the accommodation process

In some cases, an organization may have fulfilled its procedural and substantive duty to accommodate, because the person may not have taken part in the process. For example, a person may be considered to have not taken part if they refuse to comply with reasonable requests for information necessary to show and/or meet their accommodation needs, or where they refuse to take part in developing accommodation solutions.

Before concluding that a person has not co-operated, accommodation providers should consider if there are any disability or *Code*-related factors that may prevent the person from taking part in the process. These factors may then need to be accommodated. The accommodation provider should also consider whether an accommodation plan needs to be adjusted because it is not working.

It may be challenging for organizations when they perceive that a person has a mental health issue or addiction and needs an accommodation, but the person denies that he or she has a disability. In these cases, organizations should still attempt to start the accommodation process, and continue to offer accommodation, as appropriate. However, there will be a limit to the extent that an organization can accommodate someone's disability in the absence of the person's participation.

> **Example:** In one case, a student at a college showed behaviour at school such as "abusive outbursts," incidents of unexplained crying, incoherent speech, and strange accusations directed towards classmates. Students and teachers became concerned about her well-being. The administration believed that she might have an undisclosed mental disability that required accommodation, and approached her to talk about her behaviour. The student did not consider her behaviour to be inappropriate and did not seek any accommodation. The HRTO ruled that "when an organization perceives a person to have a disability but the person denies it, it is unclear whether the duty to accommodate arises and precisely what form any such duty would take." It was the claimant's obligation to take part in efforts to accommodate her, and because she did not take part, the HRTO found she could not claim she experienced discrimination based on a disability.[267]

3. Balancing the duty to accommodate with the rights of other people

Generally, when a person makes an accommodation request, the organization or institution responsible for accommodation will be able to provide the accommodation without it affecting the legal rights of other people.

Sometimes, however, a request for accommodation may turn out to be a "competing human rights" situation. This will be the case if, while dealing with an accommodation request, it turns out that the legal rights of another person or group might also be affected.

This complicates the normal approach to resolving a human rights dispute where only one side claims a human rights violation. In some cases, only one party is making a human rights claim, but the claim conflicts with the human rights of another party or parties.

Organizations and institutions operating in Ontario have a legal duty to take steps to prevent and respond to situations involving competing rights. The OHRC's *Policy on competing human rights*[268] sets out a framework for analyzing and addressing competing human rights situations. It also provides concrete steps on how organizations can proactively take steps to reduce the potential for human rights conflict and competing rights situations.

Claims that affect business operations alone are properly considered within the scope of the duty to accommodate (that is, whether an accommodation is appropriate or amounts to an undue hardship) and are not competing human rights claims.

> **Example:** An employee claims discrimination when her employer denies her request for modified work hours so that she can attend weekly appointments with her psychiatrist. Her request does not appear to affect the legal rights of others. Therefore, this situation is not a competing rights claim, but rather is one involving a request for human rights accommodation. The employer might try to argue undue hardship based on financial impact for his business, which could limit his duty to accommodate.

Organizations must distinguish between claims that solely affect business operations and therefore fall within the duty to accommodate, from competing claims that affect the rights of other individuals and groups.

16. Consent and capacity

Many people with psychosocial disabilities do not have difficulty with decision-making capacity. However, there may be times in a person's life when, due to their disability, they are deemed to lack the capacity to make important life decisions.[269] In general, a person is deemed to have capacity if they are able to understand the information that is relevant to making a decision and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[270]

In Ontario, there is a complex legislative scheme that governs matters related to mental capacity. The *Substitute Decisions Act*,[271] the *Health Care Consent Act*[272] and the *Mental Health Act*[273] all deal with aspects of decision-making and mental capacity. While a comprehensive examination of this legislative framework and its implications is beyond the scope of this policy, it is important to note that the *Code* has primacy over these pieces of legislation.[274] Therefore, decisions that take place under these pieces of legislation must have regard for the *Code* and human rights principles.

Human rights principles to keep in mind in matters related to consent and capacity are inclusive design, individualized assessment, respect for dignity, autonomy, confidentiality, opting for the least intrusive and restrictive options wherever possible, and integration and full participation wherever possible.

The power to make decisions about matters that affect one's own life and to have them respected by law is a fundamental part of realizing one's rights as an autonomous adult, and indeed, is fundamental to personhood itself. Capacity issues can affect a person's ability to make decisions about getting married, managing property, personal care, health care, whether to receive treatment, consenting to go to a long-term care facility,

instructing counsel, *etc.* The Ontario Court of Appeal has recognized that the right to personal autonomy, self-determination and dignity is "no less significant" for people with mental health disabilities, and "is entitled to no less protection, than that of competent persons suffering from physical ailments."[275]

Capacity is not an inherent unchanging trait, but exists on a spectrum, is contextual and assessments can be influenced by the social environment. There may also be social, economic and legal barriers that a person with a mental health disability may face in making and implementing decisions.[276] For example, perceptions about someone's capacity could be wrongly influenced by stereotypes.

In Ontario, adults are presumed to be capable, depending on the type of decision being made, unless there are reasonable grounds[277] to believe otherwise. Capacity should be measured on a case-by-case basis, with an eye to the purpose of the relationship or transaction in question.[278] For example, a person may be capable of consenting to treatment, but not creating a will. They may be able to make a simple decision, but not a complex one. [279]

> **Example:** In one case, the Ontario Court of Appeal found that a woman in the early stages of Alzheimer's disease had the capacity to decide to leave her husband. The Court determined that decisions related to marriage, separation and divorce required a low level of capacity. It distinguished these types of decisions from those related to instructing counsel, which it said required a higher level of capacity that included being able to understand financial and legal issues. In the Court's view, instructing counsel was on a "significantly higher" level on the "competency hierarchy." The Court decided that, "While Mrs. Calvert may have lacked the capacity to instruct counsel, that did not mean that she could not make the basic personal decision to separate and divorce."[280]

People with capacity also have the right to make decisions that others do not agree with, even where a decision made by a capable person with a mental health disability is thought by others not to be in his or her best interest.[281]

Environments should be designed inclusively to facilitate participation in decision-making, wherever possible. For example, organizations should:

- offer plain-language self-help resources to help people with disabilities make their own decisions about taking part
- establish an accessibility office, or trained staff that act as a resource for people with capacity issues to seek information or assistance
- make sure that everyone can provide informed consent – that is, make sure everyone has the information they need to make a decision, including possible outcomes flowing from that decision
- involve a support network or circle of support (such as family or friends) to help the person make decisions, or interpret what a person wants when they need to make a decision.[282]

Before determining that a person lacks capacity, an organization, assessment body, evaluator, *etc.* has a duty to explore accommodation options to the point of undue hardship. This is part of the procedural duty to accommodate under the *Code.* Accommodation may mean modifying or waiving rules, requirements, standards or practices, as appropriate, to allow someone with a psychosocial disability to access the service equitably, unless this causes undue hardship.

> **Example:** A woman arrives at a government office to apply for public assistance. Upon approaching the service counter, she seems confused and speaks very slowly. The service provider takes the time to explain things patiently and in plain language. He answers the woman's questions, helps her to understand the application and assessment process, and provides her with relevant brochures to take home with her. With this support, the woman is able to make an informed decision about whether to apply for benefits.

People with psychosocial disabilities who lack capacity are often highly vulnerable to mistreatment. Organizations and institutions dealing with people with psychosocial disabilities should recognize that people who lack capacity may be more at risk for exposure to exploitation and abuse, particularly if they are isolated from social supports, do not know their rights, or have people acting on their behalf who are in a conflict of interest.

Organizations should monitor practices relating to people with capacity issues to prevent situations that may expose people to violations of the *Code* or other forms of exploitation. Where people who are incapable are treated inequitably without regard to their specific *Code*-related circumstances, or exposed to disadvantage compared to other people who are capable, this may be discriminatory.

People acting on behalf of people with psychosocial disabilities (for example, guardians, support workers, substitute decision-makers, *etc.*) also have protection under the *Code.* Section 12 protects people from discrimination where they are associated with someone who identifies by a prohibited ground of discrimination. For example, if an organization disregards the input of a substitute decision-maker acting on behalf of a person with a disability, while taking into account the wishes of people with disabilities who do not require substitute decision-makers, this could be discrimination against both the person with the disability and their substitute decision-maker.

Given that many people in Ontario may need help with decision-making at some point in time, either due to dementia related to aging and disability, a mental health disability or an intellectual disability, organizations should develop policies and procedures to address these needs. The failure of an organization to do so could contribute to evidence of a *Code* breach if an adverse effect on persons with disabilities is found.

17. Preventing and responding to discrimination

The ultimate responsibility for maintaining an environment free from discrimination and harassment rests with employers, housing providers, service providers and other responsible parties covered by the *Code*. It is not acceptable to choose to stay unaware of discrimination or harassment of a person with a mental health disability or addiction, whether or not a human rights claim has been made.

Organizations and institutions operating in Ontario have a legal duty to take steps to prevent and respond to breaches of the *Code*. Employers, housing providers, service providers and other responsible parties must make sure they maintain accessible, inclusive, discrimination and harassment-free environments that respect human rights. All of society benefits when people with mental health or addiction disabilities are encouraged and empowered to take part at all levels.

Employers, housing providers, service providers and other responsible parties violate the *Code* where they directly or indirectly, intentionally or unintentionally infringe the *Code,* or where they authorize, condone or adopt behaviour that is contrary to the *Code*.

Under section 46.3 of the *Code*, a corporation, trade union or occupational association, unincorporated association, or employers' organization will be held responsible for discrimination, including acts or omissions, committed by employees or agents in the course of their employment. This is known as vicarious liability. Simply put, it is the OHRC's position that an organization is responsible for discrimination that occurs through the acts of its employees or agents, whether or not it had any knowledge of, participation in, or control over these actions.

> **Example:** Staff in a group home refuse to investigate a tenant's allegation that another tenant is discriminating against her based on her sex and mental health disability. The organization operating the group home would be responsible and potentially liable for condoning discrimination and not responding to this allegation.

Vicarious liability does not apply to breaches of the sections of the *Code* dealing with harassment. However, since the existence of a poisoned environment is a form of discrimination, when harassment amounts to or results in a poisoned environment, vicarious liability is restored. Further, in these cases the "organic theory of corporate liability" may apply. That is, an organization may be liable for acts of harassment carried out by its employees if it can be proven that management was aware of the harassment, or the harasser is shown to be part of the management or "directing mind" of the organization.[283]

The decisions, acts or omissions of the employee will engage the liability of the organization in harassment cases where:

- the employee who is part of the "directing mind" engages in harassment or inappropriate behaviour that is contrary to the *Code*, or
- the employee who is part of the "directing mind" does not respond adequately to harassment or inappropriate behaviour he or she is aware of, or ought reasonably to be aware of.

In general, managers and central decision-makers in an organization are part of the "directing mind." In employment, employees with only supervisory authority may also be part of the "directing mind" if they function, or are seen to function, as representatives of the organization. Even non-supervisors may be considered to be part of the "directing mind" if they have *de facto* supervisory authority or have significant responsibility for the guidance of others. For example, a member of the bargaining unit who is a lead hand may be considered to be part of the "directing mind" of an organization.

There is also a clear human rights duty not to condone or further a discriminatory act that has already happened. To do so would extend or continue the life of the initial discriminatory act. This duty extends to people who, while not the main actors, are drawn into a discriminatory situation through contractual relations or in other ways.[284]

Depending on the circumstances, employers, housing providers, service providers and other responsible parties may be held liable for failing to respond to the actions of third parties (such as service users or customers, contractors, *etc.*) who engage in discriminatory or harassing behaviour.[285]

Multiple organizations may be held jointly liable where they all contribute to discrimination. For example, a union may be held jointly liable with an employer where it has contributed towards discriminatory workplace policies or actions – for example, by negotiating discriminatory terms in a collective agreement, or blocking an appropriate accommodation, or failing to take steps to address a harassing or poisoned workplace environment.[286]

Human rights decision-makers often find organizations liable, and assess damages, based on the organization's failure to respond appropriately to address discrimination and harassment.

> **Example:** In one case, a man with bipolar disorder alleged that he was subjected to cruel taunts and negative treatment by his co-workers based on his mental health disability, and a perception that he was gay. He alleged that his co-workers called him homophobic names, teased him for taking medication for his disability, called him "crazy," and openly accused him of wanting to molest children. He brought these issues to the attention of his employer, but nothing changed. The HRTO found that the employer had breached the man's right to be free from discrimination based on both disability and sexual orientation when it failed to investigate and address his complaints of harassment.[287]

An organization may respond to complaints about individual instances of discrimination or harassment, but they may still be found to have not responded appropriately if the underlying problem is not resolved. There may be a poisoned environment, or an organizational culture that condones discrimination, despite punishing the individual perpetrators. In these cases, organizations must take further steps, such as training and education, to better address the problem.

Some things to consider when deciding whether an organization has met its duty to respond to a human rights claim include:

- procedures in place at the time to deal with discrimination and harassment
- the promptness of the organization's response to the complaint
- how seriously the complaint was treated
- resources made available to deal with the complaint
- whether the organization provided a healthy environment for the person who complained
- how well the action taken was communicated to the person who complained.[288]

The following steps are some ways that organizations can prevent and eliminate discrimination against people with mental health disabilities or addictions in their organizations. Organizations should develop strategies to prevent discrimination based on all *Code* grounds, but should give specific consideration to people with psychosocial disabilities.

A complete strategy to prevent and address human rights issues should include:

- a barrier prevention, review and removal plan
- anti-harassment and anti-discrimination policies
- an education and training program
- an internal complaints procedure
- an accommodation policy and procedure.

In its publication entitled, *A policy primer: Guide to developing human rights policies and procedures*,[289] the OHRC provides more information to help organizations meet their human rights obligations and take proactive steps to make sure their environments are free from discrimination and harassment.

Here are some things organizations should consider with respect to people with mental health or addictions issues when implementing barrier prevention, review and removal plans, developing human rights policies and procedures, and in education and training programs.

17.1 Barrier prevention, review and removal

Ensuring full accessibility means making sure that barriers to employment, services and housing for people with psychosocial disabilities are not embedded into new organizations, facilities, services or programs. It also means identifying and removing

barriers where they already exist. A barrier removal process should include reviewing an organization's physical accessibility, policies, practices, decision-making processes and overall culture.

Under the *Accessibility for Ontarians with Disabilities Act*, employers, service providers, many housing providers and the government will be required to comply with accessibility standards for people with disabilities. Part of complying with the standards means that government, large organizations and designated public sector organizations will have to develop accessibility plans to prevent and remove barriers to accessibility.

The principles around designing inclusively and barrier removal apply to people with psychiatric disabilities or addictions as they do to people with mobility or other types of disabilities. However, these techniques may differ depending on the needs to be addressed. For example, the needs of people with psychosocial disabilities may at times include needs related to concentration, memory, organization or communication.[290] An organization may need to focus more on its policies, procedures or organizational culture than on physical accessibility.

> **Example:** A social housing provider starts a barrier review process with its staff and tenants and finds that organizational and attitudinal barriers – such as the existence of stereotyping about people with mental health and addiction issues and a lack of knowledge about how to ask for accommodation – are pressing barriers.

When designing inclusively and removing barriers, organizations should consult with people with psychosocial disabilities to gain a greater understanding of people's diverse needs, and how to most effectively meet them. It is important that people with psychosocial disabilities have the opportunity to provide input into information-gathering processes and are consulted about the barriers that affect them.

> **Example:** A medical centre reviews barriers to its service by interviewing its service users. It finds that low-income people with multiple mental health and addiction issues are not as likely to be long-term clients because they are consistently told that centre staff do not have the expertise to deal with their concerns. Based on service users' feedback, the centre revises its practices by using a "team" approach so each client has better access to a number of professionals – medical professionals with expertise in different areas, social workers, housing workers and peer support workers. It seeks out continuing professional education on issues relating to mental health, addiction and other related issues, such as poverty, to increase the expertise of its staff.

When identifying barriers, organizations should take into account that discrimination based on mental health issues or addictions may intersect with discrimination based on other *Code* grounds, including race, sex, and other kinds of disabilities. As well, someone may experience different barriers based on their level of income. Someone

who has a mental health issue, has low income, is a newcomer to Canada, and speaks English as a second language may experience unique barriers when trying to access a service compared to other service users. When collecting information about barriers, organizations should include ways for people to tell the organization about all of the circumstances that may prevent them from taking part equally.

17.2 Data collection and monitoring

Collecting numeric (quantitative) and word-based or pictorial (qualitative) data can help an organization understand the barriers that exist, and identify and address concerns that may lead to systemic discrimination. Some methods to do this include surveying employees, service users or tenants (in larger housing organizations), doing interviews, focus groups or asking for verbal or written feedback.[291] Where an organization suspects that systemic discrimination may be taking place, it should adopt proactive measures to address it including monitoring and, where appropriate, collecting data.

Because of the stigma surrounding mental health and addictions, people may fear that their private information will be shared unnecessarily with others, with negative consequences. It helps to make surveys or data collection anonymous and ensure people will know how their information will be used and how it will be kept private.

Many people with mental health or addiction issues will not have access to mainstream methods of written surveys or doing interviews. They may be prevented from entering housing, employment or using a service altogether because of barriers such as poverty, isolation or homelessness. Consultation processes themselves must be accessible. For assistance on getting information from people from hard-to-reach populations, it may be helpful to contact accessibility consultants with expertise in mental health, or local agencies that are run by or work with people with mental health issues or addictions.

Information about barriers to accessibility, discrimination and harassment can be monitored through periodic data collection over time. Data collection can also help an organization understand if its efforts to combat discrimination, such as putting in place a special program, are helping or need to be modified.

17.3 Developing human rights policies and procedures

Developing anti-harassment and anti-discrimination policies, an internal human rights procedure, and an accommodation policy and procedure are part of an overall human rights strategy, but these should also be developed with the needs of people with psychosocial disabilities in mind.

For example, people with mental health issues and addictions should be explicitly referred to as protected under the ground of “disability.” An accommodation procedure should contemplate situations where a person is perceived to have an accommodation

need related to a mental health issue or addiction but may be unable to disclose it. The organization should also outline how the confidentiality of people's private medical information will be maintained in any procedures dealing with how people's human rights concerns or accommodation requests will be dealt with.

Under the *Occupational Health and Safety Act*, all workplaces in Ontario are expected to develop harassment policies and review these at least annually. Harassment policies should explicitly include harassment based on a mental health issue or addiction. The *AODA* requires that obligated organizations develop, implement and maintain accommodation policies that govern how the organization will achieve accessibility.[292]

The stigma associated with mental health and addictions, lack of knowledge about one's rights, and fear of reprisal are factors that may contribute to people not knowing how to complain or avoiding making a complaint, even where they feel their human rights are being violated. Organizations should make sure that they provide adequate information and training about complaint procedures, and clearly outline that people will not experience reprisal for making a complaint.[293]

> **Example:** A college develops a human rights complaint procedure for its service users. In addition to putting it online, it consults with a mental health disability group and develops plain-language brochures in the major languages spoken in the community, and sends these out to diverse community agencies, legal clinics and hospitals across the municipality.

17.4 Education and training

Education and training on mental health, addictions and human rights is essential to developing a "human rights culture" within an organization that supports the values and principles of the *Code*. Without an understanding of human rights issues relating to people with mental health or addiction disabilities, and support for human rights principles, human rights policies and procedures will be less likely to succeed.

Under the *AODA*'s "Integrated Accessibility Standard," organizations also have a duty to train their employees and others on human rights and accessibility. Every obligated organization[294] must make sure that training is given to employees, volunteers, people who help develop the organization's policies, as well as others who provide goods services and facilities on behalf of the organization. The training must be provided on the requirements of the accessibility standard and on the Ontario *Human Rights Code* as it pertains to people with disabilities.[295]

Education on human rights works best when accompanied by a strong proactive strategy to prevent and remove barriers to equal participation, and effective policies and procedures for addressing human rights issues that do arise. Education on mental health alone is not necessarily enough to change the behaviour of individuals or organizational culture.[296]

Example: A university implements an anti-stigma and human rights program around mental health to change individual attitudes and eliminate discrimination. In addition to providing education on mental health issues and human rights to students and staff, it reviews its policies and procedures to make sure they are not contributing to barriers to education. It also interviews students with mental health issues before the program and at points afterward, to see if the school environment has become more inclusive as a result. One barrier identified is that some professors unnecessarily expect students to disclose their diagnosis to receive classroom accommodation. To overcome this barrier, it develops a set of procedures, trains professors and staff and provides further information to students on accommodation.

Programs that focus on education, raising awareness and changing attitudes should also include evaluating whether behavioural change has resulted in the short and long term and if discriminatory barriers in the organization or system have changed as a result.

In addition to training that is required by the *AODA*, the following items could be integrated into a human rights training program on mental health and addictions:

- the types of barriers that people with psychosocial disabilities face in housing, employment and services (*e.g*. stereotypes)
- the rights of people with psychosocial disabilities under the *Code*
- the human rights system in Ontario, including how to file a human rights claim
- the specific obligations that an organization has to uphold people's *Code* rights and ways it can do this
- the organization's human rights strategy and human rights policies and procedures, such as complaint procedures and anti-discrimination and harassment policies, and how these relate to people with mental health or addiction disabilities
- how the organization accommodates people with mental health disabilities or addictions
- how the organization or its employees, customers, tenants and others can be part of a broader cultural shift to being more inclusive of people with mental health issues or addictions.

Human rights education should not be a one-time event. Ongoing training should be provided to address developing issues, and regular refreshers provided to all staff.

For more information on the human rights system in Ontario, visit:
www.ontario.ca/humanrights

The human rights system can also be accessed by telephone at:
Local: 416-326-9511
Toll Free: 1-800-387-9080
TTY (Local): 416-326 0603
TTY (Toll Free) 1-800-308-5561

To file a human rights claim (called an application), contact the Human Rights Tribunal of Ontario at:
Toll Free: 1-866-598-0322
TTY: 416-326-2027 or Toll Free: 1-866-607-1240
Website: www.hrto.ca

To talk about your rights or if you need legal help with a human rights claim, contact the Human Rights Legal Support Centre at:
Telephone: 416-597-4900
Toll Free: 1-866-625-5179
TTY: 416-597-4903 or Toll Free: 1-866-612-8627
Website: www.hrlsc.on.ca

For human rights policies, guidelines and other information, visit the Ontario Human Rights Commission at www.ohrc.on.ca

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Appendix A: Historical context

The following are some examples of discriminatory practices against people with psychosocial disabilities that mark an unfortunate part of Canada's history. Many of these practices still have a profound impact on people's sense of inclusion and their ability to exercise their rights today. People with mental health disabilities or addictions and others have responded to many of these issues by actively seeking changes to laws and policies to achieve social justice.

Immigration laws

From the late 1800s, Canadian immigration laws systematically prohibited people determined to be "lunatics" (people who were perceived to be mentally ill or have mental health challenges) and people determined to be "idiots" (people who were perceived to have intellectual or development disabilities) from entering the country. These laws first barred people who were not accompanied by families that could provide financial support. The fear was that individuals would become dependent on state institutions and charities.[297] By the early 1900s, immigration laws identified people with mental and physical disabilities as being in the "inadmissible" classes of immigrants. These laws reflected perceptions of people with mental health issues and cognitive and developmental disabilities as being "morally degenerate," with mental affliction being attributed to sin and moral weakness, and later associated with criminality and disease.[298] Restrictive immigration laws also led to the deportation of many people, based on assumptions of racial inferiority and presumptions of insanity and "feeble-mindedness."[299] Until the *Immigration Act* was amended in 1967, people with disabilities were still in the "undesirable" class of potential immigrants to Canada.

Involuntary sterilization

In their harshest form, the eugenics ideology and movement[300] sought to make sure that the more "fit" or socially desirable members of society had children while "undesirable elements" were bred out of the population.[301] In the late 1920s, Alberta and British Columbia introduced sexual sterilization legislation. Alberta sterilized over 2,800 people from 1929 until the law was repealed in 1972, with several hundred sterilizations occurring from the 1960s until 1972, often without the knowledge or consent of people or their parents. The Alberta Eugenics Board ordered sterilization for people declared "in danger of transmitting mental deficiency to their children, or incapable of intelligent parenthood."[302] This was rationalized on the basis that people with mental disabilities would make poor parents, and produce children prone to crime and other social problems.[303] People who were declared "mentally defective," "mentally deficient," "psychotic," "demented," *etc.* were sterilized, as well as people who had epilepsy, neurosyphilis, and Huntington's chorea.[304] Over 800 people sued the government of Alberta for having been involuntarily sterilized. The Government of Alberta made an official apology in 1999 and provided financial compensation to the victims.[305]

Marriage laws

Several Canadian provinces, including Alberta, British Columbia and Prince Edward Island passed marriage acts that prohibited people from marrying who were declared "mentally disordered,"[306] "insane or mentally incompetent,"[307] *etc.*, regardless of whether they had the capacity to marry.

Voting restrictions

Historically, people with mental health disabilities and intellectual disabilities have been assumed to be incapable of making significant decisions affecting them. In 1988, the Federal Court of Canada declared that a section of the *Canada Elections Act* was invalid and inconsistent with section 3 of the Canadian *Charter of Rights and Freedoms* which states that "Every citizen of Canada has the right to vote in an election of members of the House of Commons or of a legislative assembly and to be qualified for membership therein." The law prohibited people with mental disabilities detained in institutions, and people who did not have personal control of their property, from voting in federal elections. The Federal Court rejected the "assumption that a person suffering from any mental disability is incapacitated for all purposes, including voting."[308]

Insane asylums

The first permanent psychiatric institution or "insane asylum" opened in Québec in 1845. Other asylums opened across Canada from this time until 1914.[309] Despite the initial benevolent motives behind the asylum movement and the intent to provide care and treatment,[310] many inhumane practices occurred in these institutions.[311] Many patients, once admitted, spent the rest of their lives in the asylum isolated from family and community.[312] Overcrowding was common, relationships between patients and staff were paternalistic,[313] and patients reported experiencing verbal, emotional, physical and sexual abuse by other patients and staff.[314] Asylums often became custodial institutions, providing limited food and shelter with inadequate treatment. There was an over-reliance on seclusion and chemical and physical restraints.[315]

Deinstitutionalization

Starting in the 1960s, under a policy of deinstitutionalization, people were moved away from long-term psychiatric facilities with the goal that they would be provided services and supports in the community.[316] It was thought that patients would be admitted to the hospital briefly when unwell, but otherwise would live successfully in their communities.[317] Unfortunately, the result was that people with less severe mental health disabilities were more likely to be admitted to psychiatric units in general hospitals, while many people with severe and persistent mental health disabilities were left to rely on provincial psychiatric hospitals that had fewer specific mental health resources.[318] Ultimately, the shift from institutional to community care was marked by a lack of community supports, such as affordable, safe housing and a lack of accountability for the care of people with severe mental health disabilities.

People with addictions

The dominant view in Canadian society in the 19th century was that addiction was a moral failing and resulted from a "lack of will power or from personality defects."[319] In the early 1900s, drug addiction, such as cocaine and opium addiction, was considered a form of mental disorder that could lead to admission to an insane asylum.[320] As such, some people with addictions who were admitted to insane asylums experienced the same isolation from family and community, overcrowding and mistreatment from asylum staff that is described above.

People with addictions were often viewed by the public as dangerous.[321] Sometimes this perception was fuelled by racism. For example, xenophobia in British Columbia resulted in stereotypes of Chinese immigrants who smoked opium and ran opium dens as "drug villains."[322] However, "the larger number of predominantly middle-class and middle-aged Caucasian users who were addicted to the products of the established pharmaceutical industry" were generally not considered dangerous.[323]

Canada developed stringent criminal drug laws in the early 1920s as non-medical substance use was considered a law enforcement problem.[324] It was not until the early 1950s that a focus on treating alcohol and drug users emerged.[325]

Movements for change

In response to the discrimination experienced by people with mental illness, many different patient groups formed across Canada during the 1970s, some of which are still in existence today.[326] These groups formed the consumer/survivor/ex-patient movement. The general goals of the movement were to bring about change to the mental health system, educate other ex-patients and the public to challenge stereotypes about mental illness, advocate for patient rights, and create alternatives to psychiatric institutions, such as facilities organized and controlled by people with mental health disabilities.[327] In the late 1980s, a number of patient groups along with other advocates successfully lobbied for changes to the *Mental Health Act*, including granting patient access to mental health records and restricting the ability of doctors to restrain patients.[328]

Following a series of deaths in a psychiatric hospital, groups also advocated for investigations into psychiatric care practices, which eventually led to the establishment of the Psychiatric Patient Advocate Office.[329] Other initiatives included developing formal and informal groups for "peer support," developing businesses completely run by ex-patients, educating the public, and networking with other ex-patients through magazines and newsletters.[330]

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Endnotes

[1] *R. v. Swain*, [1991] S.C.R. 933 at 994. This point was also made by the Supreme Court of Canada in *Battlefords and District Co-operative Ltd. v. Gibbs*, [1996] 3 S.C.R. 566, which recognized "the particular historical disadvantage faced by persons with mental disabilities" (at para. 31).

[2] A "psychosocial disability" refers to both mental health issues and addictions. The World Network of Users and Survivors of Psychiatry (WNUSP) has adopted this term as a move away from a model of individual pathology, noting: "The psychological component refers to ways of thinking and processing our experiences and our perception of the world around us. The social/cultural component refers to societal and cultural limits for behaviour that interact with those psychological differences/madness as well as the stigma that the society attaches to labelling us as disabled." World Network of Users and Survivors of Psychiatry, *Implementation Manual for the United Nations Convention on the Rights of Persons with Disabilities*, (February 2008), available online at: www.un.org/disabilities/documents/COP/WNUSP%20CRPD%20Manual.doc at 9 (Retrieved: January 7, 2014).

[3] Offord DR, *et al.* "One-year prevalence of psychiatric disorder in Ontarians 15 to 64 years of age," *Can J Psychiatry* 1996; 41: 559-563.

[4] A person is stigmatized when they "possess an attribute that marks them as different and leads them to be devalued in the eyes of others" (see Brenda Major and Laurie T. O'Brien, "The social psychology of stigma," *Annu. Rev. Psychol*. 2005 56:393-421 at 395). Inherent in this is the idea that people are seen as "deviant" from what society has deemed as the "norm" (see Schur, Edwin M. 1971. *Labelling Deviant Behaviour: Its sociological implications*. New York: Harper & Row, Publishers, as cited by the Centre for Addiction and Mental Health, *The Stigma of Substance Abuse: A Review of the Literature* (18 August 1999). Available online at: www.camh.ca/en/education/Documents/www.camh.net/education/Resources_communities_organizations/stigma_subabuse_litreview99.pdf. See also G. Scrambler, (1988), "Stigma and disease: changing paradigms," *Lancet* 352 (9133), 1054-1055; Link, B.G. and Phelan, J.C. (2001) "Conceptualizing stigma," *Annual Review of Sociology*, 27, 363-385; Corrigan P.W. & Penn D.L. 1999, "Lessons from social psychology on discrediting psychiatric stigma," *American Psychologist* 54 (9), 765 – 776; Julio Arboleda-Florez, "Considerations on the Stigma of Mental Illness," *The Canadian Journal of Psychiatry*, November 2003, at 3; Liz Sayce, "Stigma, discrimination and social exclusion: What's in a word," *Journal of Mental Health*, 1998, 7, 4, 331-343; Neasa Martin & Valerie Johnston, *A Time for Action: Tackling Stigma and Discrimination: Report to the Mental Health Commission of Canada*, (Ottawa: Mental Health Commission of Canada, 2007).

[5] Ontario Human Rights Commission, *Minds that Matter: Report on the consultation on human rights, mental health and addictions*, 2012, available online at: www.ohrc.on.ca/en/minds-matter-report-consultation-human-rights-mental-health-and-addiction

[6] *Supra*, note 1.

[7] Canadian Medical Association, *8th Annual National Report Card on Health Care*. August 2008 at page 27; available online at: www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Annual_Meeting/2008/GC_Bulletin/National_Report_Card_EN.pdf

[8] Ashley Oleniuk, C. Randy Duncan, and Raymond Tempier, "The Impact of Stigma of Mental Illness in a Canadian Community: A Survey of Patients' Experiences," *Community Mental Health Journal* 49 (2013): 131.

[9] *Supra*, note 2.

[10] Offord DR, *et al*., *supra*, note 3.

[11] Canadian Working Group on HIV and Rehabilitation, "What is an Episodic disability?", available online at: www.hivandrehab.ca/EN/resources/description_episodic_disabilties.php (Retrieved: September 25, 2012).

[12] Gerald B. Robertson, "Mental Disability and Canadian Law" (1993) 2:1 *Health L. Rev.* 23.

[13] See the section on "Ableism, negative attitudes, stereotypes and stigma" for more information on ableism and its impact on people with psychosocial disabilities.

[14] See Appendix A for a detailed overview of the historical context of discrimination against people with psychosocial disabilities.

[15] *Mellon v. Human Resources Development Canada*, 2006 CHRT 3 at para. 88 (CanLII).

[16] Ontario Human Rights Commission, *Policy and guidelines on disability and the duty to accommodate*, available online at: www.ohrc.on.ca/en/policy-and-guidelines-disability-and-duty-accommodate.

[17] This policy does not directly address issues around drug and alcohol testing. For more information about the human rights implications of drug and alcohol testing, see Ontario Human Rights Commission, *Policy on drug and alcohol testing*, available online at: www.ohrc.on.ca/en/policy-drug-and-alcohol-testing.

[18] According to a 2008 Ipsos Reid poll of over 1,000 Canadians, almost half (46%) of respondents felt that the term "mental illness" is used as an excuse for bad behaviour: see CMA, *8th Annual National Report Card on Health Care* (2008), *supra,* note 7 at 4; *The Stigma of Substance Abuse: A Review of the Literature*, *supra*, note 4; Canadian Mental Health Association, Ontario, *Violence and Mental Health: Unpacking a Complex Issue: A Discussion Paper* (September 2011), available online at: www.ontario.cmha.ca/backgrounders.asp?cID=1081747.

[19] Statistics Canada data from its 2006 Participation and Activity Limitation Survey (PALS) shows that 26.8% of people in Ontario who self-identified as having "emotional" disabilities live with low incomes compared to people with other types of disabilities (10.0%). "Emotional disabilities" are defined as emotional, psychological or psychiatric conditions that have lasted, or were expected to last, six months or more. These include phobias, depression, schizophrenia, drinking or drug problems and others. "Low income" is defined as a "member of low income economic family or low income unattached individual (after tax)." The survey is available online at: www5.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=89-628-X&CHROPG=1&lang=eng.

[20] See the section on "Intersecting grounds" for more detail.

[21] Note that case law developments, legislative amendments, and/or changes in the OHRC's own policy positions that take place after a document's publication date will not be reflected in that document. For more information, please contact the OHRC.

[22] In *Quesnel v. London Educational Health Centre* (1995), 28 C.H.R.R. D/474 at para. 53 (Ont. Bd. Inq.), the Tribunal applied the United States Supreme Court's decision in *Griggs v. Duke Power Co.*, 401 U.S. 424 (4th Cir. 1971) to conclude that OHRC policy statements should be given "great deference" if they are consistent with *Code* values and are formed in a way that is consistent with the legislative history of the *Code* itself. This latter requirement was interpreted to mean that they were formed through a process of public consultation.

[23] For example, the Ontario Superior Court of Justice quoted at length excerpts from the OHRC's published policy work in the area of mandatory retirement and stated that the OHRC's efforts led to a "sea change" in the attitude to mandatory retirement in Ontario. The OHRC's policy work on mandatory retirement heightened public awareness of this issue and was at least partially responsible for the Ontario government's decision to pass legislation amending the *Code* to prohibit age discrimination in employment after age 65, subject to limited exceptions. This amendment, which became effective December 2006, made mandatory retirement policies

illegal for most employers in Ontario: *Assn. of Justices of the Peace of Ontario v. Ontario (Attorney General)* (2008), 92 O.R. (3d) 16 at para. 45 (Sup.Ct.). See also *Krieger v. Toronto Police Services Board*, 2010 HRTO 1361 (CanLII) and *Eagleson Co-Operative Homes, Inc. v. Théberge*, 2006 CanLII 29987 (Ont. Div. Ct.) in which both the HRTO and the Divisional Court applied the OHRC's *Policy and guidelines on disability and the duty to accommodate*, *supra*, note 16.

[24] The OHRC uses this term to refer to people with mental health disabilities, not people with intellectual disabilities. In some human rights contexts, this term has been used to describe people from both groups.

[25] "Consumer/survivor" is "a term used by some people who have a mental health problem and/or who have used mental health services or programs. Some believe that they have survived a mental health problem. Others see themselves as having survived the mental health system – depending on their experiences." See: www.google.ca/#q=consumer%2Fsurvivor%2C+definition.

[26] Mental health and addiction issues have been defined differently depending on people's subjective experiences, different legislation, programs and services, the historical, social and political context, and on the theoretical model used.

[27] From the Preamble to the United Nations' *Convention on the Rights of Persons with Disabilities*, (2006), 13 December 2006, U.N.T.S. vol. 2515, p.3 [*CRPD*], (entered into force 3 May 2008, accession by Canada 11 March 2010). Available online at: www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf

[28] See Article 1 of the *CRPD*, *ibid.*

[29] *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Montréal (City); Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Boisbriand (City)*, [2000] 1 S.C.R. 665 at para. 79 ["*Mercier*"].

[30] The tribunal in *Wali v. Jace Holdings Ltd.*, 2012 BCHRT 389 (CanLII) stated at para. 82: "It is not necessary that a disability be permanent in order to constitute a disability for the purposes of the *Code.* The *Code*'s protection also extends to persons who suffer from temporarily disabling medical conditions: *Goode v. Interior Health Authority*, 2010 BCHRT 95 (CanLII). Whether a temporary condition constitutes a disability is a question of fact in each case."

[31] These are defined as "mental illnesses" in *The Human Face of Mental Health and Mental Illness in Canada*, Government of Canada, 2006, at page 2, available online at: www.phac-aspc.gc.ca/publicat/human-humain06/pdf/human_face_e.pdf.

[32] In *Granovsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703, a case that involved a challenge to the Canada Pension Plan disability pension which arose under s. 15 of the Canadian *Charter of Rights and Freedoms*, the Supreme Court of Canada rejected a notion of disability which would focus on impairment or functional limitation. The Court said (at para. 29):

> The concept of disability must therefore accommodate a multiplicity of impairments, both physical and mental, overlaid on a range of functional limitations, real or perceived, interwoven with recognition that in many important aspects of life the so-called 'disabled' individual may not be impaired or limited in any way at all.

[33] Social constructs are the product of social processes that seek to create differences between groups. These social processes may be based on real characteristics, or perceptions of difference. These can have the effect of marginalizing some in society. For example, characteristics of human nature that have been thought to deviate from the "norm" and have been assigned inferior value have sometimes been

labelled by society as “mental disabilities” or “mental illnesses” depending on the social and political context. For example, in North America, being gay, lesbian or bisexual was considered a mental illness until it was delisted from the compendium of mental illnesses, the Diagnostic and Statistical Manual of Mental Disorders (DSM), in the 1970s.

[34] In *Granovsky v. Canada (Minister of Employment and Immigration)*, *supra*, note 32, the Supreme Court of Canada recognized that the primary focus of the disability analysis in the *Charter* context is on the inappropriate legislative or administrative response (or lack thereof) of the State (at para. 39). The Court said (at para. 33):

> Section 15(1) ensures that governments may not, intentionally or *through a failure of appropriate accommodation*, stigmatize the underlying physical or mental impairment, or attribute functional limitations to the individual that the underlying physical or mental impairment does not entail, or fail to recognize the added burdens which persons with disabilities may encounter in achieving self-fulfillment in a world relentlessly oriented to the able-bodied. [Emphasis added.]

Although in *Granovsky* the focus was on State action, similar principles apply to organizations responsible for accommodation under human rights law: Office for Disability Issues, Human Resources Development Canada, Government of Canada, *Defining Disability: A complex issue,* Her Majesty the Queen in Right of Canada, 2003 at p. 39.

[35] *Devoe v. Haran*, 2012 HRTO 1507 (CanLII).

[36] See, for example, *Dawson v. Canada Post Corp.* [2008] C.H.R.D. No. 41 at paras. 90-98 (QL).

[37] *Entrop v. Imperial Oil Limited*, 2000 CanLII 16800 (Ont. C.A.).

[38] A large US epidemiological study found that 37% of people with an alcohol disorder had at least one mental disorder and 21.5% had another drug dependence disorder. For people with a lifetime history of drug abuse dependence, 53.1% also had a mental disorder: Darrel A. Regier, *et al*., “Comorbidity of Mental Disorders with Alcohol and Other Drug Abuse: Results From the Epidemiologic Catchment Area (ECA) Study,” (1990) 264:19 *J.A.M.A.* 2511.

[39] *Ontario (Disability Support Program) v. Tranchemontagne*, 2010 ONCA 593 at para. 126 (CanLII).

[40] This definition was developed by the Canadian Society of Addiction Medicine and used by the Supreme Court of Canada in *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44 (CanLII), [2011] 3 SCR 134 at para. 101. The medical literature differentiates between substance abuse and substance dependence. Substance dependence is recognized as generally more severe, as the criteria involve tolerance, withdrawal or a pattern of compulsive or uncontrolled use.

[41] In *Entrop v. Imperial Oil, supra*, note 37 at para. 89, the Ontario Court of Appeal accepted the finding of a Board of Inquiry that drug abuse and alcohol abuse are "each a handicap" [now referred to as “disability”] and that each is "an illness or disease creating physical disability or mental impairment and interfering with physical, psychological and social functioning." The Court also accepted that drug dependence and alcohol dependence are each “handicaps” entitled to protection under the *Code.* See also *Mainland Sawmills v. Industrial Wood and Allied Workers of Canada, Local 2171 (Kandola Grievance),* [2002] B.C.C.A.A.A. No. 69 at para. 69 (QL), in which it was found that “alcohol and drug addiction are illnesses and are physical and mental disabilities for the purposes of the *Human Rights Code*. There are no reasons to consider them any less an illness or disability than any other serious affliction.”

[42] *Entrop v. Imperial Oil Limited*, *ibid.* at para. 92; *Alberta (Human Rights and Citizenship Commission) v. Kellogg Brown & Root (Canada) Co*., 2007 ABCA 426 (CanLII); *Chornyj v. Weyerhaeuser Company Limited*, 2007 CanLII 65618 (ON SCDC).

[43] The issue of whether or not a gambling addiction is a disability has not been determined by the Human Rights Tribunal of Ontario. See *Mustafa v. Mississauga (City)*, 2010 HRTO 2477 (CanLII) and *Sterling v. City of London, Community Services*, 2013 HRTO 1360 (CanLII) for two cases where the issue was raised, but did not need to be decided by the HRTO.

[44] The case law on whether nicotine addiction constitutes a disability is still inconclusive. In *McNeill v. Ontario Ministry of the Solicitor General and Correctional Services*, [1998] O.J. No. 2288 (Ont. Ct. J. – Gen Div.), the Ontario Court of Justice dismissed a *Charter* challenge to a smoking ban in a detention centre because it ruled that smokers did not have a "mental or physical disability":

> Addiction to nicotine is a temporary condition which many people voluntarily overcome, albeit with varying degrees of difficulty related to the strength of their will to discontinue smoking. It can hardly be compared with the disability of deafness under review in *Eldridge*. Smokers are not part of a group "suffering social, political and legal disadvantage in our society" [para 32].

In *Cominco Ltd. v. United Steelworkers of America, Local 9705*, [2000] B.C.C.A.A.A. No. 62 (QL), addiction to nicotine was determined to be a disability in part based on scientific evidence introduced that showed how the claimant's functioning was impaired. In *Club Pro Adult Entertainment Inc. v. Ontario (Attorney General)*, 2006 CanLII 42254 (Ont. Sup. Ct.), a *Charter* challenge to the *Smoke-Free Ontario Act* failed. The Court found that although it was not "plain and obvious that smoking is not a disability within the meaning of s. 15(1) of the *Charter*," it was "plain and obvious that the plaintiffs cannot succeed. The ability to smoke in indoor public places is not an interest that engages human dignity as contemplated by s. 15." People who smoke were not found to be a group that has suffered pre-existing disadvantage, stereotyping or prejudice (see paras. 222 and 228).

[45] See the section on "Undue hardship" for more detail.

[46] Law Commission of Ontario, *Advancing Equality for Persons with Disabilities Through Law, Policy and Practice: A Draft Framework* (March 2012) at 3, available online at: www.lco-cdo.org/disabilities-draft-framework.pdf.

[47] In this context, prejudices may be defined as deeply held negative perceptions and feelings about people with mental health or addiction issues.

[48] Stereotyping is when generalizations are made about individuals based on assumptions about qualities and characteristics of the group they belong to. The Supreme Court of Canada has recently said "Stereotyping, like prejudice, is a disadvantaging attitude, but one that attributes characteristics to members of a group regardless of their actual capacities." *Quebec (Attorney General) v. A*, [2013] 1 S.C.R. 61 at para. 326.

[49] *Supra*, note 4.

[50] *Christianson v. Windsor Police Service*, 2010 HRTO 229 (CanLII) at para. 11. But see also *Aberdeen v. Governing Council of the University of Toronto*, 2013 HRTO 138 (CanLII).

[51] *Turner v. 507638 Ontario*, 2009 HRTO 249 (CanLII).

[52] *Petterson v. Gorcak (No. 3)* (2009), 69 C.H.R.R. D/166, 2009 BCHRT 439. See also *Devoe v. Haran*, *supra*, note 35.

[53] CMHA, Ontario, *Violence and Mental Health: Unpacking a Complex Issue*, *supra*, note 18.

[54] *Ibid.*

[55] Gerald B. Robertson, "Mental Disability and Canadian Law" (1993), *supra*, note 12.

[56] For example, a psychiatric model of addiction that was popular between the 1940s and 1970s attributed the individual's addiction to personality "flaws." Caroline J. Acker, "Stigma or Legitimation? A Historical Examination of the 27 Social Potentials of Addiction Disease Models" (1993) 25:3 *J. of Psychoactive Drugs* 202, as cited by the Centre for Addiction and Mental Health, *The Stigma of Substance Abuse: A Review of the Literature*, *supra*, note 4 at 7.

[57] Neasa Martin & Valerie Johnston, *A Time for Action: Tackling Stigma and Discrimination: Report to the Mental Health Commission of Canada* (2007), *supra*, note 4 at 11.

[58] Law Commission of Ontario, *A Framework for the Law as It Affects Persons with Disabilities: Advancing Substantive Equality for Persons with Disabilities through Law, Policy and Practice* (Toronto: September 2012) at 42, available online at: www.lco-cdo.org/persons-disabilities-final-report.pdf.

[59] See *Haykin v. Roth*, 2009 HRTO 2017 (CanLII) confirming that harassment in services is prohibited under the *Code.*

[60] See *Lane v. ADGA Group Consultants Inc*., 2007 HRTO 34 (CanLII); *ADGA Group Consultants Inc. v. Lane*, 2008 CanLII 39605 (Ont. Div. Ct.) and *Osvald v. Videocomm Technologies*, 2010 HRTO 770 (CanLII) at paras. 34 and 54.

[61] *Fleming v. Reid*, 1991 CanLII 2728 at IV (Ont. C.A.).

[62] *Gibbs v. Battlefords and Dist. Co-operative Ltd., supra*, note 1. See also *Moore v. Canada (Attorney General)*, [2005] F.C.J. No. 18, 2005 FC 13 (CanLII) at para. 33, in which it was stated: "If Moore had had an obvious physical disability, it is highly doubtful that there would even have been a termination of employment much less a dismissed complaint. Consistent with the purpose of the *Canadian Human Rights Act* and section 3, the same rights and respect are to be accorded those with mental disabilities as those with other forms of disability. For the purposes of the *Act*, a disability is a disability, whether mental or physical."

[63] See subsection 13.4 on "The legal test" for more information.

[64] See section 11 on "Reprisal" for more information.

[65] See, for example, *Knibbs v. Brant Artillery Gunners Club*, 2011 HRTO 1032 (CanLII) (discrimination because of association with a person who had filed a disability discrimination claim); *Giguere v. Popeye Restaurant*, 2008 HRTO 2 (CanLII) (dismissal of an employee because her husband was HIV-positive); *Barclay v. Royal Canadian Legion, Branch 12*, (1997) 31 C.H.R.R. D/486 (Ont. Bd. Inq.) (punishment of a member because she objected to racist comments about Black and Aboriginal people); and *Jahn v. Johnstone* (September 16, 1977), No. 82, Eberts (Ont. Bd. Inq.) (eviction of a tenant because of the race of the tenant's dinner guest).

[66] See section 12 on "Mental health and addictions programs, laws and policies" and "Special programs" for more information.

[67] See section 14 on "Undue hardship" for more information. See also *British Columbia (Public Service Employee Relations Comm.) v. BCGSEU*, [1999] 3 S.C.R. 3 ["*Meiorin*"].

[68] Section 52 of the *Charter* acts to make sure that any law that is inconsistent with the *Charter* is, to the extent of the inconsistency, of no force or effect.

[69] Under section 7 of the *Charter*, people cannot be deprived of these rights except according to the principles of fundamental justice. This section was used, for example, to advance the current understanding of the rights of people with mental capacity to refuse to consent to treatment.

[70] An Ontario court has confirmed that rights under the *Mental Health Act*, R.S.O. 1990, c. M. 7 must be taken to conform to similar rights under sections 9 and 10(b) of the *Charter*: *R. v. Webers*, 1994 CanLII 7552 (Ont. Ct. J.(Gen. Div.) at para. 31. The Court cited with approval a Review Board decision that noted "…the *Mental Health Act* is replete with procedural safeguards. The safeguards have been implemented in recognition of the fact that a patient who is detained under the authority of the *Mental Health Act* or who loses control over his or her own treatment or assets has been deprived of their liberty, autonomy or right to self-determination no less than an individual who has been imprisoned."

[71] *Accessibility for Ontarians with Disabilities Act*, 2005 S.O. 2005, c. 11.

[72] Letter from OHRC Chief Commissioner Barbara Hall to Charles Beer, AODA Review (October 30, 2009) regarding: Submission to the AODA review, online: Ontario Human Rights Commission www.ohrc.on.ca/en/resources/news/beer/view. In an independent review of the *AODA* in 2010, the reviewer, Charles Beer, heard from community stakeholders that the roll-out of the standards must be accompanied by substantial government investment to change the attitudinal barriers that limit opportunities for people with mental health and other disabilities. Charles Beer, *Charting a Path Forward: Report of the Independent Review of the Accessibility for Ontarians with Disabilities Act, 2005* (2010), online: Ministry of Community Social Services. www.mcss.gov.on.ca/documents/en/mcss/accessibility/Charles%20Beer/Charles%20Beer.pdf.

The OHRC has prepared an eLearning video to help organizations understand the relationship between the *AODA* and the *Human Rights Code*. Working Together: The Ontario *Human Rights Code* and the *Accessibility for Ontarians with Disabilities Act*: www.ohrc.on.ca/en/learning/working-together-ontario-human-rights-code-and-accessibility-ontarians-disabilities-act.

[73] *CRPD*, *supra*, note 27, Article 1.

[74] *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817 at para. 69.

[75] *Baker*, *ibid* at para. 70; The UN has said that ratifying the *CRPD* creates a "strong interpretive preference in favour of the Convention. This means that the judiciary will apply domestic law and interpret legislation in a way that is as consistent as possible with the Convention." UN, *From Exclusion to Equality: Realizing the Rights of Persons with Disabilities: Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol* (Geneva: United Nations, 2007) at 107.

[76] *CRPD*, *supra*, note 27 at article P of Preamble.

[77] *CRPD*, *ibid.* at article Q of Preamble.

[78] As of June 2012, "gender identity" and "gender expression" were added as new grounds protected by the *Code*.

[79] See section 8 on "Poverty, mental health and addiction" for more information.

[80] "Cultural competence" may be defined as "an ability to interact effectively with people of different cultures and socio-economic backgrounds, particularly in the context of human resources, non-profit organizations, and government agencies whose employees work with persons from different cultural/ ethnic backgrounds. Cultural competence comprises four components: (a) Awareness of one's own

cultural worldview, (b) Attitude towards cultural differences, (c) Knowledge of different cultural practices and worldviews, and (d) Cross-cultural skills. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures." See http://en.wikipedia.org/wiki/Cultural_competence (Retrieved: January 17, 2014).

[81] See Douglas A. Steinhaus, Debra A. Harley & Jackie Rogers, "Homelessness and People with Affective Disorders and Other Mental Illnesses" (2004) 35 *J. Applied Rehabilitation Counselling* 37.

[82] See *Victoria (City) v. Adams*, 2009 BCCA 563 (CanLII) at para. 75; *Victoria (City) v. Adams*, 2008 BCSC 1363 (CanLII); *Pivot Legal Society v. Downtown Vancouver Business Improvement Assn. (No. 6)* (2012), CHRR Doc. 12-0023, 2012 BCHRT 23 (CanLII).

[83] *Victoria (City) v. Adams*, 2009, *ibid.* at para. 26; *Victoria (City) v. Adams*, 2008, *ibid.* at para. 44.

[84] Ontario Common Front, *Falling Behind, Ontario's Backslide into Widening Inequality, Growing Poverty and Cuts to Social Programs.* August 29, 2012, available online at: www.WeAreOntario.ca at 6, 19, 25.

[85] For example, see *Pivot Legal Society v. Downtown Vancouver Business Improvement Assn*. (No. 6) *supra*, note 82.

[86] *James obo James v. Silver Campsites and Another (No. 2),* 2011 BCHRT 370 (CanLII) at para. 171. See also *James obo James v. Silver Campsites and Another (No. 3)*, 2012 BCHRT 141 (CanLII) which dealt with the remedy for the discrimination. The tribunal made several important statements about the particularly serious impact of a discriminatory loss of housing on a person with a mental health disability (*e.g.* at para. 41).

[87] *Pivot Legal Society v. Downtown Vancouver Business Improvement Assn. (No. 6), supra*, note 82 at para. 635: "The complainants have established that the proportion of Aboriginal and disabled people in the homeless and drug-addicted population is higher than in the general public. They have established that some of the Ambassadors' actions are targeted to the homeless population and have an adverse effect on that population"; see also *Radek v. Henderson Development (Canada) Ltd. (No. 3)* (2005), 52 C.H.R.R. D/430, 2005 BCHRT 302, and *Petterson, supra*, note 52.

[88] In *Iness v. Caroline Co-operative Homes Inc.*, 2006 HRTO 19 (CanLII) the HRTO found that a housing co-operative had discriminated against a single mother receiving public assistance in setting rent levels. The co-op set the rent for employed tenants with low incomes at 30% of their income. For members who received public assistance, rent was set at the maximum shelter allowance component of their social assistance benefits. In simply setting Iness' rent at the maximum shelter allowance, the co-op failed to take into account her actual circumstances, including her costs for utilities and property insurance. The co-op could have set the rent so that both rent and these other costs could come out of the shelter component of Iness' social assistance benefits, and still complied with their operating agreement with Canada Mortgage and Housing Corporation.

[89] See section 13 on "The duty to accommodate" for more information.

[90] This example describes a collaboration between the Canadian Mental Health Association, Ontario and Elections Ontario.

[91] See section 10.4 on "Systemic discrimination" for more information.

[92] UN Committees and Special Rapporteurs, such as the Committee on Economic, Social and Cultural Rights, and the Special Rapporteurs on Housing and Food Security, have identified a range of concerns about Canada's track record on issues related to socio-economic status since the late 1990s, including the insufficiency of minimum wage, and the inadequacy of social assistance rates to meet people's basic needs. The UN Human Rights Committee expressed concern about people with psychosocial disabilities

in Canada being detained in institutions because of the lack of supportive housing in the community: Concluding Observations of the Human Rights Committee: Canada, UN ESCOR, 2006, UN Doc. CCPR/C/CAN/CO/5 at para 17. In 2004 and 2006, the UN Committee on Economic, Social and Cultural Rights (CESCR) identified high rates of poverty for marginalized people in Canada as a concern, including people with disabilities: Concluding observations of the Committee on Economic, Social and Cultural Rights: Canada ESC 1-19 May 2006, UN ESCOR, 36th Sess., UN docs. E/C.12/CAN/CO/4 & E/C.12/CAN/CO/5, available online at: www.unhchr.ch/tbs/doc.nsf/0/87793634eae60c00c12571ca00371262/$FILE/G0642783.pdf at para.15. For more information, see the United Nations Committee on Economic, Social and Cultural Rights, Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant (Concluding Observations – Canada), 10 December 1998, E/C.12/1/Add.31; and United Nations Committee on Economic, Social and Cultural Rights, Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant (Concluding Observations – Canada), 19 May 2006, E/C.12/CAN/CO/5.

[93] These cases mostly involve the area of housing. See, for example, *Kearney vs. Bramalea Ltd. (No. 2)* (1998), 34 C.H.R.R. D/1 (Ont. Bd. Inq.), and *Shelter Corp. v. Ontario (Human Rights Comm.)* (2001), 39 C.H.R.R. D/111 (Ont. Div. Ct.) in which statistical evidence showed that landlords' use of rent-to-income ratio rental criteria had a disparate impact on people based on their sex, race, marital status, family status, citizenship, place of origin, age and receipt of public assistance. The Tribunal ruled that use of these criteria as the sole factor in assessing rental applications was discriminatory under the *Code*. See also *Iness v. Caroline Co-operative Homes Inc., supra*, note 88; *Radek v. Henderson Development (Canada) Ltd*., *supra*, note 87; and *Ahmed v. 177061 Canada Ltd (Shelter Canadian Properties Ltd.)*, 2002 CanLII 46504 (Ont. Bd. Inq.).

[94] These requirements for establishing discrimination were drawn from *Moore v. British Columbia (Education)*, 2012 SCC 61; *R.B. v. Keewatin-Patricia District School Board*, 2013 HRTO 1436 at para. 204. Note that, in a few cases, most of which have challenged government services or have raised concerns that different treatment may not amount to discrimination in a substantive sense, disadvantage is not inferred or assumed from the circumstances but may need to be shown by the claimant to establish adverse treatment or impact: see, for example, *Ontario (Disability Support Program) v. Tranchemontagne*, 2010, *supra*, note 39; *Ivancicevic v. Ontario (Consumer Services)*, 2011 HRTO 1714 (CanLII); *Klonowski v. Ontario (Community Safety and Correctional Services)*, 2012 HRTO 1568 (CanLII). However, the Court of Appeal for Ontario and HRTO have noted that in most cases under the *Code*, disadvantage can be assumed where there is adverse treatment based on a prohibited ground and that in most human rights cases it will not be necessary to go through a process of specifically proving what the disadvantage is: see *Hendershott v. Ontario (Community and Social Services)*, 2011 HRTO 482 at para. 45 (CanLII).

[95] *Gray v. A&W Food Service of Canada Ltd.* (1994), CHRR Doc 94-146 (Ont. Bd. Inq.); *Dominion Management v. Velenosi,* [1977] O.J. No. 1277 at para. 1 (C.A.); *Smith v.Mardana Ltd. (No. 1)* (2005), 52 C.H.R.R. D/89 at para. 22 (Ont. Div. Ct.); *King v. CDI Career Development Institutes Ltd.* (2001), 39 C.H.R.R. D/322 (Sask. Bd. Inq.).

[96] See *Johnson v. Halifax Regional Police Service* (2003), 48 C.H.R.R. D/307 (N.S. Bd. Inq.) at para. 57 for an example of a case where deviations from normal practice supported a finding of race discrimination.

[97] A study by the Centre for Equality Rights in Accommodation (CERA) looked at how subtle and direct discrimination play out in the Toronto housing market. Volunteers did a telephone audit to apply for rental vacancies. They used a series of scripts based on "profiles" that paired all characteristics except for the one that might lead to discrimination. For the mental disability profile, volunteers pretended they were from a mental health agency trying to find housing for their clients. Overall, the study showed that more than one-third of housing seekers with mental disabilities were discriminated against in the Toronto housing market. See *Sorry It's Rented: Measuring Discrimination in Toronto's Rental Housing Market* (July 2009) online: www.equalityrights.org/cera.

[98] *Eagleson Co-operative Homes, Inc.* v. *Théberge*, 2006, *supra*, note 23 at para. 24.

[99] See also Recommendation #39 of *Jardine-Douglas, Klibingaitis, Eligon (Re)*, Verdict of the Coroner's Jury (February, 2014) ["Eligon Jury Verdict"] which recommended that Toronto Police Service procedure documents be amended "to ensure it is clear that officers should not adopt a practice of handcuffing [people] being apprehended under the *Mental Health Act* unless those individuals exhibit behaviour that warrants the use of handcuffs."

[100] See *Johnson*, *supra*, note 96; *Nassiah v. Peel Regional Police Services Board*, 2007 HRTO 14 (CanLII); *Peel Law Association v. Pieters*, 2013 ONCA 396 (CanLII); *Shaw v. Phipps*, 2012 ONCA 155 (CanLII); *McKay v. Toronto Police Services Board,* 2011 HRTO 499 (CanLII). See also the OHRC's *Policy and Guidelines on Racism and Racial Discrimination*, 2005, available online at: www.ohrc.on.ca/en/policy-and-guidelines-racism-and-racial-discrimination, and the OHRC's 2003 report, *Paying the Price: The human cost of racial profiling*, available online at: www.ohrc.on.ca/en/paying-price-human-cost-racial-profiling.

[101] Heather Stuart, "Violence and Mental Illness: An Overview," *Journal of World Psychiatry* 2 (2003): 123.

[102] *Radek v. Henderson Development (Canada) Ltd., supra*, note 87.

[103] *R. v. Parks*, [1993] O.J. No.2157 (C.A.); *Knoll North America Corp. v. Adams*, 2010 ONSC 3005 (CanLII).

[104] See *Radek v. Henderson Development (Canada) Ltd*., *supra*, note 87 at paras. 577-579.

[105] In *R. v. Brown* (2003), 64 O.R. (3d) 161 (C.A.) the Ontario Court of Appeal recognized that racial profiling is wrong even when police conduct is justified apart from the negative stereotyping based on race. In *Brown*, the claimant was stopped for speeding, but the examination concerned whether it was a legitimate stop, or one influenced by racial stereotyping about the claimant. In a study on conducted energy weapons (Taser) use, the Commission for Public Complaints Against the Royal Canadian Mounted Police found that the RCMP deployment rate of Tasers was 49.6% for mental health incidents, which was significantly higher than it was for non-mental health cases (39.2%). It stated, "mental health incidents resulted in more deployments than did any other incident type … There was no discernable evidence that mental health cases were any more risky than other incident types." *RCMP Use of the Conducted Energy Weapon (CEW): January 1, 2009 to December 31, 2009* (June 24, 2010), available online at: www.cpc-cpp.gc.ca/cnt/tpsp-tmrs/cew-ai/cew-ai-10-eng.aspx.

[106] *R. v. Brown* (2003), *ibid*. See also, *R. v. Richards* (1999), 120 O.A.C. 344 (C.A.), *Peart v. Peel (Regional Municipality) Police Services Board*, [2003] O.J. No. 2669 (Sup. Ct.) and *R. v. Khan* (2004), 244 D.L.R. (4th) 443 (Ont. Sup. Ct.).

[107] For example, in *R. v. Khan*, *ibid*., the police officers' explanation for why they stopped Mr. Khan and searched his car was found to be inconsistent with the documentary evidence and to defy common sense. Accordingly, the Court concluded that the reasonable inference was that Mr. Khan was stopped because of racial profiling, because he was a young Black male driving an expensive car.

[108] In *Johnson v. Halifax Region Police Service*, *supra*, note 96 at para. 57, the Nova Scotia Board of Inquiry held that in deciding whether there has been a *prima facie* case of differential treatment, a board of inquiry must try to establish how events normally unfold in a given situation. Deviations from normal practice and evidence of discourtesy or intransigence are grounds for finding differential treatment.

[109] *Ibid.* The Board of Inquiry found that the unprofessional way the complainant was treated during a traffic stop was based on the complainant's race and that it would be hard to imagine similar treatment of a White driver. See also *Abbott v. Toronto Police Services Board*, 2009 HRTO 1909 (CanLII) in which a police officer's unnecessarily brusque and demanding tone supported a finding of racial profiling.

[110] See *Radek v. Henderson Development (Canada) Ltd*., *supra*, note 87.

[111] For example, see *McKay v. Toronto Police Services Board*, *supra*, note 100.

[112] *Adams v. Knoll North America*, 2009 HRTO 1381 (CanLII), upheld *Knoll North America Corp. v. Adams*, *supra*, note 103.

[113] "In order to consider if differential treatment has occurred, the board must necessarily hypothesize about how events would have unfolded if the driver and passenger of the vehicle had been white rather than black. … I find it difficult to imagine that these events would have unfolded the same way if a white driver from Texas had been involved in this stop." See *Johnson v. Halifax*, *supra*, note 96 at para. 51 and 57. See also *Abbott, supra*, note 109.

[114] See section 17 of the *Mental Health Act*, *supra*, note 70. In *Smith v. Windsor Police Service* 2009 HRTO 1440 (CanLII), the HRTO recognized that a police officer's misperceptions about the risk of violence based on a person's mental health could result in discrimination; however, the HRTO found that this was not the case in this application.

[115] See *Smith v. Windsor Police Service*, *ibid.*

[116] *Radek v. Henderson Development (Canada) Ltd*., *supra*, note 87.

[117] While the HRTO has said it will not comment on the appropriateness of police investigative techniques, the HRTO will consider whether the investigation or police actions violated the *Code*; see *Lane v. Hamilton Police Services Board*, 2011 HRTO 1145 para. 34 (CanLII).

[118] See sections 5(2) and 2(2) of the *Code*, respectively.

[119] See, for example, *S.S. v. Taylor*, 2012 HRTO 1839 at paras. 53-56 (CanLII) citing *Janzen v. Platy Enterprises Ltd.,* [1989] 2 S.C.R. 1252 and *Simpson v. Consumers' Assn. of Canada*, 2001 CanLII 23994 (ON CA), leave to appeal refused [2002] S.C.C.A. No. 83.

[120] *Van Adrichem v. Lopes*, 2010 HRTO 1091 (CanLII), at para. 34. See also *Turner v. 507638 Ontario*, *supra*, note 51.

[121] *Janzen* v. Platy Enterprises Ltd., *supra*, note 119, applied by the HRTO to confirm that harassment in services is covered by the *Code* in *Haykin v. Roth*, *supra*, note 59.

[122] Section 10(1) of the *Code.*

[123] See *Reed v. Cattolica Investments Ltd. and Salvatore Ragusa*, [1996] O.H.R.B.I.D. No. 7. See also, *Gregory v. Parkbridge Lifestyle Communities Inc*. 2011 HRTO 1535 at para. 87 (CanLII) citing *Ghosh v. Domglas Inc. (No. 2)* (1992), 17 C.H.R.R. D/216 (Ont. Bd. Inq.) at paras. 43 to 48 and *Dhanjal v. Air Canada*, (1996), 28 C.H.R.R. D/367 at p. 50 (C.H.R.T.).

[124] *Reed v. Cattolica Investments Ltd. and Salvatore Ragusa*, *ibid.* See also, *Gregory v. Parkbridge Lifestyle Communities Inc.*, *ibid.* at para. 87.

[125] In *Harriott v. National Money Mart Co*., 2010 HRTO 353 at para. 104, a sexual harassment case, the HRTO found that the respondent's continued sexualized and inappropriate comments and conduct were unwelcome in the workplace.

[126] See *S.S. v. Taylor*, *supra*, note 119 at para. 71.

[127] See, for example, *Perez-Moreno v. Kulczycki*, 2013 HRTO 1074 (CanLII) that deals with posting discriminatory comments on Facebook, and *C.U. v. Blencowe*, 2013 HRTO 1667 (CanLII) that deals with harassing text messages.

[128] See the OHRC's *Policy on preventing sexual and gender-based harassment*, available online at: www.ohrc.on.ca/sites/default/files/policy%20on%20preventing%20sexual%20and%20gender-based%20harassment_2013_accessible_1.pdf, for more information.

[129] *Selinger v. McFarland*, 2008 HRTO 49 (CanLII).

[130] In *Harriott v. National Money Mart Co*., *supra*, note 125 at para. 108, the HRTO, citing earlier case law, it was confirmed that a person is not required to protest or object to the harassing conduct.

[131] In the case of employment, amendments to the *Occupational Health and Safety Act*, R.S.O. 1990, c.O.1 require all employers with over five employees to establish policies on harassment and violence in the workplace and to review these annually. In *Berger v. Toronto (City)*, 2011 HRTO 625 (CanLII), the HRTO also confirmed that an organization has an obligation to accommodate mental health disabilities that arise due to workplace harassment or conflict, provided they are diagnosed by physician and accommodation is required based on medical evidence. This obligation exists regardless of whether the harassment is proven.

[132] See, for example, *Smith v. Menzies Chrysler Inc.*, [2009] O.H.R.T.D. No. 1906 (QL); *Dhillon v. F.W. Woolworth Co.* (1982), 3 C.H.R.R. D/743 at para. 6691 (Ont. Bd. Inq.); *Naraine v. Ford Motor Co. of Canada (No. 4)* (1996), 27 C.H.R.R. D/230 at para. 50 (Ont. Bd. Inq.); and *Cugliari v. Telefficiency Corporation*, 2006 HRTO 7 (CanLII).

[133] In *Dhanjal v. Air Canada*, *supra*, note 123, the Tribunal noted that the more serious the conduct, the less need there is for it to be repeated. Conversely, the Tribunal held the less serious the conduct, the greater the need to show its persistence. See also *General Motors of Canada Limited v. Johnson*, 2013 ONCA 502 (CanLII).

[134] *Halliday v. Van Toen Innovations Incorporated*, 2013 HRTO 583 at para. 91(CanLII).

[135] *Ibid.* at para. 100.

[136] *McKinnon v. Ontario (Ministry of Correctional Services)*, [1998] O.H.R.B.I.D. No. 10; *Vanderputten v. Seydaco Packaging Corp.*, 2012 HRTO 1977 (CanLII).

[137] *Knibbs v. Brant Artillery Gunners Club*, *supra*, note 65.

[138] *Ghosh v. Domglass Inc.*, *supra*, note 123 at para. 76. [as cited in *McKinnon v. Ontario (Ministry of Correctional Services*), [2002] O.H.R.B.I.D. No. 22].

[139] In *Moore v. British Columbia (Education)*, *supra*, note 94, the Supreme Court of Canada reaffirmed its earlier definition of systemic discrimination set out in its seminal 1987 decision *Canadian National Railway Co. v. Canada (Human Rights Commission)*, [1987] 1 S.C.R. 1114 as, "practices or attitudes that have, whether by design or impact, the effect of limiting an individual's or a group's right to the opportunities generally available because of attributed rather than actual characteristics" (at pp. 1138-1139).The OHRC uses "systemic discrimination" when referring to individual institutions, or a system of institutions, that fall under the jurisdiction of the *Code* (*e.g.* the education system).

[140] The Ontario Association of Chiefs of Police has created a Guideline for Police Record Checks that outlines what information is legitimate for release to applicants who require a background check as part of a conditional offer for paid or volunteer work with vulnerable clients. The Guideline calls for police services to generally only release non-conviction occurrences from the last five years as well as have a

reconsideration mechanism in place for seeking earlier suppression. The OHRC advised the Ontario Association of Chiefs of Police during the development of their Guideline for Police Record Checks emphasizing the need to balance the privacy and human rights of persons with mental health and addiction disabilities with community safety.

[141] See, for example, Kitchener (City) Official Plan Amendment No. 58, [2010] O.M.B.D. No. 666 (QL). The City of Kitchener was challenged at the Ontario Municipal Board when it tried to implement a zoning bylaw and official plan amendment. These were designed to limit certain housing forms in an area the City felt was over-concentrated with single-person, low-income households. The amendments targeted residential care facilities (of which people with physical and mental disabilities are the primary users) and social/ supportive housing. Comments were made that counselling services were being banned from a nearby area, because the community did not want social service users walking through the neighbourhood to counselling: "That would add to the negative social environment." The OMB commented that it left little doubt that the focus of the planning exercise was not on land use, but the users.

[142] *Canadian National Railway Co. v. Canada (Human Rights Commission)*, *supra*, note 139 at para 34.

[143] *Gichuru v. Law Society of British Columbia* (No. 6) (2009), 68 C.H.R.R. D/305, 2009 BCHRT 360 at para. 469. For a similar case, see *Thompson v. Selective Personnel (No. 1)*, 2009 HRTO 1224 (CanLII).

[144] See *Pivot Legal Society v. Downtown Vancouver Business Improvement Assn.* (No. 6), *supra*, note 82.

[145] OHRC, *Policy and Guidelines on Racism and Racial Discrimination*, *supra*, note 100.

[146] Section 7(3)(b) of the *Code* also prohibits reprisal for rejecting a sexual solicitation or advance, where the reprisal is made or threatened by a person in a position to confer, grant or deny a benefit or advancement to the person.

[147] *Noble v. York University*, 2010 HRTO 878 at paras. 30-31, 33-34 (CanLII).

[148] *Ibid*. See also *Bertrand v. Primary Response*, 2010 HRTO 186 (CanLII).

[149] *Noble v. York* University, *supra*, note 147 at paras. 30-31.

[150] *Knibbs v. Brant Artillery Gunners Club*, *supra*, note 65 at para. 156.

[151] *Ibid.*

[152] Adapted from the Law Commission of Ontario, *The law as it affects persons with disabilities. Preliminary consultation paper: Approaches to defining disability* (2009) at 6-8, online: Law Commission of Ontario www.lco-cdo.org/en/disabilities-threshold-paper.

[153] *J and J obo R v. B.C. (Ministry of Children and Family Development) and Havens (No. 2)*, 2009 BCHRT 61 (CanLII), para 256; *Berg* (*University of British Columbia v. Berg*, [1993] 2. S.C.R. 353.

[154] *J and J obo R v. B.C.*, *ibid.*; *Ball v. Ontario (Minister of Community and Social Services)*, 2010 HRTO 360; *Ontario (Director, Disability Support Program) v. Tranchemontagne*, 2010, *supra*, note 39.

[155] *El Jamal v. Ontario (Minister of Health and Long-Term Care)*, 2011 HRTO 1952, at para 21.

[156] In *J and J obo R v. B.C.*, *supra*, note 153 at paras. 299-300, the applicant had a developmental disability and had applied for community living services to adults and children with developmental disabilities. These services were mandated by the BC *Community Living Authority Act*, SBC 2004, c. 60.

The BC Human Rights Tribunal determined that in denying the applicant the service, the respondents chose to adopt a narrower definition of "developmental disability" than was reasonably available. In doing so, they imported criteria that were not stated in the legislation or created by regulation. This was discriminatory.

[157] *Ontario (Disability Support Program) v. Tranchemontagne*, 2010, *supra*, note 39 at para. 121.

[158] See *Kline v. Ontario (Community Safety and Correctional Services)* 2012 HRTO 1167 (CanLII); *Wilson v. Dixie Road Medical Association,* 2011 HRTO 1607 (CanLII); *TenBruggencate v. Elgin (County),* 2010 HRTO 1467 (CanLII); *J.M. v. St. Joseph's Health Centre*, 2012 HRTO 239 (CanLII); *Egan v. Kennedy*, 2006 BCHRT 15; and *Sparks v. Vancouver Coastal Health Authority* (2006), 58 C.H.R.R. D/268, 2006 BCHRT 575. In *Haskins v. Religious Hospitaliers of Hotel Dieu of St. Joseph*, 2010 HRTO 2112 (CanLII), the HRTO stated that it is not an appeal mechanism for decisions around mental health assessments and it is the Consent and Capacity Board and the College of Physicians and Surgeons where a person can raise concerns about the appropriateness or correctness of medical assessments and decisions.

[159] *Wilson v. Dixie Road Medical Association*, *ibid*. at para. 13; *Egan v. Kennedy*, *ibid*.; *Marshall v. Durham Regional Police Services*, 2013 HRTO 2029 (CanLII).

[160] See, for example, *Sparks v. Vancouver Coastal Health Authority*, *supra*, note 158 in which the Tribunal stated at para. 17: "most if not all decisions relating to persons apprehended and detained under the relevant provisions of the *Mental Health Act* will have some connection with mental disability, real or perceived. That is not sufficient to ground a human rights complaint. A complainant alleging discrimination in this context must allege that they were in some way adversely treated because of their mental disability, real or perceived." See also, *S.D. v. Grand River Hospital*, 2011 HRTO 2165 at para. 18.

[161] For more information about special programs, see the OHRC's *Special programs and the Ontario Human Rights Code: A self-help guide*, available online at: www.ohrc.on.ca/en/special-programs-and-ontario-human-rights-code-self-help-guide.

[162] In *Ontario (Human Rights Commission) v. Ontario* (1994), 19 O.R. (3d) 387 (C.A.), the Ontario Court of Appeal stated: "Special programs aimed at assisting a disadvantaged individual or group should be designed so that restrictions within the program are rationally connected to the program. Otherwise, the provider of the program will be promoting the very inequality and unfairness it seeks to alleviate." See also *Ball v. Ontario*, *supra*, note 154 at para. 121.

[163] *Ball*, *ibid.*; *XY v. Ontario (Government and Consumer Services)* (2012) HRTO 726 at paras. 264-66 (CanLII); and *A.T. and V.T. v. The General Manager of O.H.I.P*, (2010) ONSC 2398 (CanLII).

[164] These policies are available on the OHRC's website at: www.ohrc.on.ca.

[165] See *Meiorin*, *supra*, note 67 at paras. 65-6 and *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)*, 1999 CanLII 646, [1999] 3 S.C.R. 868, at paras. 22 and 42-45 ["*Grismer*"]. In *Gourley v. Hamilton Health Sciences* 2010 HRTO 2168 (CanLII), the adjudicator stated (at para. 8): "The substantive component of the analysis considers the reasonableness of the accommodation offered or the respondent's reasons for not providing accommodation. It is the respondent who bears the onus of demonstrating what considerations, assessments, and steps were undertaken to accommodate the employee to the point of undue hardship…"

[166] *Lane v. ADGA Group Consultants Inc.*, *supra*, note 60; *ADGA Group Consultants Inc. v. Lane*, *supra*, note 60 at para. 106.

[167] *Stevenson v. Canadian Security Intelligence Service* (2001), 41 C.H.R.R. D/433 (C.H.R.T.).

[168] *Ibid.*; *Gibbs v. Battlefords*, *supra*, note 1.

[169] *Duliunas v. York-Med Systems*, 2010 HRTO 1404 (CanLII).

[170] *Eaton v. Brant County Board of Education*, [1997] 1 S.C.R. 241.

[171] In *Eaton v. Brant County Board of Education*, *ibid.*, the Supreme Court of Canada stated that "integration should be recognized as the norm of general application because of the benefits it generally provides" (at para. 69). However, the Court found that in Emily Eaton's circumstances, segregated accommodation was in her best interests. The Court was of the view that this was one of those unusual cases where segregation was a more appropriate accommodation.

[172] Law Commission of Ontario, *A Framework for the Law as It Affects Persons with Disabilities*, *supra*, note 58 at 79.

[173] *Eaton, supra*, note 170 at para. 67.

[174] *Meiorin, supra*, note 67 at para. 68.

[175] *Ibid.*

[176] See www.ncsu.edu/project/design-projects/udi/center-for-universal-design/the-principles-of-universal-design/.

[177] *Supra*, note 71.

[178] This example is adopted from the approach by Great West Life Centre for Mental Health in the Workplace and Mental Health Works. See: www.workplacestrategiesformentalhealth.com/display.asp?l1=177&l2=207&l3=229&d=207.

[179] See section 13.6.1 entitled "Duty to inquire about accommodation needs" for more information.

[180] *Quesnel v. London Educational Health Centre*, (1995), *supra*, note 22 at para. 16.

[181] The test for undue hardship is set out fully in the OHRC's *Policy and guidelines on disability and the duty to accommodate*, *supra*, note 16 and is discussed in greater detail in the "Undue hardship" section of this policy. The same standard applies to all grounds of the *Code*, including to people with mental health disabilities or addictions.

[182] *Meiorin, supra*, note 67 at para. 54.

[183] See *Hydro-Québec v. Syndicat des employé-e-s de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000*, [2008] 2 S.C.R. 561 for the Supreme Court of Canada's comments on what the third part of this test means, in a practical sense, in the context of a disability accommodation in the workplace.

[184] *Grismer, supra*, note 165 at para. 20.

[185] *Meioirin, supra*, at para. 65.

[186] *Duliunas v. York-Med Systems*, *supra*, note 169 at para. 74. Along the same lines, see *Ilevbare v. Domain Registry Group*, 2010 HRTO 2173 (CanLII), in which the HRTO states at para. 52: "The termination of a disabled employee's employment, in the midst of a medical leave of absence, is *prima facie* discriminatory and likewise demands an explanation." This suggests that *prima facie* discrimination will be found where an employee is terminated while on medical leave and the onus will be on the employer to provide a non-discriminatory reason for the termination.

[187] *Grismer*, *supra*, note 165; *Cameron v. Nel-gor Nursing Home* (1984), 5 C.H.R.R. D/2170 at D/2192 (Ont. Bd. of Inq.). See also *Crabtree v. 671632 Ontario Ltd. (c.o.b. Econoprint (Stoney Creek)*, [1996] O.H.R.B.I.D. No. 37 (QL) (Ont. Bd. Inq.).

[188] See *Vanegas v. Liverton Hotels International Inc.*, 2011 HRTO 715 (CanLII). See also *Briffa v. Costco Wholesale Canada Ltd.*, 2012 HRTO 1970 (CanLII).

[189] Human rights case law recognizes that employers have a duty to consider temporary and permanent alternative work for people who can no longer remain in their position even with accommodation. This duty includes diligently investigating accommodation and proposing job options that are within functional limitations. This is consistent with the Supreme Court of Canada decision in *Hydro-Quebec*, *supra*, note 183. The HRTO has identified a number of "best practices" related to this process. For example, in at least two cases the HRTO commented favourably on an employer's practice of canvassing vacant positions that match an employee's disability-related needs and qualifications and then "holding" or "'protecting" those positions to make sure that they are not first filled by someone who does not require accommodation; see *Harnden v. The Ottawa Hospital*, 2011 HRTO 1258 (CanLII) and *Gourley v. Hamilton Health Sciences*, *supra*, note 165. Direct placement in an alternative position, without being required to succeed in a job competition, may be required: see *Fair v. Hamilton-Wentworth District School Board*, 2012 HRTO 350. But see also *Buttar v. Halton Regional Police Services Board*, 2013 HRTO 1578 (CanLII) and *Formosa v. Toronto Transit Commission*, 2009 HRTO 54 (CanLII) for possible exceptions in specific circumstances. For more information about these and other accommodation strategies, see "Workplace Strategies for Mental Health," online: Great West Life, Centre for Mental Health in the Workplace http://gwlcentreformentalhealth.com/display.asp?l1=175&l2=6&d=6#3 (retrieved April 24, 2014).

[190] See section 16 on "Consent and capacity" for more information.

[191] *Allen v. Ottawa (City)*, 2011 HRTO 344 (CanLII) and *Kelly v. CultureLink Settlement Services*, 2010 HRTO 977 (CanLII). Note that delays must be shown to be related to a psychosocial disability and must be made in good faith: see *Arcuri v. Cambridge Memorial Hospital*, 2010 HRTO 578 (CanLII) and *Vallen v. Ford Motor Company of Canada*, 2012 HRTO 932 (CanLII). Note also that in relation to adjudicators or in the context of administrative tribunals, the "Doctrine of Judicial Immunity" may apply to protect adjudicators who are alleged to have not provided accommodation in the exercise of their decision-making and dispute resolution functions: see *Thomson v. Ontario Secondary School Teachers' Federation*, 2011 HRTO 116 (CanLII); *Hazel v. Ainsworth Engineered*, 2009 HRTO 2180 (CanLII); *McWilliams v. Criminal Injuries Compensation Board*, 2010 HRTO 937 (CanLII).

[192] See section 13.8 on "Confidentiality" for more information.

[193] In *Lane v. ADGA Group Consultants Inc.*, *supra*, note 60, the Tribunal stated at para. 144: "The procedural dimensions of the duty to accommodate required those responsible to engage in a fuller exploration of the nature of bipolar disorder and to form a better informed prognosis of the likely impact of his condition in the workplace."

[194] See *Dawson v. Canada Post Corp.*, *supra*, note 36 at paras. 243-245.

[195] See section 13.6.1 entitled "Duty to inquire about accommodation needs" for information on when an organization is expected to inquire about accommodation needs, even when a person may not have made a specific request.

[196] In *Baber v. York Region Dist. School Board (No. 3)* (2011), 71 C.H.R.R. D/293, 2011 HRTO 213 (CanLII), the HRTO found that even if the duty to accommodate was triggered, the employer had fulfilled its duty to accommodate because Ms. Baber failed to co-operate in the accommodation process by refusing reasonable requests for information that would confirm her needs. She consistently refused to provide the necessary medical information. The HRTO found that the employer did not breach its duty to accommodate her when it terminated her employment.

[197] This may include the manager, landlord, a union representative or human rights staff.

[198] See section 13.6.1 entitled "Duty to inquire about accommodation needs" for information on when an organization is expected to inquire about accommodation needs, even when a person may not have made a specific request.

[199] *Meiorin, supra*, note 67 at paras. 65-66.

[200] *Conte v. Rogers Cablesystems Ltd.,* (1999) 36 C.H.R.R. D/403 (C.H.R.T.); *Mazuelos v. Clark* (2000) C.H.R.R. Doc. 00-011 (B.C.H.R.T.); *Lane v. ADGA Group Consultants Inc*., *supra*, note 60; *Krieger v. Toronto Police Services Board*, 2010, *supra*, note 23.

[201] *Central Okanagan School Dist. No. 23 v. Renaud*, ["*Renaud*"], [1992] 2 S.C.R. 970.

[202] *Puleio v. Moneris Solutions*, 2011 HRTO 659 (CanLII).

[203] The Supreme Court of Canada's decision in *Renaud*, *supra*, note 201 sets out the obligations of unions. See also *Bubb-Clarke v. Toronto Transit* Commission, 2002 CanLII 46503 (HRTO).

[204] *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624.

[205] However, human rights case law has not yet determined whether this would include the cost of treatment such as therapy, medication, *etc.*

[206] *Convention on the Rights of Persons with Disabilities*, *supra*, note 27 at Article 13(1), Article 24(2)(c), and Article 27(1)(i), respectively. "Reasonable accommodation" is covered under Article 5 generally.

[207] For example, people may experience a first episode of a mental health disability that renders them unaware that they are experiencing impairment. Also, denying the presence of a disability may be an aspect of having an addiction.

[208] The Supreme Court of Canada has recognized that the stigma and embarrassment of mental illness may discourage disclosure: *Battlefords and District Co-operative Ltd. v. Gibbs*, *supra*, note 1at para. 31. See also: *Mellon v. Human Resources Development Canada*, 2006, *supra*, note 15 at para.100.

[209] See, for example, *Lane v. ADGA Group Consultants Inc*., *supra*, note 60; *ADGA Group Consultants Inc. v. Lane*, *supra*, note 60; *Krieger v. Toronto Police Services Board*, 2010, *supra*, note 23; *Mellon*, *ibid.* at paras. 97-98; *Willems-Wilson v. Allbright Drycleaners Ltd.* (1997), 32 C.H.R.R. D/71 (B.C.H.R.T.); *Zaryski v. Loftsgard* (1995), 22 C.H.R.R. D/256 (Sask. Bd. Inq.).

[210] For more information about the accommodation responsibilities related to drug and alcohol disabilities, see the OHRC's *Policy on drug and alcohol testing*, *supra*, note 17.

[211] *Krieger v. Toronto Police Services Board*, 2010, *supra*, note 23.

[212] See, for example, *Lane v. ADGA Group Consultants Inc*., *supra*, note 60; *Krieger v. Toronto Police Services Board*, 2010, *supra*, note 23; *Mellon v. Human Resources Development Canada*, *supra*, note 15; *Willems-Wilson v. Allbright Drycleaners Ltd.*, *supra*, note 209; *Zaryski v. Loftsgard*, *supra*, note 209.

[213] See *Krieger, ibid.*; *Zaryski, ibid; Bowden v. Yellow Cab Co. (No. 2)* (2011), CHRR Doc. 11-0014, 2011 BCHRT 14; *Trask v. Nova Scotia (Correctional Services) (No. 1)* (2010), 70 C.H.R.R. D/21 (N.S. Bd. Inq.). In cases of misconduct, a person with a psychosocial disability would have to show a causal relationship between the misconduct and a psychosocial disability to engage the *Code's* protection; *Fleming v. North Bay (City)*, 2010 HRTO 355 (CanLII), *Walton Enterprises v. Lombardi*, 2013 ONSC 4218 (CanLII).

For example, in *Fleming*, the applicant did not establish a causal relationship between his addiction to alcohol and conduct for which he was suspended and ultimately fired (there were eight criminal convictions between 1992 and 2007, including several threats or acts of violence against women and an incident in an arena where he allegedly threw a stick over the glass).

[214] See *Fleming* and *Lombardi, ibid*. and *Wright v. College and Association of Registered Nurses of Alberta* (Appeals Committee), 2012 ABCA 267.

[215] In *Morris v. British Columbia Railway Co.* (2003), 46 C.H.R.R. D/162, 2003 BCHRT 14, a tribunal found that if performance problems related to a disability are a reason for the termination, the disability is a factor in the termination. Knowing of the claimant's depression, the employer should have considered whether the disability was affecting his performance and sought further medical assessment. It failed to do so. The case also confirms that an employer can't "blind itself to its observations of an employee's behaviour…All relevant factors must be considered by an employer dealing with an employee with a disability, including medical evidence, its own observations, and the employee's own comments and concerns." (at para. 238).

[216] *Ibid.*; *Yeats v. Commissionaires Great Lakes*, 2010 HRTO 906 at paras. 47-8 (CanLII).

[217] This example is based on CIBC's disability management program; see: Andrea Davis, "DM Diagnostic" (1 March 2006), available online at: www.benefitscanada.com/news/dm-diagnostic-8220 (Retrieved: May 3, 2012).

[218] People with mental health or addiction issues who use service animals to assist with them with disability-related needs (such as anxiety) are also protected under the definition of "disability" in section 10 of the *Code*. Service animals for people with psychiatric disabilities or addictions do not have to be trained or certified by a recognized disability-related organization. However, where it is not immediately obvious that the animal is performing this service, a person must be able to show evidence (such as medical evidence, or from a similar service provider) that they have a disability and that the animal assists with their disability-related needs. Service providers and others who receive such documentation should not use their own assumptions and observations to second-guess this verification. See *Allarie v. Rouble*, 2010 HRTO 61 (CanLII).

[219] In *Providence Care, Mental Health Services v. Ontario Public Service Employees Union, Local 431*, 2011 CanLII 6863 (ON LA), the arbitrator distinguishes the "nature of disability" from a "diagnosis" by saying at para. 33: "However, I continue to be of the view that nature of illness (or injury) is a general statement of same in plain language without an actual diagnosis or other technical medical details or symptoms. Diagnosis and nature of illness are not synonymous terms, but there is an overlap between them, such that a description of the nature of an illness or injury may reveal the diagnosis and in others it will not."

[220] See *Duliunas v. York-Med Systems , supra*, note 169; *Devoe v. Haran*, *supra*, note 35; and, Eagleson *v. Co-operative Homes Inc. v. Théberge*, 2006, *supra*, note 23.

[221] See *Morris v. British Columbia Railway Co.*, *supra*, note 215; *Russell v. Indeka Imports Ltd.*, 2012 HRTO 926 (CanLII). But also see *Oak Bay Marina Ltd. v. British Columbia (Human Rights Tribunal) (No. 2)* (2002), 43 C.H.R.R. D/487, 2002 BCCA 495.

[222] In *Simpson v. Commissionaires (Great Lakes)*, 2009 HRTO 1362 (CanLII), a case dealing with a physical disability, the HRTO stated at para. 35:

> For the purposes of a request for employment accommodation, generally the focus should be on the functional limitations of the employee's condition (capacities and symptoms) and how those functional aspects interact with the workplace duties and environment. Consequently, an employer need not be informed of the specific cause of the employee's condition or the exact diagnosis in order to be put on notice that an employee has disability-related needs requiring accommodation.

See *Wall v. The Lippé Group*, 2008 HRTO 50 (CanLII), 2008 HRTO 50 (CanLII); *Mellon v. Canada (Human Resources Development)*, [2006] C.H.R.D. No. 2. See also *Ilevbare v. Domain Registry Group*, *supra*, note 186.

[223] *Complex Services Inc. v Ontario Public Service Employees Union, Local 278*, 2012 CanLII 8645 (ON LA) and *Canadian Bank Note Company, Limited v International Union of Operating Engineers, Local 772*, 2012 CanLII 41234 (ON LA). Also, accommodation providers should keep in mind that diagnoses for certain mental health issues can be difficult to get, may change over time and may result in vastly different symptoms and experiences for different people. Therefore, a general statement that a person has a disability and identifying what a person needs in relation to their functional limitations may be more helpful to the accommodation process than a diagnosis. See *Mellon v. Human Resources Development Canada*, *supra*, note 15 at para. 99: "An individual with a disability and, in particular, somebody with a mental disability may not know the exact nature and extent of that disability at the time they are experiencing the symptoms. In such circumstances, we cannot impose a duty to disclose a conclusive medical diagnosis." Some people may present with a set of symptoms, but without a specific diagnosis. See *Ball v. Ontario*, *supra*, note 154.

[224] See *Canadian Union of Public Employees, Local 831 v. Brampton (City)* [2008] O.L.A.A. No. 359 (QL).

[225] The Canadian Human Rights Tribunal has found that requests for a person with autism to undergo a psychiatric examination after asking for a leave of absence because of workplace harassment was in itself a form of harassment. It stated, "Indeed, the evidence shows that the Respondent remained deaf to the pleas of Ms. Dawson who did not want to see a physician whom she did not know and who knew nothing about autism, of her union representatives who expressed concern and consternation about Ms. Dawson having to submit to a medical examination by a Canada Post designated physician but more importantly, of her treating physician who stated that she was very concerned that this could provoke a serious emotional reaction from Ms. Dawson. …However well-intended Canada Post management was in seeking a medical evaluation, the Tribunal finds that, in the present circumstances, the general behaviour of those Canada Post employees who were involved in the medical evaluation process constitutes harassment." See *Dawson v. Canada Post Corp.* [2008] C.H.R.D. No. 41at paras. 216 and 219.

[226] See, for example, *Oak Bay Marina Ltd. v. British Columbia*, *supra*, note 221.

[227] See, for example, in *Crowley v. Liquor Control Board of Ontario*, 2011 HRTO 1429 (CanLII), in which the Tribunal stated at para 62: "A bare assertion of 'stress' and other symptoms by an applicant is not sufficient to establish a mental disability within the meaning and protection of the *Code*." [63] Rather, consistent with the decision in *Skytrain*, *supra*, I agree that in order to meet the definition of mental disability within the meaning and protection of the *Code*, where the case does not involve an allegation of discrimination on the basis of perceived disability, there needs to be a diagnosis of some recognized mental disability, or at least a working diagnosis or articulation of clinically-significant symptoms, from a health professional in a report or other source of evidence that has specificity and substance." Similarly,

in *Matheson v. School District No. 53 (Okanagan Similkameen)*, 2009 BCHRT 112 (CanLII), 2009 BCHRT 112, the BC Human Rights Tribunal dismissed a claim where a person revealed to her employer that she experienced "stress" when seeking an accommodation. The claimant did not disclose enough information to enable her employer to fulfill its duty to accommodate, and the Tribunal found that her refusal to disclose her disability was fatal to her claim.

[228] *Alberta (Human Rights and Citizenship Comm.) v. Federated Co-operatives Ltd.* (2005), 53 C.H.R.R. D/496, 2005 ABQB 58, *Duliunas v. York-Med Systems, supra*, note 169 at para. 77 and *Pridham v. En-Plas Inc*., 2007 HRTO 8 (CanLII).

[229] See *Baber v. York Region District School Board*, *supra*, note 196 and *C.U.P.E., Local 831 v. Brampton (City)*, *supra*, note 224.

[230] *Knibbs v. Brant Artillery Gunners Club*, *supra*, note 65.

[231] In Ontario, the *Occupational Health and Safety Act*, R.S.O. 1990, c.O.1, ss. 32.0.5(3), (4) includes workplace harassment and violence prevention provisions that lay out obligations for employers to assess workplace risk. Employers must also warn workers about the threat of violence from individuals that the worker could encounter during the course of their work, including from other workers, if the person has a history of violent behaviour and there is a risk that another worker could experience physical injury. However, employers and supervisors must not disclose more personal information about the risk than is necessary to protect the worker from physical injury.

[232] See: www.priv.gc.ca/index_e.asp and www.ipc.on.ca/english/Home-Page/. Different privacy laws apply to different organizations – for example, private housing providers may be covered by *Personal Information Protection and Electronic Documents Act* (*PIPEDA*), and are only permitted to disclose personal health information under certain circumstances (see Section 7(3)).

[233] Example taken from: Office of the Information and Privacy Commissioner of Ontario, Fact Sheet: "Disclosure of Information Permitted in Emergency or Other Urgent Circumstances," Number 7, July 2005, p.2.

[234] The *Health Care Consent Act*, S.O. 1996, Ch.2, Schedule A states in s. 2(1) that "treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include:

(a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,

(b) the assessment or examination of a person to determine the general nature of the person's condition,

(c) the taking of a person's health history,

(d) the communication of an assessment or diagnosis,

(e) the admission of a person to a hospital or other facility,

(f) a personal assistance service,

(g) a treatment that in the circumstances poses little or no risk of harm to the person,

(h) anything prescribed by the regulations as not constituting treatment.

[235] In *Fleming v. Reid*, *supra*, note 61, the Ontario Court of Appeal affirmed a competent person's right to determine what should be done with his or her own body, and the right to be free from non-consensual medical treatment. As well, the case found that if a person becomes incompetent, his or her prior wishes about treatment that were expressed while he or she was competent cannot be overridden. The Court made the comparison that people in a psychiatric facility have just as much right to refuse to take a doctor's advice or medication as patients who have physical illnesses. Hospitalizing someone against their will does not automatically make them unable or incompetent to make treatment decisions. The Court recognized that at paragraph 34 that, "Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, than that of competent persons suffering from physical ailments." A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if they are able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision: see the *Health Care Consent Act,* S.O. 1996, c. 2, Sched. A. s. 4(1).

[236] Under section 7 of the Canadian *Charter of Rights and Freedoms*, all people have the right to life, liberty and security of the person and cannot be deprived of these rights except according to the principles of fundamental justice.

[237] See the *Health Care Consent Act*, S.O. 1996, Ch.2, ss. 10(1)(b) and 20.

[238] *Bobyk-Huys v. Canadian Mental Health Assn*., [1994] O.J. No. 1347 (Gen Div.).

[239] See section 13.4 entitled "The legal test" for more information.

[240]*Alladice v. Honda of Canada*, 2010 HRTO 1453 (CanLII). See also *Buttar v. Halton Regional Police*, *supra*, note 189.

[241] Last chance agreements also take place in housing and service situations.

[242] In *Capital Health Authority v. Alberta Union of Provincial Employees, Local 054 (K.M. Grievance),* [2006] A.G.A.A. No. 40, it was stated: "…last chance agreements often are a suitable mechanism to address workplace problems brought about by addiction, and where the employment relationship has by then been greatly damaged but is possibly still salvageable. However, obviously, great care should be taken to draft the agreement to reflect achievable results through a realistic recovery program." [para 49].

[243] *Ibid*.; *Edmonton (City) v. Amalgamated Transit Union, Local 569 (Ezeard Grievance)*, [2003] A.G.A.A. No. 71. See also *Ontario Human Rights Commission v. Gaines Pet Foods Corp.* (1994) 16 O.R. (3d) 290.

[244] In Justice LeSage's report on the eviction of Al Gosling from the Toronto Community Housing Corporation and his subsequent death, one recommendation made was, "TCHC must better communicate its mandate. It is a landlord, not a direct provider of social work services, but it must assist tenants to identify, locate and contact appropriate support services." The Honourable Patrick J. Lesage, Report on the eviction of Al Gosling and the Eviction Prevention Policy of Toronto Community Housing Corporation. May 2010, at page 84; available online at: www.torontohousing.ca/webfm_send/6512/1

[245] Adapted from Open Society Foundations, *Harm Reduction at Work, A Guide for Organizations Employing People Who Use Drugs*, December 2010, pp. 18-19. New York: Open Society Foundations, p. 26-27.

[246] Note that, in rare cases, the HRTO has indirectly considered other factors as part of costs or health and safety. See, for example, *Espey v. London (City)*, 2009 HRTO 271 (CanLII); *Munroe v. Padulo Integrated Inc.*, 2011 HRTO 1410 (CanLII); and *Wozenilek v. City of Guelph*, 2010 HRTO 1652 (CanLII). Also, in *Bubb-Clarke v. Toronto Transit Commission*, *supra*, note 203, the HRTO speculated in *obiter* that an accommodation that could result in bumping another employee from a job may result in undue hardship. But see also *Fair v. Hamilton-Wentworth District School Board*, *supra*, note 189.

[247] *Grismer, supra*, note 165 at para. 42.

[248] *Meiorin, supra*, note 67 at para. 78-79; *Grismer*, *ibid.* at para. 41. Cases since *Meiorin* and *Grismer* have also applied this stringent requirement for objective evidence; see, for example, *Miele v. Famous Players Inc*. (2000), 37 C.H.R.R. D/1 (B.C.H.R.T.).

[249] Grismer, *ibid.* at para. 41.

[250] *Moore v. British Columbia (Education)*, *supra*, note 94.

[251] See *Buttar v. Halton Regional Police*, *supra*, note 189 at para. 132. See also, *R.B. v. Keewatin-Patricia District School Board*, *supra*, note 94.

[252] *Lane v. ADGA Group Consultants Inc.*, *supra*, note 60; *ADGA Group Consultants Inc. v. Lane*, *supra*, note 60. See also *Bobyk-Huys v. Canadian Mental Health Assn.*, *supra*, note 238.

[253] *Meiorin*, *supra*, note 67. See *Radek v. Henderson Development (Canada) Ltd.*, *supra*, note 87.

[254] See *Walmer Developments v. Wolch*, 2003 CanLII 42163 (ON SCDC).

[255] See *Barton v. Loft Community Centre*, 2009 HRTO 647 (CanLII).

[256] The information contained in this section applies not just to psychosocial disabilities, but to disabilities in general. The OHRC's *Policy and guidelines on disability and the duty to accommodate*, *supra*, note 16, was published in 2000, should be read with this newer case law in mind.

[257] See *Hydro-Québec*, *supra*, note 183; *McGill University Health Centre (Montreal General Hospital) v. Syndicat des employés de l'Hôpital général de Montréal* ["*McGill*"], 2007 SCC 4, [2007] 1 S.C.R. 16.

[258] Section 17 of the Ontario *Human Rights Code.*

[259] In a case involving an employee with alcoholism, an arbitrator found that the employer had taken many steps to try to accommodate him before discharging him. The arbitrator stated: "When an alcoholic employee has failed to respond to multiple rehabilitation efforts and there is no objective evidence that further efforts at accommodation would be likely to succeed, it is generally concluded that the employee has been accommodated to the point of undue hardship." See *Kellogg Canada Inc. v. Bakery, Confectionary, Tobacco Workers & Grain Millers, Local 154-G (Fickling Grievance)*, [2006] O.L.A.A. No. 375 at 60.

[260] *McGill*, *supra*, note 257 at para. 38. See also *Keays v. Honda Canada*, [2008] 2 S.C.R. 362 in which the Supreme Court overturned a lower court award of punitive damages in a wrongful dismissal case that was awarded because the employer had required an employee with a disability to take part in an attendance management program. The Court found that the conduct of the employer was not punitive, and accepted that the need to monitor the absences of employees who are regularly absent from work

is a *bona fide* work requirement in light of the very nature of the employment contract and responsibility of the employer to manage its workforce. While these statements made by the Supreme Court are significant, they must be considered in the context of the type of claim that was before the Court. The issue was whether the conduct of the employer was sufficiently "harsh, vindictive, reprehensible and malicious" to justify an award of punitive damages in the context of a wrongful dismissal lawsuit. The Court found that creating a disability management program such as the one at issue could not be equated with a malicious intent to discriminate. The employer's conduct was not sufficiently outrageous or egregious for there to be an award of punitive damages.

[261] *Gourley v. Hamilton Health Sciences*, *supra*, note 165.

[262] *Hydro-Québec*, *supra*, note 183.

[263] *Arends v. Children's Hospital of Eastern Ontario*, 2012 HRTO 1574 (CanLII) at para. 29.

[264] *Briffa v. Costco*, *supra*, note 188 at paras. 52-54 and 60.

[265] *McGill*, *supra*, note 257.

[266] See also *Hall v. Chief of Police, Ottawa Police Service*, 2008 CanLII 65766 (ON SCDC), where the Divisional Court considered the seriousness of the offence when considering if an employer has a duty to accommodate an employee with an addiction. It also agreed with the OCCPS [original appeal body] decision that found that it would have constituted undue hardship for the Police Service to continue employing the employee. In its undue hardship analysis, it considered the employee's significant risk of relapse and the fact that if the claimant were to remain a police officer it would seriously damage the reputation of the Service [paras. 85 and 91]. The Court found that the duty to accommodate is not bottomless, and placed weight on the fact that the officer's career was brief, the number and seriousness of the offences, the fact that they were not isolated, the need for general deterrence, and the damage to the reputation of the Police Service in concluding that it was reasonable to dismiss him. But the decision also noted that the reasonableness of the decision to dismiss in this instance does not imply that an officer with an addiction to drugs can never be accommodated without undue hardship. (80-81)

[267] *Wang v. Humber Institute of Technology and Advanced Learning,* 2011 HRTO 29 (CanLII) at paras. 35, 37.

[268] Available online at: www.ohrc.on.ca/en/policy-competing-human-rights.

[269] Mental health issues and addictions are often cyclical, meaning a person with a mental health disability or addiction may be capable at one time, but not another. See Tess Sheldon, "Addressing the Capacity of Parties before Ontario's Administrative Tribunals: Promoting Autonomy and Preserving Fairness," ARCH Disability Law Centre, October, 2009, 5. See also *K (Re),* 2009 CanLII 54129 (ON CCB).

[270] See section 4(1) of the *Health Care Consent Act*, *supra*, note 234 and section 45 of the *Substitute Decisions Act*, 1992, S.O. 1992, c. 30. See also Article 12 and Article 14 of the United Nations' *Convention on the Rights of Persons with Disabilities*, *supra*, note 27.

[271] *Ibid.*

[272] *Supra*, note 234.

[273] *Supra*, note 70.

[274] Section 47(2) of the *Code* states "Where a provision in an Act or regulation purports to require or authorize conduct that is a contravention of Part I, this Act applies and prevails unless the Act or regulation specifically provides that it is to apply despite this Act."

[275] *Fleming v. Reid*, *supra*, note 61.

[276] Michael Bach and Lana Kerzner, "A New Paradigm for Protecting Autonomy and the Right to Legal Capacity"; available online at: www.lco-cdo.org/en/disabilities-call-for-papers-bach-kerzner.

[277] See the *Substitute Decisions Act*, *supra*, note 270: Section 2(3) Presumption of Capacity: (3) A person is entitled to rely upon the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable of entering into the contract or of giving or refusing consent, as the case may be. 1992, c. 30, s. 2 (3).

[278] *Godelie v. Pauli (Committee of)*, [1990] O.J. No. 1207 (Ontario District Court); *M.K. v. Nova Scotia (Minister of Community Services)*, [1996] N.S.J. No. 275 (N.S. Family Ct.).

[279] *Calvert (Litigation Guardian of) v. Calvert,* (1997) 27 R.F.L. (4th) 394 at para 52 (Ont. Ct. (Gen. Div.)); affirmed by *Calvert (Litigation Guardian of) v. Calvert,* [1998] O.J. No. 505 (Ont. C.A.); leave to appeal to the Supreme Court of Canada denied by *Calvert (Litigation Guardian of) v. Calvert,* [1998] S.C.C.A. No. 161.

[280] *Ibid.* at para. 56.

[281] *Starson v. Swayze*, [2003] 2003 SCC 32, at para. 19.

[282] This list was adapted from Bach and Kerzner, *supra*, note 276; Lana Kerzner, *Paving the Way to Full Realization of the CRPD's Rights to Legal Capacity and Supported Decision-Making: A Canadian Perspective* (2011), Prepared for "From the Margins: New Foundations for Personhood and Legal Capacity in the 21st century," April, 2011, online: The University of British Columbia, Centre for Inclusion and Citizenship http://cic.arts.ubc.ca/research-knowledge-exchange/supportive-decision-making.html at 16; Sheldon, *supra*, note 269, at iii.

[283] *Olarte v. DeFilippis and Commodore Business Machines Ltd. (No. 2)* (1983), 4 C.H.R.R. D/1705 (Ont. Bd. Of Inq.), aff'd (1984), 14 D.L.R. [4th] 118 (Div. Ct.).

[284] See *Payne v. Otsuka Pharmaceutical Co. (No. 3)* (2002), 44 C.H.R.R. D/203 (Ont. Bd. Inq.) at para. 63:

> The nature of when a third party or collateral person would be drawn into the chain of discrimination is fact specific. However, general principles can be determined. The key is the control or power that the collateral or indirect respondent had over the claimant and the principal respondent. The greater the control or power over the situation and the parties, the greater the legal obligation not to condone or further the discriminatory action. The power or control is important because it implies an ability to correct the situation or do something to ameliorate the conditions.

[285] See, for example, *Wamsley v. Ed Green Blueprinting*, 2010 HRTO 1491 (CanLII).

[286] *Renaud*, *supra*, note 201.

[287] *Selinger v. McFarland*, *supra*, note 129.

[288] *Wall v. University of Waterloo* (1995), 27 C.H.R.R. D/44 at paras. 162-67 (Ont. Bd. Inq.). These factors help to assess the reasonableness of an organization's response to harassment. A reasonable response will not affect an organization's liability, but will be considered in deciding the appropriate remedy. In other words, an organization that has reasonably responded to harassment is not absolved of liability but may experience a decrease in the damages that flow from the harassment. See also *Laskowska v. Marineland of Canada Inc.*, 2005 HRTO 30.

[289] Available online at: www.ohrc.on.ca/en/guidelines-developing-human-rights-policies-and-procedures.

[290] Beth Loy, *Accommodation and Compliance Series: Employees with Mental Health Impairments, Job Accommodation Network*. Available online at: http://askjan.org/media/psychiatric.html#acc (Retrieved: November 15, 2012).

[291] For more information on data collection, see the OHRC's guide: *Count me in! Collecting human rights-based data*, available at www.ohrc.on.ca/en/count-me-collecting-human-rights-based-data.

[292] *Accessibility for Ontarians with Disabilities Act*, 2005, *supra*, note 71, ss.7(1).

[293] See section 8 of the *Code*.

[294] "Obligated organizations" mean the Government of Ontario, the Legislative Assembly, a designated public sector organization, a large organization (50 or more employees in Ontario) and a small organization (under 50 employees in Ontario).

[295] *Accessibility for Ontarians with Disabilities Act*, 2005, *supra*, note 71, O. Reg. 191/11, s.3.

[296] See, for example: Neasa Martin & Valerie Johnston, *A Time for Action: Tackling Stigma and Discrimination: Report to the Mental Health Commission of Canada* (2007), *supra*, note 4 at 17; and Penn, D.L., Guynan K., Daily T. Spaulding, W.D., Garbin, C.P., and Sullivan, M. (1994). "Dispelling the stigma of schizophrenia: What sort of information is best?" Schizophrenia Bulletin, 20, 567-578.

[297] Ena Chadha, "'Mentally Defectives' Not Welcome: Mental Disability in Canadian Immigration Law, 1859-1927", *Disability Studies Quarterly*, Winter 2008, Volume 28, No.1, www.dsq-sds.org, available online at: http://dsq-sds.org/article/view/67/67.

[298] John P. Radford, "Intellectual Disability and the Heritage of Modernity" in *Disability Is Not Measles: New Research Paradigms In Disability*, eds. M.H. Rioux and M. Bach (North York: Roeher Institute, 1994); Metzel and Walker, "The Illusion of Inclusion: Geographies of the Lives of People with Developmental Disabilities in the United States", available online at: http://dsq-sds.org/article/view/323/394.

[299] In the 1906 federal *Immigration Act*, mentally ill people were among the prohibited classes who could be legally deported. Immigrants who were within two years of arriving in Canada and who lived in publicly-funded charitable institutions (such as an asylum), were eligible for deportation. See Ian Dowbiggin, "'Keeping this Young Country Sane': C.K. Clarke, Immigration Restriction, and Canadian Psychiatry, 1890-1935," *The Canadian Historical Review*, 76 (1995); and Chadha, *supra*, note 297. In 1935, in part due to intense racial prejudice against Chinese immigrants who had come to Canada, 65 Chinese male mental patients were deported from British Columbia to a Hong Kong mental institution. Some of the men had lived in Canada for more than 30 years: see Robert Menzies, "Race, Reason and Regulation: British Columbia's Mass Exile of Chinese 'Lunatics' aboard the Empress of Russia", 9 February, 1935 in *Regulating Lives: Historical Essays on the State, Society, the Individual and the Law*, ed. John P. S. McLaren, Robert Menzies, and Dorothy E. Chunn, 196-230, Vancouver: UBC Press, 2002.

[300] Eugenics may be defined as "the study of or belief in the possibility of improving the qualities of the human species or a human population, especially by such means as discouraging reproduction by persons having genetic defects or presumed to have inheritable undesirable traits (negative eugenics) or encouraging reproduction by persons presumed to have inheritable desirable traits (positive eugenics)." See http://dictionary.reference.com/browse/eugenics (Retrieved: January 15, 2014).

[301] J. Grekul, H. Krahn, D. Odynak, "Sterilizing the 'Feeble-minded': Eugenics in Alberta, Canada, 1929–1972", *Journal of Historical Sociology*, Vol. 17 No. 4 December 2004, at 358.

[302] Deborah C. Park & John P. Radford (1998), "From the Case Files: Reconstructing a history of involuntary sterilisation", *Disability & Society*, 13:3, 317-342, at 318.

[303] The Law Reform Commission of Canada, Working Paper 24, *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons* (1979), at 32, available online at: https://archive.org/details/sterilizationimp00lawr. For more information about the impact of involuntary sterilization, see *Muir v. Alberta*, 1996 CanLII 7287 (AB QB).

[304] Park and Radford, *supra*, note 302.

[305] CBC News Canada, "Alberta apologizes for forced sterilization" (November 9, 1999). Available online at: www.cbc.ca/news/canada/story/1999/11/02/sterilize991102.html (Retrieved: December 10, 2012).

[306] *Marriage Act*, R.S.B.C. 1979, c. 251, s. 34 [am. 1981, c. 21, s. 41]. The *Interpretation Act*, R.S.B.C. 1979, c. 206, s. 29 defined "mentally disordered person" by adopting the definition contained in the *Mental Health Act*, R.S.B.C. 1979, c. 256, s. 1.

[307] *Solemnization of Marriage Act*, S.A. 1925, c. 39, s. 29.

[308] *Canadian Disability Rights Council v. Canada* [1988] 3 F.C. 622 para. 7.

[309] Sam Sussman, "The first asylums in Canada: A response to neglectful community care and current trends" (1998) 43 *Canadian Journal of Psychiatry*, available online at: https://ww1.cpa-apc.org/Publications/Archives/CJP/1998/April/apr98_revpap1.htm.

[310] *Ibid.*; Janet Miron, *Prisons, asylums, and the public: Institutional visiting in the nineteenth century* (Toronto: University of Toronto Press, 2011), 23.

[311] Practices included insulin shock or insulin coma therapy, which involved injecting patients with insulin to induce temporary comas, and electroconvulsive therapy without anaesthesia, which involved passing an electric current through the brain to induce seizures, and lobotomies, which involved surgically removing part of the brain. See J. T. Braslow, "Punishment or therapy. Patients, doctors, and somatic remedies in the early twentieth century," The *Psychiatric Clinics of North America*, 17 (1994): 493, and Harvey G. Simmons, *Unbalanced: Mental health policy in Ontario, 1930-1989* (Toronto: Wall & Thompson, 1990), 15, 231.

[312] Parliament of Canada, *Mental health, mental illness and addiction: Overview of policies and programs in Canada. Interim report of the standing senate committee on social affairs, science and technology. Report 1* (2004): 7.2.2 at para. 1. Available online at: www.parl.gc.ca/Content/SEN/Committee/381/soci/rep/report1/repintnov04vol1part3-e.htm#_ftnref356.

[313] Cyril Greenland, Jack D. Griffin, and Brian F. Hoffman, "Psychiatry in Canada from 1951 to 2001," in *Psychiatry in Canada: 50 years (1951 to 2001*), ed. Quentin Rae-Grant (Ottawa: Canadian Psychiatry Association, 2001), at 2.

[314] Geoffrey Reaume, "Accounts of abuse of patients at the Toronto hospital for the insane, 1883-1937" (1997) 14 *Canadian Bulletin of Medical History*, 66.

[315] Parliament of Canada, *supra*, note 312 at 7.2.2, para. 4.

[316] Between 1960 and 1975, 35,000 beds were closed in provincial psychiatric hospitals (leaving 15,000). These beds were replaced by approximately 5,000 beds in new general hospital psychiatric units. See Donald Wasylenki, "The paradigm shift from institution to community," in *Psychiatry in Canada: 50 years*

(1951 to 2001), ed. Quentin Rae-Grant (Ottawa: Canadian Psychiatry Association, 2001), 95; Geoffrey Reaume, "Lunatic to patient to person: Nomenclature in psychiatric history and the influence of patients' activism in North America," *International Journal of Law and Psychiatry* 25 (2002), 405.

[317] Wasylenki, *ibid.* at 96-97.

[318] *Ibid.* at 97.

[319] Parliament of Canada, *supra*, note 312 at 7.3 para. 1. See also CAMH, *The Stigma of Substance Abuse: A Review of the Literature*, *supra*, note 4.

[320] Daniel Malleck, "'A state bordering on insanity'?: Identifying drug addiction in nineteenth-century Canadian asylums," *Canadian Bulletin of Medical History* 16 (1999), 247.

[321] R. Solomon and M. Green, "The first century: The history of nonmedical opiate use and control policies in Canada, 1870-1970," *University of Western Ontario Law Review* 20 (1982), 307.

[322] *Ibid*. at 308.

[323] *Ibid*.

[324] *Ibid*. at 309.

[325] *Ibid*.; Parliament of Canada, *Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada. Interim Report of the Standing Senate Committee on Social Affairs, Science and Technology.* Report 1 (2004): 7.3 at para. 2. Online: www.parl.gc.ca/Content/SEN/Committee/381/soci/rep/report1/repintnov04vol1part3-e.htm#_ftnref356.

[326] Geoffrey Reaume, "Keep your labels off my mind! Or "now I am going to pretend I am craze[*sic]* but dont [*sic*] be a bit alarmed": Psychiatric history from the patients' perspectives," *Canadian Bulletin of Medical History*, 11 (1994), 397.

[327] "Phoenix takes off," *Phoenix Rising: The Outspoken Voice of Psychiatric Inmates*, Spring 1980, Vol 1, No 1, 1-2.

[328] Harvey G. Simmons, *supra*, note 311 at 231.

[329] *Ibid.* at 232-235.

[330] Reaume, *supra*, note 326, at 416 and 421.