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Colliding Intersections in Law: Culture, Race and Mental Health

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As the colliding intersections of culture, race, mental health disability and other identities infuse the legal and mental health system, the conceptual and practical challenges of dealing with these intersections must be analyzed. Mental health law is a complex area of law to explore these colliding intersections, since the exact reasons for the inequities faced by racialized psychiatric consumer/survivors is contested by practitioners in both law and psychiatry, making them difficult to prove in a legal forum (McKenzie and Bhui 2007: 397). Consequently, as practitioners grapple with the predominance of culture and race-based inequities in the mental health system, they continue striving to provide safeguards against these deprivations of liberty (Dhir 2008: 104).

This paper will explore the following questions: To what extent can a conception of justice address these colliding intersections without essentializing and stereotyping the identities of racialized psychiatric consumer/survivors? What theoretical approaches are necessary to understand the complexities of these intersections, while taking into account the context, systemic racism and multiple power hierarchies inherent in both law and psychiatry?

In Part I of the paper, I examine the inherent dangers with using cultural factors and cultural evidence/ information in the legal and mental health system. In order to address these

1 As a lawyer of South Asian descent, my desire to pursue research in mental health law stems from my legal work and involvement with Hiltz Szigeti LLP, ARCH Disability Law Centre, the University of Ottawa Community Legal Clinic and the Mental Health Legal Committee (MHLC), and life experiences with family and friends who are psychiatric consumer / survivors.

dangers, I suggest practitioners in mental health law consider theoretical approaches such as intersectionality combined with the institutional racism paradigm and the social model of disability theory. Drawing from interdisciplinary literature and theories, the analysis in Part II of this paper will articulate the tenets of these approaches, their applicability to mental health law and the larger fields of law and psychiatry in particular, and their strengths and weaknesses in regard to the issues at play. Lastly, I examine various interdisciplinary strategies and guidelines that practitioners can use to put these theoretical approaches into practice.

The terminology for this research is academically and politically contested. Within disability and mental health discourse, the terms and language being referenced are contextual and socially constructed (Barham and Barnes 1999: 138). I will adopt the following meanings of the terms, given their relevance to the research and their common use amongst mental health and legal researchers. I use the term "psychiatric consumer/survivors" to refer to those who are recipients or former recipients of psychiatric and/or addiction services. I refer to "intersectionality" as an analytical approach to highlight the intersections between aspects of identity and differences such as disability, race, class, gender and ethnicity, and various forms of systemic oppression (Dhamoon and Hankivsky 2011: 16). The "social model of disability" refers to the model of disablement, which suggests that the social environment creates barriers for people with disabilities to participate in society (Pothier 1992; Wendell 1996; Davis 1996; Bickenbach 1993). A "color-blind approach" refers to a legal approach which "ignores the fact that [racialized people] and Whites have not been and are not similarly situated with regard to legal doctrines, rules, principles and practices" (Alyward 1999: 34). Lastly, I use the term "racialized" to refer to those who come from an immigrant, refugee, ethno-racial or ethno-cultural community with diverse and unique social realities (Mental Health Commission of Canada and CAMH 2009: 4). The term is socially constructed "to view persons or groups who share (or are perceived to share) a given ancestry

as different and unequal in ways that matter to economic, political and social life…" (Manitoba Human Rights Commission 2007; Report on the Commission on Systemic Racism in the Ontario Justice System 1995: 40-41).

Part I: Fear of Essentialization: An Interdisciplinary Quandary

The legal and mental health systems' treatment of culture, and other colliding intersections of race, mental health disability and class has been problematic, resulting in differential outcomes and inequities for racialized psychiatric consumer/survivors. The challenge is immense for practitioners in both law and psychiatry, since psychiatric symptoms can present themselves differently amongst racialized psychiatric consumer/survivors; and in the event lawyers do present cultural evidence/ information, they may risk creating unjust stereotypes based on culture, race, class, gender, etc. (Hicks 2004: 21). For example, the subjective bias inherent in the field of psychiatry and cultural misunderstandings may result in inaccurate capacity assessments and diagnoses for racialized psychiatric consumer/survivors (Jarvis, Toniolo, Ryder, Sessa, Cremonese 2010: 247). Misdiagnosis may jeopardize the validity of one's capacity assessment in the legal system and legal outcomes for him or her (Hicks 2004: 22). Consequently, according to Suman Fernando, "black/ethnic minorities are more often diagnosed as schizophrenic, compulsorily detained under the *Mental Health Act*, admitted as offender patients, held by police under Section 136 of the *Mental Health Act*, transferred to locked wards, not referred to for psychotherapy, given high doses of medication and sent to psychiatrists by courts" (Fernando and Keating 2009: 47).

In light of these challenges, legal scholars have debated the extent to which culture, and other intersections can infuse the legal system without inculcating stereotypes. Specifically, Sonia Lawrence explores the problematic nature of infusing culture into the legal process. She argues,

What goes on in courtrooms can be seen as a modern project

of racialization, namely a more 'sophisticated' version of the blunt attribution of inferior traits to non-Whites that thereby attaches the inferiority label not to the individuals but rather to their culture. In belittling the content of other cultures and depicting the members of these cultures as either ignorant victims or zealous followers of deviant norms, legal processes are assigning traits to people. Of course, these 'traits' are ostensibly based on cultural, rather than racial affiliations. However, given the often simplistic or confused reading that courts give to cultural material, can they be absolved because they are relying on cultural labels rather than on skin colour? (Lawrence 2001: 112)

Lawrence suggests that judges are often not equipped and in some cases "unwilling" to understand the complexities of cultural evidence/ information (Lawrence 2001: 112). By only identifying differences between the non-mainstream, "Other" culture, and a construction of Canadian norms, the practice of adopting "cultural sensitivity" in courtrooms has created "an essentialized view of culture" giving deference to the constructed view of Canadian norms (Lawrence 2001: 116). In Canadian courtrooms, Lawrence indicates that judges are often unable to glean through and interpret the nuances within the cultural evidence/ information being presented by lawyers. There is little attempt to see similarities between the "Other" cultures and the majority culture, and distinguish differences within cultures themselves. In this vein, stereotypes can occur by reducing cultures to certain identifiable elements, practices, traditions, customs and traits without accounting for the contextual complexities of such information and a consideration of culture as non-static and changing (Lawrence 2001: 117-118). Accordingly, Lawrence questions whether cultural evidence/ information should even be presented in legal cases, if it continues to perpetuate such stereotypes and create unjust legal outcomes it is intended to avoid (Lawrence 2001: 135). This further raises the following questions: Who is putting the cultural evidence/ information forth and what power/control/expertise does he or she have to do so? Within legal and quasi-judicial legal

processes, are those from minority cultures given the opportunity to present this cultural evidence/ information in light of the rules of evidence and the type of forum in which cases are heard? How are expert witnesses able to respond to these issues at hand?

Despite these unresolved tensions, it is also evident that altogether ignoring culture, and other intersecting identities can perpetuate further inequities. In this regard, Razack describes that in certain legal cases, "we see the violent underpinnings of universality- how the very language fairness, sameness, rationality, equal treatment and neutrality can be used to expel racialized bodies from personhood" (Razack 2000: 7; Goldberg 1993: 149). Similarly, Alyward points to the dangerous consequences of adopting a "color-blind" approach. Theorists such as Alyward and Razack, therefore, emphasize the importance of deconstructing the impact that power hierarchies, history and systemic racism can have within the legal context (Alyward 1999; Razack 1998).

The problems with a "color-blind" approach are particularly relevant in a mental health law context where racialized psychiatric consumer/survivors may have unique needs such as those in regard to communication, culturally appropriate treatment options, and assessment procedures that take into account cultural context and beliefs (Tseng and Matthews 2004: 25). According to Suman Fernando, a "color-blind" approach in psychiatry is a "denial both of individual perceptions in a racist society, and, more importantly, the fact that race matters because of the way most-or all-societies function" (Fernando 2002: 132).

Part II: Considering Alternative Conceptual and Theoretical Frameworks

In addressing the underlying debate surrounding issues of "universalism vs. cultural relativism," the challenge for practitioners and scholars remains in attempting to find a balance between accommodating cultural and other colliding differences without creating varying standards for those

from diverse cultures and those from the dominant culture, while maintaining an efficient legal and mental health system (Tseng and Matthews 2004: 24). To account for the colliding intersections of culture, race, mental health disability, class and other identities, I suggest practitioners consider adopting theoretical approaches, which are grounded in social constructivism. The following discussion will explore and examine the relevance of using an intersectional approach in tandem with tenets of the institutional racism paradigm and the social model of disability. Lastly, I articulate a few interdisciplinary strategies and guidelines that have been proposed in law and psychiatry, which attempt to put the theoretical underpinnings of these frameworks into practice.

2.1 Intersectionality

Intersectionality recognizes the multi-dimensional (Crenshaw 1990-91: 1265) and fluid construction of an individual's identity (Yuval-Davis 2006: 194). The approach is "concerned with simultaneous intersections between aspects of social differences and identity (as related to meanings of race, ethnicity, indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion) and forms of systemic oppression (racism, classism, sexism, ableism, homophobia) at macro and micro levels" (Dhamoon and Hankivsky 2011: 16). According to Nitya Duclos (Iyer), an individual's distinctive experiences of oppression are caused by complex socio-economic and psychological factors, which occur within the system and the individual. (Duclos [Iyer] 1993: 29). Through an analysis of 299 reported Canadian human rights cases, Duclos (Iyer) found that the cases rarely mentioned racial affiliation, and there was little recognition of the intersection of religion, culture, ethnicity, class, and other social complexities (Duclos [Iyer] 1993: 29). In later research, (Duclos) Iyer (1993: 180) suggests that anti-discrimination laws create mutually exclusive categories, which result in individuals having to reinvent and deny their identity in order to fit into the rigid categorization being subscribed to them by the law. Adjudicators may treat "race,

colour, ethnic origin, ancestry, and place of origin as a single category" (Ontario Human Rights Commission 2001: 3). This is problematic because these social categories must be seen to operate relationally and they cannot stand alone as additive categories (Stienstra 2002: 3).

In a legal context, intersectional approach enables one to consider the historical, social, political, economic and cultural context, which contributes to the experiences and barriers an individual may face. An intersectional approach highlights the intersection between these grounds, which may adversely impact an individual who is identified with more than one ground. (*Canada v. Mossop*). To avoid essentalization, the intersectional approach "shifts the gaze from the othered identity and/or category of otherness to the relational processes of othering and normalization, and their pertinent contexts of power" (Dhamoon and Hankivsky 2011: 25).

As Justice Claire L'Heureux-Dubé argued in Mossop:

> It is increasingly recognized that categories of discrimination may overlap, and that individuals may suffer historical exclusion on the basis of both race and gender, age and physical handicap, or some other combination. The situation of individuals who confront multiple grounds of disadvantage is particularly complex …categorizing such discrimination as primarily racially oriented, or primarily gender-oriented, misconceives the reality of discrimination as it is experienced by individuals. Discrimination may be experienced on many grounds, and where this is the case, it is not really meaningful to assert that it is one or the other. It may be more realistic to recognize that both forms of discrimination may be present and intersect. On a practical level, where both forms of discrimination are prohibited, one can ignore the complexity of the interaction, and characterize the discrimination as of one type or the other. The person is protected from discrimination in either event (*Canada v. Mossop*: para 152).

Courts and tribunals have attempted to use an intersectional approach in human rights jurisprudence to understand the complexities of the intersecting oppressions and identities that result in discrimination. In *Falkiner v. Ontario (Ministry of Community and Social Services, Income Maintenance Branch*), Justice Laskin of the Ontario Court of Appeal accepted that the definition of spouse is impacted by various socio-economic and familial factors (Falkiner: para 72). In his analysis, he reasoned that "multiple comparator groups are needed to bring into focus the multiple forms of differential treatment alleged" (Falkiner: para 72). Similarly, in *Radek v. Henderson Development* (Canada) *Ltd*., the British Columbia Human Rights Tribunal used an intersectional approach to examine the intersections between the grounds of race, gender, disability and class (*Radek*). In its decision, the Tribunal stated: "I find it difficult to imagine that events would have unfolded in the same way if Ms. Radek had been white" (Radek: para. 471). Thus, the tribunal recognized that Radek's experience of discrimination was complex and unique because of the "multiple facets" of her identity (*Radek*; HIV/AIDS Policy and Law Review 2005: 2).

In law, despite the impact that the intersectional approach has had upon certain courts and tribunals, there has not been an explicit analytical legal framework developed for its implementation (Marchetti 2008; Gilbert and Majury 2006: 124; Sampson 2006: 269). Scholars have suggested that the approach has not been fully understood and endorsed in law because it is challenging for judges and adjudicators to simultaneously understand and discuss the intersections between identities such as disability, gender, sex, race, ethnicity and class (Marchetti 2008; Gilbert and Majury 2006: 124; Sampson 2006: 269). When applying the analysis, there is a danger of misunderstanding individual identities and perpetuating stereotypes. In this regard, intersectionality is often critical of the notion that identities are uncomplicated. For instance, race, sex, gender, disability and other socially constructed categories are not fixed and cannot be oversimplified. As Mary Coombs highlights, "identity is not fixed or absolute;

rather, it is determined by particular persons for particular purposes at particular times in a process in which the person identified participates with varying degrees of freedom" (Coombs 1996: 223). Accordingly, these critiques can inform an understanding of the "contextuality and complexity of identity" when applying an intersectional approach to a legal case and its underlying legal processes (Coombs 1996: 224).

In this vein, other scholars such as Maneesha Deckha and Rosemary Coombe suggest intersectionality should also be used to recognize the inherent hierarchies within law and culture. They suggest that the relationship between law and culture is dynamic, and cultural claims must be made within a context that recognizes social location and the "continually emergent differentiation, contestation, negotiation and agency" within cultures (Deckha 2004: 26; citing Coombe 1998: 21). To accomplish this, Marchetti suggests that legal processes "require adequate resources and a sufficient amount of time for the collection and analysis of the different narratives" (Marchetti 2008: 170).

In the mental health context, an intersectional approach is key to addressing how the colliding intersections and factors such as culture, race, ethnicity, gender, age, disability, class and sexuality affect racialized psychiatric consumer/survivors interacting with the law. For instance, Dossa's research emphasizes how an intersectionality paradigm can be used to highlight the interface between disability and culture (Dossa 2008: 83). Using this approach for cultural claims "gives weight to the politics of recognition," by "reversing the medical and rehabilitation model with its emphasis on normalizing the individual body" (Dossa 2008: 83).

When adopting an intersectional approach, mental health practitioners and mental health researchers must be cautious to ensure that findings are not generalized and negative stereotypes are not perpetuated. There must be a constant analysis and understanding of the power dynamics at play between those who are in the mental health system and practitioners such as lawyers, service providers, psychiatrists and

adjudicators working with them. Further, the lived experiences of racialized psychiatric consumer/survivors should underlie the analysis within a context that highlights how systemic racism and other forms of social exclusion may have affected their experiences. Accordingly, practitioners and researchers themselves must be self-reflective about their own biases, lived experiences and prejudices when adopting the approach.

2.2 Institutional Racism Paradigm

By acknowledging the existence of institutional racism within mental health services, mental heath researchers use the institutional racism paradigm in tandem with an intersectional approach to understand and develop solutions aimed at "systems," rather than "individuals" (McKenzie 1999: 616-617). "Institutional racism" is defined as "the collective failure of an organization to provide an appropriate and professional service to people because of their colour, or ethnic origin. This can be seen or detected in processes, attitudes, and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantages people in ethnic minority groups" (McKenzie and Bhui 2007: 650 citing Macpherson: 1999). For instance, McKenzie and Bhui suggest that the higher rates of involuntary admission and treatment by coercion amongst some minority ethnic groups in the United Kingdom can be attributed to institutional racism within the mental health care system (McKenzie and Bhui 2007: 649). It appears that "these disparities reflect the way health services offer specific treatment and care pathways according to racial groups, and therefore seem to satisfy the well established and widely known definition of institutional racism" (McKenzie and Bhui 2007: 649).

In the mental health law context, the institutional racism paradigm can be used to examine the relationships and interaction between mental health care services, mental health laws and racialized psychiatric consumer/survivors. Accord-

ing to Gary King and further articulated by Kwame McKenzie, mental health researchers should use this paradigm to 1) focus on the practices perpetuating inequities within institutions instead of upon the practices amongst individuals, 2) focus on reducing health inequities, 3) examine the connections between medicine and discrimination, 4) recognize how colonization and history affect racialized psychiatric consumer/survivors, 5) understand how other intersections of race, class, gender and sexual orientation affect mental health disability, 6) acknowledge the changing effects of racism through time and within institutions, and 7) emphasize the social factors that have contributed to the inequities instead of the biomedical ones (McKenzie 1999: 616-617; King 1996) .

Critics of this paradigm suggest that clinicians and researchers need to be cautious about placing an inappropriate emphasis on culture and ethnicity at the "expense of sound clinical judgment" (Singh 2007: 366). To address such issues, practitioners, regardless of the differing political views, need to make a commitment to using multi-disciplinary approaches within law and psychiatry and collaborate with all of the participants in the mental health system (McKenzie and Bhui 2007: 369).

2.3 Social Model of Disability

In conjunction with intersectionality and the institutional racism paradigm, one can draw from disability scholarship to explain how disability is influenced by the complex circumstances surrounding one's health condition, personal and external social factors (Hartley and Muhit 2003: 104). Contemporary disability theorists such as Dianne Pothier, Susan Wendell, Lennard Davis and Jerome Bickenbach argue that people with disabilities experience inequality as a result of social factors (Pothier 1992; Wendell 1996; Davis 1996; Bickenbach 1993).

Social constructionists argue that society has perceived a negative attitude about disability using essentialist assumptions about what a normal body or mind should constitute.

As Dianne Pothier argues:

> The social construction of disability assesses and deals with disability from an able- bodied perspective. It includes erroneous assumptions about capacity to perform that come from an able bodied frame of reference. It encompasses the failure to make possible or accept different ways of doing things (Pothier 1992: 526).

However, within mental health disability, the model rejects the deference given to psychiatry and the focus on using anti-psychotic drugs. For instance, the social model's "elimination of the false dichotomy between mind and body" can be used to emphasize how an individual experiences mental illness by acknowledging the effects of stigma, discrimination and institutional barriers in society (Andersen-Watts 2008: 155).

The social model has been critiqued and debated amongst scholars. As Susan Wendell suggests, strictly adhering to the social constructionist approach and outright rejection of the biomedical model may ignore the multi-dimensionality of disablement. In this regard, one of the main critiques of the social model of disability is that changing the environment does not eradicate all disability. This critique is particularly relevant to psychiatric consumer/survivors, who face serious psychiatric issues and may need medication to address them. Therefore, Wendell suggests that an understanding of disability must balance the "uncontrollable and immutable" reality of an individual's limitations along with social factors that continue to put people with disabilities at a disadvantage (Wendell 1996: 45). Secondly, it is important to note that the relationship between the psychiatric consumer/survivor movement and the disability movement is complex and contested. There are differences between the philosophical underpinnings of the disability movement and the psychiatric consumer/survivor movement (Campbell and Oliver 1996). The social model has been critiqued within the consumer/survivor movement since it was historically created for persons with physical and sensory impairments, and there is

a fear that such a theory will marginalize psychiatric consumer/survivors similar to those within psychiatry (Beresford 2004: 218).

Intersectionality is also relevant to a critique of disability discourse because the unmarked disability identity is often modeled on a white Euro-American disability experience, disregarding history, colonization, and social exclusion. As Fellows and Razack suggest, "the systems of domination that position white, middle-class, heterosexual, nondisabled men at the centre continue to operate among all other groups, limiting in various ways what [marginal groups] know and feel about one another" (Fellows and Razack 1998: 358). Although the intersections of identities such as race, culture, class, and mental health disability have not been readily explored, parallels can be drawn. As contemporary theorists of disability and race suggest, what constitutes a disability and a racial category are social constructions (Asch 2001: 6).

Similarly, the social model has provoked interest amongst mental health researchers. The model has the potential to examine the experiences of psychiatric consumer/survivors in a framework that focuses on eliminating societal stigma regarding mental health issues.

As Plumb argues,

> Such a model would also have to take into account of the strong sense that many survivors have that their processing in the psychiatric system is related not only to them being seen as defective but also frequently dissident, non-conformist and different in their values from dominant societal values (Plumb 1999: 467).

In mental health law, practitioners adopting this model are committed to critically evaluating laws, policies, processes, health inequalities, and social exclusion impacting psychiatric consumer/survivors (Duggan, Cooper and Foster 2002: 19). According to Perlin, to combat the sanism within mental health law, this model can help create a framework where individuals are given respect, dignity and ownership of their

condition and treatment (Perlin 2006: 74). He describes "sanism" as "an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry..."Sanism is primarily based upon "stereotype, myth, deindividualization, and is sustained and perpetuated by our use of alleged 'ordinary common sense' (OCS) and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process" (Perlin 2006: 74). In this regard, as Kathleen Anderson-Watts suggests, an understanding and adopting of the social model can enable practitioners to analyze the social factors such as poverty, unemployment, and access to health care that impact psychiatric consumer/survivors. The model itself can envision alternative psychiatric treatment options, high standards for mental health lawyers and the involvement of non-medical consultants in involuntary admission hearings (Anderson-Watts 2008: 159).

2.4 Strategies for Change: From Theory to Practice

The challenge for practitioners and scholars alike lies in transforming the theoretical and conceptual underpinnings of the intersectional approach combined with tenets of the institutional racism paradigm and the social model of disability into practice. In order to embrace such a framework, I draw from interdisciplinary research and literature to examine the various strategies and guidelines that have been put forth in law and psychiatry. For instance, Leti Volp recognizes that people may have a "negotiated relationship with their culture" and, therefore, she proposes that the following guidelines be set in order to deal with the emerging problems of cultural evidence/information within legal processes (Volpp 1994: 65). When presenting cultural evidence/information, there should be a focus on understanding the individual's testimony instead of attempting to create a generalization of a certain ethnic group's behavior and then trying to mold the behavior of the accused to fit this generalization (Volpp 1994: 85). Secondly, transcultural psychology and

psychiatry should be used to ensure that cultural differences are properly understood (Volpp 1994: 85). Thirdly, courts [and tribunals] should consider using consultants with the same cultural background (or perhaps even gender) as the individual (Volpp 1994: 85). Fourthly, dominant norms should not be construed to be neutral (Volpp 1994: 85). And lastly, the information should not be constructed in a manner, which subordinates certain groups such as women within the culture (Volpp 1994: 100-101).

Lawrence suggests that practitioners should use cultural evidence/information cautiously. The inner multi-faceted and complex nature of culture requires "testimony about practices be taken as a guide and not as a strict template of behavior" (Lawrence 2001: 129). There must be a recognition of the "intra-cultural dissent and power struggles" inherent within any culture when such testimony is used (Lawrence 2001: 129). Practitioners should strive to include alternative narratives to explain cultural practices within legal processes, and they should attempt to compare the dominant culture's practices with those of the minority culture (Lawrence 2001: 129). Community members should also try to be involved in cases where cultural evidence/ information is an issue by submitting *amicus* briefs and highlighting the facts that legal rules, doctrines and conventions are "cultural and contested" (Lawrence 2001: 129).

In psychiatry, the DSM–IV–TR (2000) includes an outline for psychiatrists to include a "Cultural Formulation" in capacity assessments, diagnosis, and general care (Diagnostic and Statistical Manual of Mental Disorders 2000). To accomplish this, psychiatrists have recently proposed specific recommendations and guidelines. For instance, a clinician is expected to be self-reflective about his or her own cultural context and beliefs. This may include "1) cultural influences of the dominant society; 2) the cultural identity and background of the practitioner; 3) the institutional culture of the hospital, clinic, or other setting where diagnosis and treatment are delivered; and 4) the professional cultures of biomedicine

and psychiatry" (Mezzich, Caracci, Fabrega, Kirmayer 2009: 392). Drawing from tenets of intersectionality, Mezzich et al. encourage clinicians to understand the lived experiences and context of patients in a compassionate, open and emphathetic manner (Mezzich et al. 2009: 394).

Education and on-going awareness training should occur for all stakeholders in the mental health system. This includes: psychiatric consumer/survivors, mental health lawyers, adjudicators, psychiatrists, health care professionals, and service providers.

In this respect, health inequity literature suggests that intersectional training and workshops can be used to teach practitioners how to avoid a cookie cutter approach to culture, debunk the universalism, color-blind approach and to emphasize the impact of power hierarchies, institutions of oppression and structural racism upon racialized psychiatric consumer/survivors (Dhamoon and Hankivsky 2011: 25). These training workshops should be organized in collaboration with racialized psychiatric consumer/survivors. Specifically, institutions should consider implementing a consultation-liason model, to ensure that service providers who specialize in providing care for racialized communities can provide education, training and support to staff within the hospitals. Further, lawyers and adjudicators should be trained on how to recognize if cultural, racial and other social issues are relevant to an ethno-racial psychiatric consumer/survivor's case, and how to incorporate these issues into their arguments before the courtrooms or tribunals.

Conclusion:

As the interplay of race, culture, mental health disability and other intersectional identities infuse the legal and mental health system, these intersecting identities must be understood and appropriately addressed. Psychiatrists, lawyers and all practitioners should strive to understand the impact

of race and ethnicity on diagnosis, capacity assessments and treatment incapacity decisions. However, as Part I of this paper illustrates, there are inherent challenges when cultural evidence/information is presented in the legal and mental health system. There is a danger of misunderstanding individual identities and perpetuating stereotypes without accounting for the contextual complexities of such information. On the other hand, it appears that using a "color-blind approach," is similarly problematic because it ignores the impact of systemic racism, cultural context and beliefs, along with other social factors within the practice of law or psychiatry.

To achieve an inclusive conception of justice for racialized psychiatric consumer/survivors, as I described in Part II of this paper, I suggest practitioners consider adopting a theoretical framework embracing an intersectional approach, combined with tenets from the institutional racism paradigm and the social model of disability. These theoretical approaches can be used by practitioners in mental health law to question their own positions of power and cultural biases, to question the power hierarchies embedded within the institutions of the legal and mental health system, and to create practical strategies which reflect a contextualized understanding of the colliding intersections of race, culture and mental health disability.

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