MOTHERHOOD, MADNESS, AND THE ROLE OF THE STATE

by

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ABSTRACT

This thesis examines the state processes that are involved in removing children from mothers with mental health histories. In particular, the thesis analyzes the ways in which the ideology of motherhood intersects with the expert discourses of psychology and psychiatry to affect child welfare decisions. The study reviews mental health and child welfare legislation in each province in Canada and 61 court decisions where the mother had a mental health history. In examining the statutory frameworks, the thesis suggests that the legislative provisions treat children and mentally disordered persons similarly because they include the following common factors: a positive duty on the state to intervene in defined circumstances, procedures for responding to a crisis, legitimation of state intrusion to the otherwise private, an explicit or implicit best interest test, and the importance of expert opinion. In order to analyze their influence on judicial decision-making, this thesis examines the underlying assumptions of psychiatry and the ideology of motherhood. Four important elements of psychiatric discourse are: a focus on the individual, reliance on assessment and taxonomy, predictability of human development, and expertise in analyzing hidden motivation. By providing the scientific underpinnings, psychiatry reinforces the ideology of motherhood and cultural conceptions of which women are fit mothers. The thesis outlines the following components of the ideology of motherhood which inform judicial decision-making in child welfare cases: motherhood as an essential part of being a woman, the context of a heterosexual nuclear family, the intrinsic rewards of mothering, and the extreme selflessness required of motherhood. In combination, the
influence of psychiatry and the ideology of motherhood undermines the possibility that a woman can be coincidentally both a "good" mother and a "good" patient. In addition to describing the underlying assumptions of mainstream psychiatry, the thesis reviews radical psychiatry as an alternative approach which, if considered, could lead judges to be skeptical of psychiatric evidence in specific child welfare proceedings. The data indicates that mothers with mental health histories overwhelmingly tend to lose their children in court proceedings during which judges defer to the opinions of psychiatrists. The reasoning in the decisions reflect the courts acceptance of the unexamined assumptions of psychiatry and their relationship to the ideology of motherhood. Further, the cases show that the purportedly neutral standard of the "best interests" of the child" is a malleable concept that is heavily influenced by the opinions of psychiatrists. Mothers with mental health histories are not perceived as credible in determining the best interests of the child, especially where the mother's evidence is inconsistent with the expert's. This thesis suggests that the presumption of the primary caregiver, a standard recently offered by some feminists to be applied in private custody disputes may be equally problematic for mothers with mental health histories. The critical perspective of radical psychiatry has had no impact on judicial decisions in this area. Further, the cases indicate that even where the court decides custody in favour of the mother, the decisions are not confirmations of her fitness. Rather, the "victories" for mothers with mental health histories may occur either because the authorities flagrantly breached procedures or may include conditions which return the mother and the child to the ongoing supervision of mental health professionals.
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DEDICATION

This work is dedicated to Jim Russell, Benjamin Russell and Leah Mosoff.
CHAPTER 1: INTRODUCTION

The ideas in this thesis originate from my practice as a lawyer representing clients at a large mental health facility. Shirley's situation stands out in my memory. A hospital social worker contacted me when a Family Court judge had expressed concern at an initial apprehension hearing that no one appeared before him on behalf of the mother, that she was currently an involuntary patient in a psychiatric hospital and that she had been given no notice of the proceeding. The Superintendent of Family and Child Services had apprehended the baby girl from the hospital because of the mother's prolonged, although non-violent and relatively uneventful mental health history, as well as numerous bizarre remarks that the woman had made in labour. When I first interviewed my client, this was her first psychiatric hospitalization. It was clear that she was heavily medicated and very sad. About seven weeks after her admission to the hospital she was discharged. Over the next eight months Shirley was allowed supervised access visits to her baby which were observed by those who would eventually be called to give evidence about her capacity as a mother. Her visits with the baby took place though the haze of medication which blurred her vision, made her

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mouth dry and rendered her movements stiff. She was told to be spontaneous and
demonstrative with the child. Talks with social workers, public health nurses and
psychiatrists strongly suggested to Shirley that her mental health prevented her from
being a good mother. Eventually she agreed that she needed to remove herself from
her child in the best interests of the child. The case ended with a consent order giving
permanent custody to the Superintendent so that the child could be adopted. Shirley
told me that her own life was over. Less than two weeks after her decision she was
again involuntarily committed to a psychiatric ward.

As this story shows, mental health law and child protection law intersect in a manner
that dramatically affects women with psychiatric disabilities, particularly in situations
where a mother is involuntarily committed to a mental health facility and her children
are apprehended by the state. In combination, the apprehension proceedings and mental
health history put both the woman's mental health and her relationship with her child
in extreme jeopardy. Under the auspices of law and bureaucracies designed to protect
certain vulnerable people, the state asserts its power in remarkably similar and
interconnected ways in the mental health setting and in the child protection setting.

In child protection matters state power is asserted both with direct force by police or
other entities and is legitimated through ideology. By ideology, I mean the taken-for-

Throughout this paper I will use phrases such as "women with a psychiatric
disability," "women who have been psychiatrically labelled" and "women with
mental health histories" interchangeably.

I do not take ideology in the simplest Marxist sense as "duping" people who
act within it through a process of "false consciousness" nor do I think that
ideology springs directly from the relations of production in a mechanistic way.
The conception of ideology that I adopt stems from a socialist feminist
granted ideas and values that guide the way people in a culture think and give meaning to social practices. Ideology constitutes cultural "common sense" and pervades the conception of what is "natural" and inevitable to explain events and phenomena. It arises out of the material conditions and power relations of the social order and is manifested in conjunction with these.


influences the choices women make in society and constitutes an important set of standards against which women's lives are measured. In our society, ideology in child protection issues relies on a particular construction of "motherhood" and its relationship to "the best interests" test for children, an extremely malleable concept which permits any number of ideas and biases to influence its content. An important feature of legal thought in determining whether a child is at risk and in formulating the best interests test is the extensive influence of psychology and psychiatry, disciplines that are firmly embedded in a context of science.

While apprehending children is a direct and obvious expression of state intervention, the state often acts more subtly in power relations with important consequences for gender and disability. The way that the child welfare process effects women with mental health histories is an example of a more general phenomenon of a two-tiered system of law that is linked to social class. Marginal populations are regulated and


processed through particular socio-legal systems: the criminal justice, social welfare and mental health systems. Instead of the adversarial model of law that applies to legal processes that impinge on the lives of middle and upper class people, an inquisitorial model of law characterizes the legal processes that surround the mental health and social welfare systems. While the spheres of law that regulate poor people seem distinct in substance, the clientele among the spheres is interchangeable and people are regulated through the ideas of "socialized justice." Poverty then is the gateway and justification for state intervention into the lives of certain people and its consequent regulation of them. Central to a successful inquiry about entitlements and breaches of law for poor people are the actors cast by the state to engineer the regulatory systems, that is social workers, psychiatrists and financial aid workers.

In order to maintain its legitimacy, the liberal state must be seen as even-handed, neutral and non-coercive. Although the state operates in complicated ways through


8 Social workers, in particular, may legitimately extend an inquiry outside of the clinical frame and into the community. See for example, the role of social work documents in Menzies, Survival, supra note 6 at 147, in incorporating the views of family and other legitimate informants.
various institutions, at different sites of social life and through a number of discourses, the fundamental question is how the state can regulate and control people, discipline deviance, and at the same time maintain a benign or at least neutral face. In protecting the "endangered" from the "dangerous" the state relies on expert discourses to assess risk. Consistent with this view of the state, the twentieth century has seen a shift in the ways that state control is asserted through law. The change is away from the exercise of power via the criminal law to modes of administrative regulation. Criminal law is used as the last resort when other efforts to regulate have failed.

One mechanism of control to regulate women's lives arises from an historically unprecedented interconnection among law, science and the state. Child welfare is one way in which dominant norms of womanhood and mothering are imposed on particular groups of women whose behaviour is idiosyncratic or non-conforming to


10 T. Stang-Dahl, *Women's Law: An Introduction to Feminist Jurisprudence* (Oxford: Oxford University Press, 1987) suggests that the three areas of law that are most important to women are welfare benefits, maintenance and child support and the policies of administrative agencies.

11 See D. Chunn, *From Punishment to Doing Good: Family Courts and Socialized Justice in Ontario 1880-1940* (Toronto: University of Toronto Press, 1992) at 18 describing the imperceptible erosion of the line between crime and poverty as functions previously performed by civil society were taken over by the state.
cultural ideals. Just as punishment in the criminal process may be dependent on the sentencer's findings about a woman's traditional characteristics and performance of expected roles as wife, mother, or daughter, other less formal aspects of justice will also rely on normative cultural conceptions of women, particularly when the issue is defined explicitly as motherhood. It follows that the women most vulnerable to a process that undermines their fitness as mothers are those who are already marginalized by poverty and otherwise regulated by the state. The idea of the perfect mother is even more powerful with the addition of science. The specific contribution of modern science is a psychological and psychiatric assertion that the physical health, psychological well-being, and moral development of children is a direct result of child-bearing and child-rearing, activities that are viewed almost exclusively as a mother's responsibility.

While women with mental health histories are like other marginalized groups because of poverty and modes of regulation by the state, there are important differences


13 B. Ehrenreich and D. English, For Her Own Good: 150 Years of the Experts Advice to Women (London: Pluto Press, 1979) [hereinafter Own Good].
between this population and others. As feminists increasingly have rejected an essentialist view of women's experience and theoretical formulations of oppression, they have acknowledged that the state and law operate in varying ways for different types of women. But simply declaring difference is not helpful. At the forefront of the discussions of the ways in which diversity matters are the "differences" of class, race and sexual orientation. The role of disability is much less developed.

The manner in which child protection proceedings affect women with mental health histories is an example both of how difference complicates legal treatment and how law contributes to the construction of difference. For instance, women in these circumstances can expect the smallest and most intimate details of their lives to be considered legitimate subject matter of the public domain. While this intrusion into


the otherwise private is true of other marginalized women, the particular nuance for women with mental histories is in the breadth of the official authorization to question whether her thoughts, perceptions, and feelings are "normal". Such women have little claim to any vestige of privacy because of a medical-scientific assertion about a person that creates and names her difference. Once articulated, the label raises immediate concerns that her children are in jeopardy, not because of what she has done but what she might do in the future, based on who she is as defined by an expert.

In this thesis I explore two ways in which women with mental illness are different from other marginalized groups: first, by an analysis of the primary caregiver as a strategy option, and second by a discussion of mental illness as a form of resistance. The presumption of the primary caregiver is one currently popular strategic option for feminists in child custody work. While this option might be useful for many women, it may have devastating effects for mothers with disabilities, especially mothers with mental health histories. As well, I suggest that madness itself represents a particular mode of resistance to power, albeit not very successful. The demand on a woman to be simultaneously a good mother and a good patient is essentially contradictory, but

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17 For examples of how resistance is carried out as micropractices in a range of conditions of women's lives, see S. Fisher and K. Davis (eds.) Negotiating at the Margins: The Gendered Discourses of Power and Resistance (New Brunswick, N.J.: Rutgers University Press, 1993).
the psychiatric paradigm underpins both. Radical psychiatry offers some support and explanation of the resistance.

For the sake of simplicity, I will use the terms "psychiatrist/psychologist" and "psychiatry/psychology" interchangeably to refer to the range of mental health personnel, particular theoretical models and clinical practices which are associated with the analysis and treatment of the individual human psyche or individual behaviour. However I recognize that there are important distinctions among different mental health approaches. There is a particularly important difference between psychiatry and the others because of psychiatry's medical foundation and the important duties delegated to physicians or psychiatrists in mental health legislation. Besides the powerful position of doctors in mental health statutes, disability rights activists have seriously criticized the influential medical model as an inappropriate way to understand disability issues. Medical and rehabilitative thinking concentrates on something broken that needs "fixing" by a professional in the individual (which often cannot be fixed)

18 These would include psychoanalysis, psychology, psychiatry, certain forms of social work and counselling.

19 See infra note 52.

20 Increasingly, human problems are analyzed through a medical, particularly psychiatric framework. This reflects the rising expectation that all human problems can be solved by finding the appropriate and competent professional. See I.K. Zola, "Medicine as an Institution of Social Control" (1972) 20 Social Review 487. See the medical, economic and social political models outlined in J. Bickenbach, Physical Disability and Social Policy (Toronto: University of
rather than a re-orientation of society to be inclusive and non-discriminatory.

The disability rights community focuses on the socio-economic consequences of disability. Women with disabilities have been especially oppressed by a medical model that has been applied by doctors who usually are male. Issues specific to women with disabilities, such as sexuality, reproductive rights and body image\(^21\) have been misunderstood through the predominance of a medical model of disability.\(^22\) For the purpose of this thesis, what unites the people who are associated with psychiatry, psychology and related disciplines is that they are all seen in law to have important expertise which assists in explaining how the human mind works, how a particular mind works and how personality is formed. In exercising the accompanying power these professionals all perform functions of surveillance and control as designated state agents in child protection.

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\(^{22}\) The same critique that is directed at doctors can probably be levied against all clinical notions of disability that construct disability from a medical frame. However, doctors are trained explicitly with this perspective and therefore symbolize the view most directly. As well, doctors operate at the apex of the clinical hierarchy.
Increasing regulation through the disciplines of psychology and psychiatry does not mean that law is no longer an important source of power. On the contrary, law remains important because of the way it can disqualify the legitimacy of other knowledge, especially when legal knowledge is buttressed by psychiatric "truth." In the process, non-lawyers such as social workers, public health nurses and psychiatrists become incorporated within law and act as legal agents. As non-lawyers become important actors in the legal structures, they are important in transforming legal structures, but the process is reciprocal. As the experts transform law and its operation, they are governed by law and legal structures in terms of how they apply their expertise. Because the powerful combination of an elevated and exclusionary legal discourse and an explicitly scientific discourse exists alongside direct state force there is little room for other perspectives. In short, law extends its territory by incorporating scientific-medical knowledge such that:

It is not correct to depict this historical development in terms of the law being challenged by the new discourses: rather law attempts to extend its sovereignty over areas constructed by the discourses of the human sciences as significant to the disciplining of the social body. But law extended its legitimacy by embracing the objects of this discourse. ... As children were identified as a special category of great importance to the regulation of populations (through 'proper' socialization, education health matters etc.) so the law extended its 'protection' of children by introducing legislation on the age of consent, procurement, incest, and


24 This theme pervades the forensic system as demonstrated in the METFORS study. See Menzies, *Survival*, supra note 6.
so on. So we can see a form of cooperation rather than conflict and a process by which law extends itself into more and more 'personal' and 'private' areas of life.25

Psychological and psychiatric theory influence a variety of social institutions and in some cases dominate them. The child protection system is an example and increasingly, psychiatry and psychology tend to govern most child protection proceedings. As a general rule, women involved in child protection proceedings are viewed as having serious inadequacies of a psychological or mental nature because of the implicit assumptions that they have failed as mothers. However, when there has been an independent psychiatric diagnosis of mental disturbance or inadequacy apart from the mothering question, there is even greater legitimation of the psychiatric paradigm and consequent reliance on the expertise of psychiatric professionals in the child protection proceedings. In short, I argue that psychology has become an element of every child protection matter, but where the mother is defined as mentally ill the process is organized and driven much more directly by the disciplines of psychology or psychiatry. In such cases the judicial role is abdicated in favour of the psychological or psychiatric expert26, with the judge retaining only the power to monitor the most flagrant abuses of process.

25 Smart, supra note 24 at 17.

My criticisms of how the child protection process works to disadvantage women with mental health histories is not meant to suggest that protecting children is not crucially important nor do I mean that any mother regardless of her actions is entitled to remain a custodial parent with no intervention by the state or other entities. Indeed, keeping children safe is arguably the most justifiable reason for state intervention in our society. My quarrel here is with the twofold presumption that a mother is necessarily unfit because of a mental health diagnosis, and that psychiatrists and psychologists are the appropriate arbiters of questions about good mothering.27 As psychological ideas become widely disseminated in our culture, "pop" psychology is increasingly seen as the best explanation for much human behaviour. An accompanying set of values that favours those defined as mentally able results in discrimination and oppression of mothers who have been labelled mentally ill both before and during the legal proceeding. "Sanism" does not stop at the courtroom door.28

The background of this study is a review of each of the child protection and mental health statutes in Canada and review of 128 Canadian child protection decisions decided since 1980 where the mental health of the mother was mentioned in the

27 While this thesis is critical of the role of psychiatry in child protection matters, it takes no position on the value of therapy or counselling in any particular instance.

28 For some comments of the pervasiveness of "sanism" in our culture, including jurisprudence and lawyering practices, See M. Perlin, "On Sanism" (1992) 46 Southern Methodist University Law Review 373.
decision. My analysis is based on a sample of 61 cases which will be described more fully in Chapter 4. This thesis is concerned with the processes that lead to the state removing children from mothers who are labelled mentally ill. I am referring to women who have been identified by the mental health system as having some form of mental illness, whether or not they have been hospitalized for the condition. I am specifically not referring to self definitions of mental illness although there is clearly overlap. In addressing these issues, I will draw on work from feminist writing, especially on the best interests test, and work on the role of professional discourse.

The fact that a woman has consented to or chosen help may be extremely important. Social class however, is a very significant variable in whether a person is a voluntary or involuntary patient.

in defining and maintaining social relations. I propose to add a disability rights perspective and an anti-psychiatry perspective to these debates as they arise when

I rely here on work that describes the historical development of the power of professionals. See the now classic I. Illich, "Disabling Professions" in I. Illich et. al. (eds.) Disabling Professions (London: Marion Boyars Publishers Ltd., 1977).


women with mental health histories resist state removal of their children.

The thesis is divided into 6 chapters. In Chapter 2, I outline Canadian child protection and mental health legislation in Canada in order to describe the similarity in legal schemes organized for protecting children and mentally disordered persons. Since both children and mentally disordered persons are seen to have limited legal capacity, I argue that the similarities in the two systems are important indications of how the law reflects and contributes to the construction of disability. As well, I argue that mental health professionals are central in the operation of both statutes. Assessing risk is the objective of both statutes. The role of mental health professionals is explicit in mental health legislation and governs child protection proceedings by the ideological underpinnings of the statutory framework.

In Chapter 3, I present an overview of the ideology of science and the basic elements of psychological and psychiatric discourse that underlie the construction of the normal and the deviant. In addition I outline the ideology of motherhood and discuss its connection to psychiatric discourse. I argue that the tenets of psychiatry begin with an idea that an abstracted asocial individual may be categorized in important ways by appropriate assessments which are conducted by psychiatrists and psychologists because they purport to have specialized knowledge to measure what underlies the superficial presentation of self. As an alternative, radical psychiatry incorporates a critique of science as well as an historical and political perspective on the process of
psychiatrization. In allowing that the subjectivity of persons with mental illnesses is legitimate, radical psychiatry recognizes the particular form of resistance to a dominant ideology.

The ideology of motherhood requires a self-sacrificing devoted woman who appreciates the intrinsic rewards of mothering. The ideology demands that a mother have no point of view because that would detract from her ability to concentrate fully on her children's needs. I argue that psychology and psychiatry interact with the ideology of motherhood in two major ways. First, psychiatry has produced and reinforced "mother-blaming" by its focus on the importance of early experience as determinative of adult development when mothers are expected to be the critically important early influence. Second, I argue that psychology and psychiatry highlight the subjectivity of women who have been labelled mentally ill because psychiatry has defined their point of view as pathological. This heightened attention to the existence of a point of view, especially its "abnormality", disqualifies such women as fit mothers. As a consequence, medical-legal discourse constructs an adversarial relationship between a bad mother and her children.

In Chapter 4, I describe my methodology and results and analyze judicial decision-making in child protection cases where the mental health of the mother is in issue. Overall, women with mental health histories lose in court. I argue that judges defer to mental health professionals on matters of substance and interfere with the actions
of the authorities only when they have committed extremely serious breaches of required procedures. In particular, I argue that the occasional court "victories" for women in these circumstances are often judicial pronouncements which further legitimate the ongoing vigilance of psychiatrists and psychologists because of the conditions attached to the court order that returns the child to the woman.

In Chapter 5, I evaluate the impact of two legal standards on mothers with mental health histories. First, I discuss how the "best interests" of the child imposes an ostensibly neutral legal standard but in reality has specific negative effects on women with mental health histories because the test places significant weight on the psychiatric paradigm. Second, I examine the feminist suggestion that the "presumption of the primary caregiver" be used as an alternative to the best interests test in private custody disputes. I argue that while the alternative may be a useful strategy for some mothers in private custody disputes, the presumption of the primary caregiver is problematic for women with disabilities in child welfare cases, especially women with mental health histories because it supports the dominant ideology of motherhood.

In Chapter 6, I summarize my work and pose suggestions for future research.
CHAPTER 2: LEGISLATIVE PROVISIONS

The notion of "risk" underpins both mental health and child protection legislation.\(^{34}\) Despite the numerous "non-legal" processes and actors that precede their application and enable the laws to be applied, these statutes operate as the ultimate tool to avert risk. Mental health statutes are premised on the idea that mentally disordered persons present a risk to society or to themselves. In child welfare statutes, mothers are portrayed as actual or potential risks to their children.

In this section I will outline those legislative provisions of the child protection system that correspond closely to the procedures and legal standards in mental health legislation. The superficial similarities in the two systems obscure the inconsistencies within each. I argue subsequently in this thesis that there is an inherent contradiction in the coinciding roles of mental health professionals as healers and as particular legal actors.\(^{35}\) The dual roles are contrary to both the therapeutic interest and the parental

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\(^{34}\) R.J. Menzies, D. Chunn and C. Webster, "Risky Business: the Classification of Dangerous People in the Canadian Carceral Enterprise" in L.A. Visano and K.R.E. McCormick (eds.) *Canadian Penology* (Toronto: Canadian Scholars Press, 1992) [hereinafter "Risky"].

\(^{35}\) Much the same is true of probation officers and parole officers who have a dual function, as a helper in rehabilitation and as a state actor in the criminal justice system who may ultimately discipline an individual's deviance.
interest of a woman with a mental health history. However, this role conflict is accepted and largely unquestioned due to the hegemony in our culture of psychology and psychiatry as explanatory tools for human behaviour.

My purpose in drawing the parallels between child protection and mental health statutes is two-fold: first to demonstrate that the underlying legal thinking behind child protection issues differs little from legal thinking about mental health issues. Both laws originate from the state’s *parens patriae* power and the subjects of both statutes are persons who are deemed to have diminished capacity and require state protection. Second, I use the overview to locate psychiatrists and psychologists as legal actors within both legislative schemes. In each system the input of these professionals provides the rationale for what protections are seen as needed and why.

1. Child Protection Law: The Scheme

The typical statutory scheme of child protection law is a two step process. An apprehension is the initiating event where statutorily empowered authorities remove a child from a situation when the child is considered at risk or in need of protection. Children are seen to be in need of protection when there are acts or omissions that endanger the child’s security or survival. To carry out child apprehensions, the state uses an existing apparatus which may include government social workers, Childrens’
Aid Societies and police. The particular state actors responsible for the apprehension may be specifically named in the governing statute or the responsibility may be delegated by a certain official who is ultimately responsible for child welfare in the jurisdiction.\[36\] The legislation permits a swift reaction to what is considered an urgent situation and will specify the grounds upon which a child is considered in need of protection,\[37\] but may or may not outline the criteria to apply in making this

\[36\] Those individuals responsible for emergency apprehensions are provided for in the legislation as follows: *Child Welfare Act*, S.A. 1984, c. C-8.1, s.17(1): the director, a child welfare worker and any person named in an order and any peace officer called on to assist; *Family and Child Service Act*, S.B.C., 1980, c.11, s.9: the Superintendent or a police officer; *Child and Family Services Act*, S.M. 1985-86, c.8, (C.C.S.M. C-80), s.21: the director, a representative of the agency or a peace officer; *Family Services Act*, S.N.B. 1980, c. F-2.2, ss. 31(5), 32: a peace officer or the Minister; *Child Welfare Act*, R.S.N. 1990, c. C-12, s.13: a constable or other peace officer, a social worker, the director, or a person authorized by the director; *Child Welfare Act*, R.S.N.W.T. 1974, c. C-3, s.16(1): the Superintendent, a child welfare worker, a peace officer, the executive director or any person authorized in writing by the Commissioner or Superintendent; *Children and Family Services Act*, S.N.S. 1990, c.5, s.33: an agent (person appointed by the Minister) who can enlist the assistance of a peace officer; *Child and Family Services Act*, R.S.O. 1990, c. C.11, s.40: a child protection worker and a peace officer where required; *Family and Child Services Act*, R.S.P.E.I. 1988, c.F-2, ss. 15(1.1), 16: the director or a peace officer; if someone else apprehends the child, he/she must report within 24 hours to the director who will assume custody; *Child and Family Services Act*, S.S. 1989-90, c.-C-7.2, s.17: an officer (person designated by the Minister); *Children's Act*, R.S.Y.T., 1986, c.22, s.119: the director, an agent or a peace officer.

determination. While removing the child may be without incident and may involve the complete cooperation of all involved, the full force of state police power is available to apprehend if deemed necessary.

Within a specified and relatively short time the grounds of the apprehension must be presented and reviewed by a court. At this point the child is kept in care if there is continuing risk or, if not, is returned. Notice requirements for this first hearing are generally not stringent, and an initial hearing may take place without notice to the parents. Often the first hearing is a rather pro-forma affair. Counsel for the


Child Welfare Act, S.A. 1984, c. C-8.1, s.2 - outlines the matters to be considered in making any decision relating to a child in need of protective services; Children’s Act, R.S.Y.T. 1986, c.22, s.116(2) outlines considerations to be applied in determining whether or not a child is in need of protection but only in situations where the use of physical discipline is at issue.

Some child protection statutes list illustrations of a child in need of protection. These statutes do not however, provide any considerations or standards in applying the list to a given situation. For example, the Family and Child Service Act, S.B.C. 1980, c.11, s.17(2) provides, as part of a list of illustrations, that a child who is without adequate supervision is in need of protection. The statute does not address the question of what standard is to be applied in determining what constitutes 'adequate' supervision. Similar lists can be found in other child protection statutes: Family Services Act, S.N.B. 1980, c. F-2.2, s.31(1); Child and Family Services Act, R.S.O. 1990, c. C.11, s.37(2).

Child protection legislation generally provides for some form of notice prior to any initial hearing. In some jurisdictions, the legislation also provides either
mother may not be present although the state is almost certainly represented by legal counsel in this first instance and throughout the proceedings.

If there is a decision that the apprehension was proper, the court proceeds to the next stage and determines whether the child is in need of protection. Unlike the decision to apprehend, this determination is not made in a crisis environment. In comparison with initial hearings, the second-stage hearings are becoming increasingly formal and trial-like as the model of child protection proceedings becomes increasingly rights oriented. At these hearings evidence is called, and expert witnesses may give oral testimony or submit expert reports. If the child is found in need of protection, the court must make an order regarding disposition. The court may order a child to remain in care for some period of time or permanently, or order the child returned to the parent with or without conditions, or order custody to another party.\(^{40}\)

\(^{40}\) that the notice can be dispensed with (Family and Child Services Act, R.S.P.E.I. 1988, c.F-2, s.28) or that the validity of the proceedings shall not be affected if notice is not given in accordance with the Act (Child Welfare Act, S.A. 1984, c.C-8, s.19). Quite clearly in some jurisdictions, initial hearings take place with notice to the parents only where practicable (Family and Child Service Act, S.B.C. 1980, c.11, s.11(1.1)) or conceivably not at all (Child and Family Services Act, S.S. 1989-90, c. C-7.2, s.20 where a family review panel hearing may be held without the presence of the parents and where the panel is not bound by the rules of law).

Where a child is found to be in need of protection, the legislation allows for an order to be made. The type of orders provided for in the legislation are fairly consistent among jurisdictions. The orders include: the return of the child to the parents with or without supervision, temporary or permanent guardianship granted to another party, or a custody order. There are alternatives provided for in some legislation, for example: the Child Welfare
In its disposition the court must consider what is in the "best interests of the child," a much wider question and even more pliable concept than the standard of whether a child is in need of protection. Many Canadian child protection statutes provide some principles or factors which must be considered in determining the "best interests" of the child. Even when a statute does not state that the best interests of the child is

See for example statutes outlining best interest considerations: Child and Family Services Act, S.M. 1985-86, c.8, (C.C.S.M. C-80), s.2(1); Family Services Act, S.N.B. 1980, c. F-2.2, ss. 57, 58 allows for an order sending the child to a place of safety or an order for protective intervention; and the Child Welfare Act, R.S.N.W.T. 1974, c.C-3, s.19(2) allows for an adjournment of the case for one year in addition to the supervision or custody order. Only the Ontario legislation specifically requires that the less restrictive alternatives are to be preferred, Child and Family Services Act, R.S.O. 1990, c. C.11, s.57.

Some statutes require a child of a certain age to consent at the dispositional stage. The child's wishes then constitute some evidence to be weighed in the decision of what is in the child's best interest, a partial legal disability. See: Child Welfare Act, S.A. 1984, c. C-8.1, s.2 which provides that the child's opinion should be considered; Family and Child Service Act, S.B.C., 1980, c.11, s.11(2); Child and Family Services Act, S.M. 1985-86, c.8, (C.C.S.M. C-80), s.2(2); Family Services Act, S.N.B. 1980, c. F-2.2, s.1 (where ascertainable, the child's views are to be considered); Child Welfare Act,
the principle underlying a disposition, the courts have applied this test to child protection proceedings.\textsuperscript{42}

It is difficult to characterize clearly the nature of child protection proceedings.\textsuperscript{43} The

\begin{itemize}
\item R.S.N. 1990, c. C-12, s.18 (the right of a child to exercise free choice); \textit{Child and Family Services Act}, R.S.O. 1990, c. C.11, s.4; \textit{Children's Act}, R.S.Y.T., 1986, c.22, s.168.
\end{itemize}

\textsuperscript{42} See: \textit{Racine v. Woods}, [1983] 2 S.C.R. 173 where the Supreme Court of Canada emphasized that the best interests of the child is the paramount concern in child welfare and custody matters, particularly where psychological bonding has occurred; This case has been widely criticized because the "best interests test" failed to consider the First Nations heritage of the child and concentrated on "bonding". The important principle according to the critics is whether the court will find collective or racial concerns as compelling or more compelling than individual concerns. An underlying racist ideology has been thought to account for the failure to recognize the important ways in which First Nations culture affects custody decisions about children. \textit{King v. Low}, [1985] 1 S.C.R. 87, 16 D.L.R.(4th) 576, [1985] 3 W.W.R. 1, 44 R.F.L.(2d) 113, sub nom. \textit{K.K. v. G.L. et al.}, 58 A.R. 275, 57 N.R. 17, sub nom. \textit{King v. Mr. and Mrs. R.} where the Supreme Court of Canada ruled that even where a statute does not specify, the best interest test is the standard to be applied in questions of contested custody; \textit{Dir. of Child Welfare v. L. (K.L.)} (1986), 5 R.F. L. (3d) 53 (Alta Q.B.) where the court held that the provincial court had erred by failing to find whether returning or failing to return a child to a parent within a reasonable time was in the child's best interest (at 58). The statute did not specify that the best interest test applied on this matter of timeliness and the usual application is to more substantive considerations of best interest; and \textit{Re: M. (S.J.)} (1990), 26 R.F.L.(3d) 173 (B.C.S.C.) where the court notes that section 47 of the \textit{Law and Equity Act} provides that in proceedings...under the \textit{Family and Child Services Act}, the court shall consider the best interests of the child.

\textsuperscript{43} See for example, Lamperson J. who declined to hear constitutional arguments not raised at trial and declined to overturn the trial judge's decisions stating in \textit{N.P. v. British Columbia (Superintendent of Family and Child Service)}, [1992] B.C.J. No.1828 (B.C.C.A.) "that a child apprehension hearing is not a trial,
process has some elements common to a criminal adversarial model, some to a summary civil proceeding and some to a quasi-administrative hearing. Although the state is clearly represented in court in the form of a Superintendent of Child Welfare or a Children's Aid Society, the criminal law model has been rejected as inappropriate because the explicit purpose of the hearing is to protect a child, rather than to prosecute a parent. While the parent is recognized as an interested legal actor in the process, the subject is supposed to be the child and the most important consequences of the court’s decisions are the effects on the child and society generally, rather than the parents. Rejecting a criminal law model means that there is no criminal standard of proof nor is there any equivalent to the presumption of innocence for the parent. The legal protections of the Charter may or may not be available to a parent in child protection proceedings.\footnote{The American standard of proof in the termination of parental rights hearings is higher than the civil balance of probabilities, because a "clear and convincing evidence" standard is a Fourteenth Amendment requirement. See \textit{Santosky et al. v. Kramer, Commissioner, Ulster County Department of Social Services, et. al.} (1982) 455 U.S. 745, 102 S. Ct. 1388, 71 L.Ed. 2d 599, 50 U.S.L.W. 4333, See \textit{In Re Chrysler} (1978), 5 R.F.L.(2d.) 50 (Ont. Prov. Ct., Fam.Div.) at 58, the court described the onus, while civil, as very demanding where the contest of custody is between a mother and a Children’s Aid Society.}

\footnote{Probably the most important Charter argument for the benefit of parents in child protection proceedings that goes to substance involves the right of a child to remain with a family as a section 7 liberty interest. Other areas of Charter scrutiny are the standard of proof, legislation permitting apprehension without warrant generally, delays in proceedings, and notice proceedings. For but an inquiry to determine what is in the child's best interest." The mother in this case was diagnosed as paranoid schizophrenic.
Probably the best formal description of a child protection matter is as a summary civil proceeding, but the process unfolds as an example of a quasi-criminal inquisitorial model. The summary nature of these proceedings means that there is no requirement for pre-trial disclosure, unless specifically required by the particular child welfare statute. Although reports are often exchanged by counsel, there is usually no requirement to do so. The other forms of disclosure normally available in civil proceedings, such as discovery of documents, discovery of witnesses and interrogatories, are absent in child protection proceedings. In combination, rejecting a criminal model and limiting-pre-trial discovery means few of the usual procedural safeguards in law are available to the parent in a child protection proceeding.

2. Mental Health Law: The Statutory Scheme


Exactly why certain legal proceedings are designated as summary, rather than comprehensive procedures, is somewhat mystifying to me. Two possibilities seem reasonable: that these are matters that have some urgency so that they should be adjudicated quickly or that the interest is of lesser importance than others. Neither of these rationales seems to apply to child protection proceedings since they are often protracted proceedings from start to finish, and there is almost no interest more important than those involved here.
Mental health legislation in Canadian jurisdictions\textsuperscript{47} maintains two general requirements for involuntary committals. First, there must be a finding of mental illness or mental disorder. The manner in which this test should be applied however, is unclear. For example, many of the statutes have circular definitions for mental disorder, defining it as any disease or disability of the mind.\textsuperscript{48} Usually the second statutory criterion for involuntary committal is two pronged: protection of others or protection of self. Protection of self is especially problematic. The obligation to protect an adult from self imposed harm or neglect raises important questions about what process ought to be in place to make such a determination. Equally important is the question of what qualifications are necessary for persons charged with this responsibility.

Under each mental health statute in Canada, doctors are made responsible for detaining a person in a mental health facility against the person's will. This process usually requires examining the person and completing the necessary documents, although the

\textsuperscript{47} For an overview, see H. Savage and C. McKague, \textit{Mental Health Law in Canada} (Vancouver: Butterworths, 1987).

\textsuperscript{48} \textit{Mental Health Act}, S.N.B. 1985 c.59, s.1; \textit{Mental Health Act}, R.S.N. 1990, c.M-9, s.2(g); \textit{Hospitals Act}, R.S.N.S. 1989, c.208, s.2; \textit{Mental Health Act}, R.S.O. 1990, c.M.7, s.1; \textit{Mental Health Act}, R.S.P.E.I. 1988, Cap.M-6, s.1(j); Similarly, only Ontario (\textit{Mental Health Act}, R.S.O. 1990, c.M.7, s.15) and the Northwest Territories (\textit{Mental Health Act}, S.N.W.T. 1985 (2nd), c.6 as amended by 1989 c.15, s.9) have precise indicators for establishing the criterion for dangerousness.
statutes often are silent about what constitutes an "examination" or the extent of detail necessary to complete documents properly. Usually the doctor will be a psychiatrist, although the statute may not require this specialization. What is

49 There is no definition for "examination" in any of the mental health statutes. Some statutes even provide for both a "psychiatric assessment" and or an "examination" without differentiating or defining either term. See: The Mental Health Act, R.S.M. c. M110, as amended, s.10 (the emergency provision where an individual is brought in for an "examination"), s.16 (application for an involuntary psychiatric assessment); Mental Health Act, S.N.W.T. 1985 (2nd) c.6, as amended by 1989, c.15, ss. 9,10,11,12,13 allow for a psychiatric assessment but in order to issue a certificate of involuntary admission, the medical practitioner must personally "examine" the individual; Mental Health Act, R.S.O. 1990, c.M.7, s.15 provides for a physician to make application for a psychiatric assessment while s.17 requires an "examination".

50 The statutes generally require that the certificate of involuntary admission include the name and address of the individual in respect of whom the certificate is issued and of the issuing physician and facility; the date and time of the examination and issuing of certificate; and the facts upon which the physician formed his or her opinion that the individual is suffering from a mental disorder. Some, but not all provisions require that the facts upon which the physician's opinion is based be those observed personally as differentiated from those communicated to the physician.

51 There is no requirement in any of the statutes that the initial examination required for involuntary admissions be conducted by a psychiatrist. The Northwest Territories specifically allows for a psychiatric assessment to be conducted by a medical practitioner which is defined separately from a psychiatrist in the statute (Mental Health Act, S.N.W.T. 1985 (2nd), c.6, as amended by 1989 c.15, ss. 9, 10, 11, 12, 13). There are some statutes that require an examination by a psychiatrist at a later stage in the process. See for example: in Nova Scotia, if an individual is admitted for observation, he or she shall be examined by a psychiatrist within 3 days (Hospitals Act, R.S.N.S. 1989, c.208, s.42); and in Alberta where a renewal certificate is issued, at least one of the two issuing physicians shall be a psychiatrist (Mental Health Act, S.A. 1988, c.M-13.1, s.8).
important is that doctors are charged with interpreting a legal question of what constitutes a mental disorder or mental illness in effecting a committal or extending a period of committal.

Persons who have been involuntary patients may be discharged from hospital by their doctors on the basis of a medical opinion that hospitalization is no longer necessary or appropriate. Patients may also be discharged by a statutorily based tribunal usually having a doctor in its composition, but this discharge is presumed to be decided according to legal criteria. Although the legal definition may resemble a medical definition of mental illness, these are inevitably different. Due to their training and predisposition however, it would be difficult for doctors to avoid being prone to apply medical definitions of mental disorder or mental illness. Usually, people who appear before tribunals have had their requests for release turned down by their doctors because presumably, the doctors believed they were not ready for release, were at risk in the community and therefore likely to be re-admitted. However, according to at least one empirical study, the particular "discharge route", that is via physician or via tribunal is not a good predictor of readmission over the next year.

Except in circumstances where the person was extremely defiant or incompetent, the METFORS clinicians were reluctant either to "excuse" or to institutionalize the people they assessed. They relied on outpatient treatment. See Menzies, *Survival*, supra note 6.

The relative rate is 43% vs. 45% See J. Parades, et. al., "The Review Panel Process: Interpretation of the Findings and Recommendations" (1987) 32
In emergency situations, police have the power to apprehend an apparently mentally disordered person for the express purpose of taking that person to a doctor for an examination. In addition to the emergency admissions that involve the police, there may be other categories of short-term emergency admissions which have lesser requirements of legal process than would a regular involuntary admission. All of these emergency provisions are relatively short-lived and must be followed either by release, or by fuller legal process within a given period of time if lawful involuntary

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55 For example: the *Mental Health Act* R.S.B.C. 1979 s. 23 permits a 72 hour detention on the basis of only one medical certificate if there is no other physician in the vicinity able to complete a second certificate.

For an example of other emergency measures, see the *Mental Health Act*, R.S.Y.T. 1986, c.115, s.3(4) which allows for "the detention of an alleged mentally disordered person who has been apprehended to be detained in any place of secure detention, whether within or outside an approved institution, where his conduct creates danger to others and proper provision cannot be made for his detention in an approved institution". It is important to note that 'detain' is defined in s.1 as "keeping under control by such use of force, mechanical apparatus, secure enclosure, or drugs as is reasonable having regard to the conduct and the apparent physical and mental condition of the person".
committal is to be completed.\textsuperscript{56} As in the child protection proceedings, the state has provided a mechanism for an immediate response to a crisis even though the potential harm may be only self-directed in these circumstances.

After a person has been involuntarily committed, mental health statutes set out some process of external review of detention by a tribunal or by the courts. This process may be mandatory or may be available only on the application of the detainee. As well, the legislation outlines the requirements that the hospital authorities must fulfil in order to extend the period of committal once it has expired. Generally there is less procedural protection and lower standards required for the authority to continue the hospitalization than there is for the initial committal. For instance, some reviews have decided that whether a person is benefitting from hospitalization is the test of whether the individual should continue to be detained in the hospital rather than whether the person could be involuntarily committed at the time of the review.\textsuperscript{57} While a person

\textsuperscript{56} Emergency committals vary from 24 to 72 hours before a decision to admit or release the individual must be taken. Where an emergency certificate of admission is issued, the involuntary committal may be completed and the period of committal extended through renewals.

\textsuperscript{57} See: \textit{Hoskins v. Hislop} (1981) 26 B.C.L.R. 165 at 174 where the court held that under the \textit{Mental Health Act}, R.S.B.C., 1979, c.256, it was authorized to order the continued detention of a patient:

whose mental state has improved due to treatment to the extent that he no longer requires care, supervision and control for his own protection or welfare or for the protection of others but who is still mentally ill and requires continued medical
may not meet the initial criteria for committal under the statute, the individual may not be released in the review process because the person is seen as "better off" in hospital despite not being a danger to self or others. Arguably then, once a person is caught by the net of the initial statutory criteria for involuntary admission, the process may allow a type of best interest test to be inserted implicitly in subsequent stages of the proceedings.

3. Discussion

(a) General Similarities

Although the statutes apply to different categories of persons, either children or mentally disordered persons, both categories refer to persons with forms of legal disability. Establishing "a separate body of law and specialized agencies to deal with abuse and neglect both justifies and ensures differential treatment of children." The existence of mental health law and mental health services ensures the same differential
treatment in a provincial mental health facility if recovery is to be achieved or mental stability maintained.

But see McCorkell v. Riverview Hospital (Director) [1993] B.C.J. No. 1518 (B.C.S.C.) stating that the standard for release by the tribunal is the same as the committal standard.

treatment for people with mental health diagnoses. Therefore, the common features in the legislation may reflect a more general orientation in law to disability and capacity which has a direct impact on mothers with mental histories. If these women are perceived by law to be like children, they are not likely to be perceived by law as capable of taking care of children.

The underlying legislative model of child protection statutes has been described as falling either into the "rights" category where parents have a more substantial focus or the "social welfare" category where the child is supposedly more central. There is a similar ongoing debate about mental health systems in which "rights" models are distinguished from "treatment models." The social welfare model finds its most extreme legislative niche in the majority of child welfare statutes in Canada that now permit parents to terminate custody of their children on a permanent basis. The mother who "voluntarily" terminates her parental rights may be seen in a completely different and more positive light than a mother who resists the state. Underlying

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the social welfare model is the obvious influence of psychology/psychiatry and sociological knowledge which is reflected in the professional ideology of social work. The social welfare model envisions intervention by helping professionals in a troubled family and would avoid a legalistic court process. However, the current trend in Canada is toward rights-based models\(^6^1\) and despite some differences in emphasis, there is a general similarity of the legislative schemes in both spheres across Canadian jurisdictions. The legislation reflects in part, the ultimate reliance in these spheres on the wisdom of psychology and psychiatry, albeit it through different mechanisms. The rights model contemplates resolution of the issues in court. It may describe the function of experts more directly in the legislation and/or will find psychiatrists and psychologists as expert witnesses in court.

Four important similarities can be drawn out of the child welfare and mental health legislative schemes: the responsibilities of the state, the implications of a "crisis," intrusions into privacy, and the notion of best interests. First, there is understood to be a positive duty on the state to intervene in the affairs of an apparently mentally disordered person or a child in certain circumstances. The legitimate target of the state's action are people who are dangerous in order to protect people who are

\(^6^1\) See for example the Ontario mental health statute and child welfare statute. The current Family and Child Services Act R.S.O, 1984, ch 55 is a rights-based model and replaced four pieces of legislation that were constructed around a social welfare model: Child Welfare Act R.S.O., 1980 c 66; Children’s Institutions Act R.S.O., 1980 c 67; Children’s Residential Services Act R.S.O., 1980 c 71; Children’s Mental Services Act R.S.O., 1980 c 69.
endangered. Those needing protection of the state are individuals seen to be both especially vulnerable to harm and limited in their capacity to avert the harm. Save for the legal legitimacy that arises from the notion of impaired capacity, these interventions would be at least inappropriate, if not unlawful[62] but people with mental disabilities are viewed as having "immutable differences that set them apart from the rest of society and thus warrant different legal treatment."[63]

Second, police powers of the state may be brought to bear when the situation is defined as a crisis. In adopting a quasi-criminal framework in both processes, an emergency permits the authorities, either police or social workers to take an individual into custody without obtaining a warrant or without legal process of any kind. Inherent in the emergency provisions is wide discretion vested in the authorities to decide whether a child or apparently mentally disordered person should be taken into custody. The response to the crisis makes for an immediate imbalance in power between the legal actors: [64] that is between the individual and the state in the mental health

[62] If there were no issue of the capacity of the individual, the involuntary committal of an adult could otherwise constitute false imprisonment and non-consensual treatment of an adult could otherwise constitute battery.

[63] Minow, Making All the Difference, supra note 33 at 107.

[64] Compare with the description of the accused (referred to as a "dependent" rather than a "defendant") as a 'one-shot' or occasional actor in a system compared to the systematic organization of the rest of the actors in the criminal process. See R. Ericson and P. Baranek, The Ordering of Justice: A Study of Accused Persons as Dependants in the Criminal Process (Toronto:
process, and between the state and the parent (usually a mother) in the child protection process. Given the unequal position created by an apprehension or committal, one might expect considerable legal process to precede an apprehension or committal in most instances. However, all legal process follows, rather than precedes these events.

Third, after an initial threshold has been crossed and the state has become involved, there is a wider definition of the legitimate spheres of an individual’s life in which the state may rightfully involve itself. Underlying these processes is an assumption that the triggering event, either a committal or an apprehension, opens an individual or a family to more state scrutiny than usual. This is in contrast to the general belief in our culture that there is a degree of autonomy of the family and a right to privacy

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Although an apprehension or committal represents the official triggering event in these circumstances, women with mental health histories have almost certainly had prior contact with state agencies through income assistance programs, community health pre-natal programs or through the public school system. Because of this history, the state will have more information about this individual or family prior to any emergency and will be particularly alert to any departures from some ill-defined standard of behaviour. Once the triggering event has occurred there is already a body of evidence from the records of the state agencies that have been in touch with this woman.

The public-private sphere does not operate in the same way for all women regardless of their family situation. See S. Boyd, "(Re)Placing the State: Family, Law and Oppression" (1994) Canadian Journal of Law and Society (forthcoming) where she describes the public-private sphere as an heuristic device.
such that the state has no right to intervene or even to pry.\textsuperscript{67}

For example, regardless of any protests, the authorities often remove personal items from the apparently mentally disordered person if the items are considered dangerous. Such issues as medical information about a child who has been apprehended, consent to the child’s medical treatment, inquiries and decisions about school progress all become legitimate business of the state. The power imbalance exists with respect to accessing information, records, and resources. The absence of pre-trial disclosure exacerbates the power imbalance between the parent and the state, especially for the parent with a mental health history. In most cases, the authorities have a vast array of documents that may be entered at trial, anything from psychiatric hospital records to interview notes of the parent with financial aid workers or comments on school records.

Despite widely held beliefs about confidentiality as well as statutory bars and common law holdings that such records are private, especially doctor-patient communications, the courts tend to order production of psychiatric records in child protection hearings. While not permitting a fishing expedition, records may be admitted if they reasonably

\textsuperscript{67} The right to a family’s privacy is class based. See: Donzelot, \textit{The Policing of Families}, \textit{supra} note 6. I am not suggesting here that the private-public distinction is analytically useful to describe social life realistically nor that the distinction applies in a universal way to women’s lives. My point is only that the heightened scrutiny of matters seen to be private is excused and applauded in these circumstances.
contain information that may directly or indirectly enable the applicants either to advance their own case or damage the case of their adversary. Hospital records may be admitted as business records and in some cases, the records issue is jurisdictional. The general reasoning for ordering production of records is that the child’s interests take precedence over the confidentiality interest. Because there is

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For example, see _Rogers v. Rogers_, [1991] N.W.T.R. 146 (S.C.) where the court found that it had inherent jurisdiction under its parens patriae power to order the assessment but that since the symptoms of the mental illness had dissipated there was no basis to order the examination. My point here is that the decision about whether or not a psychiatric assessment would be helpful relies completely on the psychiatrist’s opinion.

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But see _R. v. O’Connor_ [1993] B.C.J. No. 1466 which discusses the pre-trial disclosure order made by Associate Chief Justice Campbell on June 4, 1992 where the interest of the criminal accused is the reason for ordering the production of the psychiatric records of the complainant. Whether the woman with a mental health history is on the side of the state or not, it seems that confidentiality between her and her therapist is legally fragile. See also, _Globe and Mail_, July 15, 1993 at A3, where a Vancouver psychiatrist, Dr. Kay Parfitt, has refused to turn over her records about the mental health of a complainant in a sexual assault trial in the face of a Supreme Court order for production. She says:

The seriousness of psychological damage does not seem to be appreciated by the courts or the public...Talking with people who have been to court, this issue - that they feel they have been re-assaulted in court - this has come up a number of times. People have come to me and said they would never have gone into therapy if they knew this would happen.
no formal mechanism to demand documents, discover witnesses, or pose interrogatories in advance of the hearing, this lack of pre-trial disclosure is one way in which the road is paved for an enormous reliance on psychiatric opinion at trial.

Fourth, because an individual is perceived to be incapable or powerless to decide matters in his or her own interest, the agents of the state may insert their own definition of what is in an individual's best interest long before any judicial consideration of "best interests." These may be police officers, social workers, or mental health professionals. The best interests test assumes that it is necessary for an external authority to make the determination because the individual is unable to make a proper evaluation for himself or herself. Young children are presumed to be too inexperienced, not sufficiently developed cognitively or otherwise powerless to make decisions in their best interests. A similar belief follows from the idea that psychiatric patients have diminished capacity. Like children, someone else must make decisions for the benefit of that individual.\textsuperscript{72}

\textsuperscript{72} Recent debates about guardianship and substitute decision-making distinguish between various types of substitute decision-making: authorization obtained by a substitute of the person when the person was fully capable, standing in the shoes of the person, or acting in the best interest of the person. These reflect a hierarchy of the degree of agency of the person. Deciding in an adult's "best interest" reflects the least recognition of autonomy and is a model of greatest dependence, yet some statutes specifically require a consideration of the "best interests" of the person as the basis for substitute consent, albeit as a last resort. See for example: Mental Health Act, R.S.O. 1990, c. M.7, s.2(6) and Mental Health Act, S.A. 1988, c.M-13.1, s.28(3).
(b) Specific Effects for Women with Psychiatric Disabilities

In general, mothers in child protection proceedings are treated poorly by the legal process and viewed as child-like themselves. There are however, specific points in the child protection process where mothers with psychiatric disabilities are especially devastated by the simultaneous application of statutes about child protection and mental health. Two particular examples of these effects are pre-birth apprehensions where a mother is labelled with a mental disability, and the minimal notice provisions of post apprehension hearings when a mother is in a psychiatric facility.

In pre-birth apprehension cases, the authorities may decide that a pregnant woman is endangering the life or health of a fetus or that there is too high a risk that the woman will harm or neglect a newborn. In anticipation of harm, the authorities apprehend

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73 Most court decisions refer to adult parties or witnesses with some degree of formality, the form of address being "Mr. Mrs., Ms." but children are referred to by their first names. Routinely judges refer to women by their first names in child protection proceedings. See reference to "Carrie" infra note 76 and to "Marsha" infra note 189, quote cited in text. In my experience as an advocate, the same informal first name form of address is used consistently to address patients at mental health tribunals.

74 The use of illegal drugs is often the reason given for pre-birth apprehensions or apprehensions shortly after birth. See Superintendent of Family and Child Service v. M. (B) and O. (D.) (1982), 28 R.F.L.(2d) 278 (B.C.S.C.) where on appeal the court found that the child had been born abused and that the addiction made the child a "high risk" baby. The court found further that a
a fetus *in utero* and may invoke mental health legislation specifically for the purposes of completing an apprehension. Cases such as these reflect a facile and unfair interpretation of mental capacity. If a person is deemed to be mentally disordered, both her own body and her children become legitimate objects of state protection because perceived incompetence in one area results in presumed incompetence in all. In *Baby R* the medical authorities were concerned that the woman's refusal to consent to a Caesarian section posed grave dangers to the fetus, and they attempted to commit

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Sometimes merely a threat of using mental health legislation is enough to obtain the mother's compliance. For a typical example, see *Children's Aid Society of Niagara Region v. W. (C.A.)* [1987] O.J. No. 1838 where a mother with a mental health history, suspicious about hospitals, wanted a home birth. His Honour Judge Walmsley says:

> Carrie continued to display serious delusional thinking and to resist a hospital birth, because she thought a home birth would be healthier. Carry's attitude so concerned the workers to the point that they demanded Carrie go to hospital on October 3rd, 1985, under threat of obtaining an order under Section 10 of the *Mental Health Act*. After much persuasion, Carrie agreed to go into hospital that day.

Her child was apprehended one day after his birth. There is nothing in the decision about why a home birth was particularly inadvisable.

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the mother under the *Mental Health Act*\(^{77}\) so that the surgical delivery could occur without her consent.\(^{78}\) The objective here was not to treat the woman for a medical or a psychiatric disorder, nor to protect her from herself or from others, but to deliver the fetus surgically because this was necessary in the medical view. In *Daigle*\(^{29}\) the Supreme Court of Canada approved of the reasoning in *Baby R* and did not recognize separate legal personhood of the fetus.

The minimal notice requirements for the post-apprehension court appearance in child welfare legislation has a specific negative impact on women who are hospitalized in a mental health facility. Whether or not any information reaches her about an impending hearing may depend on the decision of her treatment team as to how such news would affect her. Even if she is informed of an important court matter, she may have limited access to counsel and to the courts because she is in a psychiatric ward.

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\(^{77}\) R.S.B.C. 1979, c. 256, as amended.

\(^{78}\) The Psychiatry Department refused to go along with this plan, presumably because the staff did not believe that the woman met the criteria for civil commitment. In my opinion the statute does not contemplate non-consensual *non-psychiatric* medical treatment and such intervention would have been unlawful in any event. A similar situation arose in which medical authorities successfully used provisions of the Ontario *Mental Health Act* (then R.S.O. 1980, c.262, s.10) to obtain an order requiring assessment by a physician of a pregnant woman who was thought to be negligent in attending to her needs when the birth was imminent. See *Re: Children’s Aid Society of Belleville, Hastings County and T. et al.* (1987), 59 O.R. (2d) 204.

\(^{79}\) *Tremblay v. Daigle*, [1989] 2 S.C.R. 530 at pp. 569-570
or she may not be well enough to attend the hearing or to represent herself.

While there may be justifiable policy reasons for the lack of notice requirements for post-apprehension court appearances in some circumstances, such as cases where the location of the parents is unknown, a mother hospitalized in a psychiatric facility is at risk of being left out of the process from the beginning and of being separated from her child for lengthy periods. The separation has obvious negative effects on the parent child relationship and significantly prejudices the mother's legal position. For example, in *Catholic Children's Aid Society of Metropolitan Toronto v. C. M.*, the mother's temporary hospitalization for psychiatric problems resulted in the apprehension of her child who was not returned to her for three years and eight months. On appeal from the trial judge's decision, the CCAS argued that the mother's delusional state at the hospital was indicative of her mental instability and "therefore a factor which should deprive her of the opportunity to parent her child". The CCAS was unsuccessful on this appeal but the time factor involved in this case is incomprehensible, particularly since there was virtually no evidence at trial to support the CCAS' position that C. was an unfit mother.

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81 *Ibid.* The mother in this case was eventually successful in regaining custody of her child. Frequently however, these cases end with consent orders where the mother eventually gives in to the overwhelming power and persuasion of the state pitted against her.
Usually there is a lengthy adjournment between the initial and more comprehensive second stage hearing. Therefore, despite the apparent interim nature of the orders at the initial hearing and the usual informality of the process, the court makes a custody and access ruling at this stage that potentially affects the remainder of the proceeding. The court’s focus on bonding and stability in interpreting the best interests of the child leads to a preference for the status quo in the ultimate disposition.\textsuperscript{82} Often the court will order supervised access at the initial hearing. The stress of such access visits cannot be exaggerated. Visits become sites where a mother must prove herself as competent, loving and spontaneous, despite the effects of medication and obvious surveillance. Inevitably there will be conflict, or at best ambiguity, in the roles of various people who are involved with a woman with a psychiatric disability during this adjournment period. The supervisor is always a potential adverse witness in the next stage of the proceedings. For the professionals involved, the objectives of caring and the objectives of social control present an inherent contradiction.

\textit{I became involved with Barbara’s case after her child was permanently apprehended. She appealed the decision. Barbara’s baby was apprehended at the hospital immediately after her birth. The public health nurse and a financial aid worker were worried that Barbara’s mental disability would put the baby at risk. Before the second stage hearing where the judge would make a finding about whether the baby was at risk, the Ministry arranged different sorts of supervised access visits for Barbara. Two such visits were to take place at Barbara and Vincent’s apartment where the Ministry supplied 24-hour homemaker support. During the 3 day visits Barbara noticed that the “homemakers” were watching her closely and making notes. Barbara told me that the “note-taking” made her very nervous, that she couldn’t concentrate well on taking

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\begin{flushright}
\textit{See} Racine v. Woods, supra note 43.
\end{flushright}
care of the baby and she thought that the notes might be important in court. She asked the homemakers if she could see the notes but the homemakers said she couldn’t. In response, Barbara and Vincent began making their own notes. Eventually however, the homemakers found Barbara and Vincent’s notes and, over objections of Barbara and Vincent, the homemakers removed the notes from the apartment and never gave them back. On cross-examination at the hearing, the homemakers said that they could not remember either finding or taking away any papers that belonged to Barbara and Vincent.
Psychiatrists and psychologists are central in both mental health and child protection legislation because of their alleged ability to assess risk. Mental health statutes are explicitly organized around definitions of mental illness and these contemplate placements in psychiatric facilities and treatment by mental health personnel. Although child protection statutes refer less directly to any special status of mental health professionals or their intervention, psychiatry and psychology give shape to the underlying ideas in this legislation in terms of how they define mothers as "unfit," especially where mothers have a mental health history.

I will argue that state process is able to sever the connection between women with mental health histories and their children relatively easily because of a dynamic combination: a psychology/psychiatry that is firmly grounded in a paradigm of science, the power of professional discourse and the ideology of motherhood. Because of the widespread acceptance in our culture of psychological ideas and of the ideology of motherhood, pre-court decisions and evaluations are necessarily guided by their content. Despite the fact that the body of psychological and psychiatric theory or the particular expert evidence in a legal proceeding may add little substance to existing social biases about mothering, the disciplines of psychology and psychiatry provide the
scientific and expert foundation to legitimate the ideology of motherhood. Psychiatry, together with ideas about good mothering, constitute the "common sense" in our culture around what is good for children both inside and outside the trial process.

1. Science, Psychology and Psychiatry

The disciplines of psychiatry and psychology are not unified theories or practices.³⁸³ Although research and clinical objectives could be viewed as separate, and sometimes in conflict, the knowledge of psychiatry and psychology as a combination of theory

³⁸³ A comprehensive discussion of the various Western psychiatries and psychologies is much beyond the scope of this paper. Any comparison is complicated by varieties of theory and varieties of therapeutic practice and varieties of research methodologies. Broadly however, psychiatry may depend on an ecological or a family systems perspective, or rely on a biochemical model. See H.I. Kaplan, A.M. Freedman and B.C. Sadock (eds.) Comprehensive Textbook of Psychiatry III (Baltimore: Williams & Wilkins, 1980). Psychological perspectives include the behaviorist perspective, which raises a machine-like image of a person who receives stimuli and responds to them. Measurement is key. Behaviour is highly deterministic. The classic works include J. Watson, Behaviorism (New York: Norton, 1930) and B.F Skinner, Beyond Freedom and Dignity (New York: Bantam, 1972). The biological perspective emphasizes physiological processes and adaptive behaviours. The cognitive perspective focuses on information processing by the individual. Subjectivity is acknowledged and thoughts, and ideas are more significant than behaviour. See the classic J. Piaget, The Moral Judgment of the Child (New York: Free Press, 1932) and L. Kohlberg, The Philosophy of Moral Development (San Francisco: Harper and Row, 1981). The humanistic perspective is interested in human potential, choice, personal change and growth. See C. Rogers, On Becoming a Person (Boston: Houghton Mifflin, 1961). The psychoanalytic perspective spans both psychology and psychiatry and occupies a different position in the discourse because of the massive influence that psychoanalytic theory has had in so many areas.
and practice is seen as unitary and useful. But, while psychiatry and psychology are not coherent at a certain level, it is fair to describe these disciplines as seeking to understand human behaviour by using common postulates that underlie certain research methodologies, theoretical constructs, and techniques of clinical practice. These ideas have dominated the discussions of motherhood and have also captured judicial attention. My purpose in this section is to describe the way scientific propositions are embodied in psychological discourse both to shape the ideology of motherhood and to form a knowledge that may co-exist easily with legal knowledge. I outline radical and feminist psychiatry to give an alternative epistemological and political view that challenges mainstream theories and methods.

Science commands a place at the pinnacle of contemporary knowledge because of its ostensible expertise, rigour and orderliness. Psychiatric and psychological knowledge is persuasive because of its position within this frame. Like law, the apparent truth that psychology offers depends on its image of objectivity. In addition to the general

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84 See M. Valverde, *The Age of Light Soap and Water: Moral Reform in English Canada, 1885-1925* (Toronto: McLelland Stewart, 1991) at 35 in which she describes this unity of theory/practice, science/charity in a holistic image of knowledge that would be simultaneously scientific, charitable, useful and true as part of the moral reform discourse in the early twentieth century.

85 C. Haney, "Psychology and Legal Change: On the Limits of a Factual Jurisprudence" (1980) 4 *Law and Human Behavior* 147, makes this point. He refers in footnote 64 to the analogous demands in law where the judicial system must be seen to be objective and unbiased to be perceived as legitimate. However, not all of the actors in the legal system need appear
critiques of the ways scientific methodology and positivism produce knowledge about the physical world, writers have repeatedly described the particular inapplicability of science in the realm of human behaviour. Nevertheless, firmly located within a positivist scientific tradition, the disciplines of psychology and psychiatry have staked their claims as expert discourses on human behaviour.

Science is seen to unravel the predictable, although complex, laws of nature. As a fundamentally reductionistic practice, the scientific method implies that the whole can be properly understood by the sum of its parts. By assuming that nature is orderly and observable (with the right techniques and technology) we say that scientists "discover" certain laws of nature rather than saying that scientists invent them. The problem with an assumption that science starts with nature as an orderly and knowable thing is the tendency to leave out factors of time, place, social context and a constellation of factors associated with the scientist as well as the nuances and relational qualities of social existence. Feminist scholars in particular have written about how and why scientific inquiry is necessarily influenced by the experience and world-view of the objective, only judges and juries who are engaged in fact-finding, as are psychologists in doing research.


Hubbard, The Politics of Women's Biology, supra note 5.
researcher. Scientific language supports the idea that an observation originated in
the world rather than in the mind of the observer and gives an aura of depersonalized
authority.

Critiques of science are often mistakenly organized around the questions of how we
know, what we know and how we use results. Any serious distinction between
scientific method, accumulated scientific fact and theory, and application of science
perpetuates existing difficulties with the scientific paradigm. This distinction wrongly
implies that basic research can be unbiased and untainted in examining the universe
and only the misapplication of results is problematic. Science has harmed
marginalized populations, not only by engaging subjects in astonishingly dangerous
practices in the name of research, but also in extending the domination of people along
lines of class, race, gender in the name of the application of science.


Basic research is never a disinterested enterprise. See for example the
interests that propel research on new reproductive technology. P. Spallone,
Beyond Conception: The New Politics of Reproduction (Granby, Mass.: Bergin
and Garvey, 1989).

The connections between basic research and its application to further the
oppression of already oppressed groups is exemplified by research on I.Q.
The objective of such research begins as an apparently neutral inquiry into a
fundamental theoretical question about "nature" vs. "nurture" as factors
Certain basic propositions common to psychiatry and psychology built into the frame of science serve to undermine the fitness of mothers with mental histories. The following principles incorporate both tenets of basic research and their application: the individual as the unit of analysis, reliance on assessment and categorization, ability to predict future events and expertise in analyzing hidden meanings and motivations.

First, psychology and psychiatry use the individual person as the unit of analysis. Emphasis on the individual as a discrete entity reflects the underlying liberal world view that permeates law\(^{91}\) as well as psychiatry and psychology. The common focus on the individual is one way that psychiatric knowledge is compatible with legal knowledge. Like law, this individualistic approach leaves psychiatry and psychology ill-equipped to address systemic problems.\(^{92}\)

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92 In the words of Judge David Bazelon "Psychologists in Corrections - Are they Doing Good for the Offender or Well for Themselves?" Appendix A in S. Brodsky, *Psychologists in the Criminal Justice System* (Urbana: University of Illinois Press, 1972) at 152 asking psychologists a critical question regarding their contribution to criminal law:

The critical issue, it seems to me, is whether the fundamental postulates of your discipline make it impossible for you to reach the central problem. Your discipline assumes, I think, that aberrant behaviour is the product of sickness, and it brings to
that a variety of external influences such as family, the physical environment or culture are important to human functioning, the goals of the disciplines remain to explain the individual's emotions, thoughts, behaviours or potential. It is the individual human psyche that the researcher, theorist or clinician has in mind. 

Second, the psychiatric paradigm relies on techniques of assessment as the starting point to understand an individual. Exactly what form the assessment takes varies widely. Depending on the specific theoretical orientation, the assessment may involve interviews with the individual or other individuals in the person’s life, direct observations of the individual’s behaviour either in a natural setting or in a laboratory-like setting, testing through paper and pencil means or testing by medical

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bear on the problem a medical or therapeutic model....Why should we even consider fundamental social changes or massive income redistribution if the entire problem can be solved by having scientists teach the criminal class-like a group of laboratory rats-to march successfully through the maze of our society?

Arguably however, the focus on "experts" at least in the criminal justice system has shifted away from any pretext of a medical or social welfare model (at least in terms of language) to a focus on risk and social defences. The concern then is not with rehabilitation but with punishment and deterrence of deviance.

Characterizing a person as "sick" through an illness model, implies that an individualized technological solution is the appropriate remedy. K. Brooks, "Freudianism is Not a Basis for a Marxist Psychology" in P. Brown (ed.) Radical Psychology (London: Harper Row, 1973).
measurements of biochemical functions or anatomical features.\textsuperscript{94} But regardless of the particular type of procedure, the objective of an assessment is to categorize the individual according to some pre-defined taxonomy seen by the professionals to categorize or type people in a useful way.\textsuperscript{95} The importance of the basic taxonomy cannot be overestimated because the particular categorization leads to a critical conclusion about the individual. The taxonomy provides a means of saying whether

\textsuperscript{94} Psychological tests, for example, differentiated as being "objective" or "projective". One example of an objective test is the MMPI (Minnesota Multiphasic Personality Inventory) which is composed of 550 affirmative statements about such things as health, sex, religion, occupation, and many more, about which the subject is to comment true/false/cannot say. Projective tests assume that a person will project on to unstructured material some aspect of his/her own thoughts, feelings or desires. For example, inkblots are the materials used in the Rorschach test, a type of projective test used by psychologists. By a complex form of scoring and by general clinical impressions, professionals are able to discern underlying aspects of personality from the responses individuals give on projective tests. But for critiques of psychological testing, see S. Cohen, \textit{Tests: Marked for Life} (Richmond Hill: Scholastic, 1988) and L. Kamin, \textit{The Science and Politics of I.Q.} (New York: Penguin, 1974).

\textsuperscript{95} Using the answers of the MMPI a person is diagnosed according to nine clinical scales: hypochondriasis; depression; hysteria; psychopathic deviate; masculinity or femininity interest pattern; paranoia; psychasthenia; schizophrenia; or hypomania. The DSM III R (Diagnostic and Statistical Manual of Mental Disorders) is the diagnostic manual of the American Psychiatric Association. It is a multiaxial classification system which categorizes symptoms according to established criteria. For example, Axis I makes the following categorizations: disorders usually first evident in infancy, childhood or adolescence; organic mental disorders; psychoactive substance use disorders; schizophrenic disorders; and delusional (paranoid) disorders are differentiated from neurotic disorders such as affective, anxiety, somatoform, dissociative, sexual and sleep disorders. Axis II categorizes personality and developmental disorders.
a person is in the "normal range" or in the "pathological range," according to the framework. In particular, the person who falls in the pathological range may be treatable or changeable by a form of therapy dictated by the findings of the assessment or may be resistant to therapeutic techniques or simply not treatable at all.

Categorizations that arise out of assessments are inevitably extreme oversimplifications, particularly if the purpose of the assessment is legal. In part, compressing a complex picture into a straightforward category is one way of legitimizing the practice of diagnosis and prognosis. At the same time that psychiatrists narrow the complexity of human experience to sharpen a diagnosis, they have taken on a wider range of problems, thereby medicalizing and pathologizing a wider range of human experience and extending their influence and power. Such labels as "anxiety," "depression"

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96 The decision-making process of the "categorizer" is critical to evaluate what can be made of the categorization. For a comprehensive review of the research in cognitive science that calls into question the processes of categorization by mental health professionals, see D.N. Bersoff "Judicial Deference to Nonlegal Decisionmakers: Imposing Simplistic Solutions on Problems of Cognitive Complexity in Mental Disability Law" (1992) 46 Southern Methodist University Law Review 327 [hereinafter "Judicial Deference"]. See also D.L. Rosenhan, "On Being Sane in Insane Places" (1973) 179 Science 250, an empirical study that indicated psychiatrists were unaware of those feigning mental illness in an institutional setting.

97 See the "decolourization" from a kaleidoscope of colours by expert forensic assessors. In Menzies, Survival, supra note 6 at 81, especially c. 3.

98 The interest of doctors as a group may be a significant factor in the direction of conceptualizations of mental disorder. See the history of madness in the nineteenth and twentieth century and the increasing domination of psychiatrists:
or "neurosis" are a "dustbin" category of diagnosis.99

Another problem with these systems of categorization is a failure to recognize the historically and culturally specific basis of assessments, taxonomy and the resulting conclusions about normalcy and pathology.100 For example, psychologists, measure what are considered permanent underlying structures of a person’s personality or abilities. Blinders arise from the notion that natural and physical science is able to find immutable laws. In positioning themselves as scientific endeavours, psychiatry and psychology consequently search for immutable laws of human behaviour.

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For a pointed example of the ways that pathology is socially defined and the roles of experts in contributing to social consensus, see the American Psychiatric Association, "Position statement on Homosexuality and Human Rights" (1974) 131 American Journal of Psychiatry 497 describing the American Psychiatric Association polling its members about removing homosexuality from the diagnostic system.
Third, this approach assumes that predictions about an individual’s development or future behaviours may be made on the basis of current assessments.\textsuperscript{101} Predictions may be quite long-term, sometimes extending from a childhood assessment into predictions about adulthood and these become the "prognosis" for the individual. In the mental health area, psychiatrists and psychologists have been long viewed as uniquely competent to make predictions about such matters as an individual’s dangerousness, general stability, and intellectual development, although there is overwhelming evidence of the frailty of their predictions,\textsuperscript{102} and a fundamental question of whether these predictions are even relevant to legal questions. Much like the question of whether "dangerousness" is a relevant legal question in forensic

\textsuperscript{101} This point has relevance to assessments in child custody law. See M. Finemen, "Dominant Discourse, Professional Language, and Legal Change in Child Custody Decisionmaking" (1988) 101 Harvard Law Review 727 for a critical analysis of mental health professionals appropriation of child custody decisions and her recommendation for returning control of decisions to the legal arena. See also P.J. Caplan and J. Wilson, "Assessing the Child Custody Assessors" (1993), 27 R.F.L. 121 for empirical work indicating the particular values and principles that child custody assessments embody and the demographic characteristics of the assessors.

psychiatry or criminal law, a similar "mixed" discourse exists when psychiatrists are imported into child protection matters. Child welfare law is about whether a child is "at risk", "in need of protection," and what is "in the best interests of the child." Yet mothers are assessed as carriers of "risk". Even when children are assessed as well as mothers, the legal questions are not directly answered by the psychiatric diagnosis of the mother because psychiatric diagnosis does not establish, and probably does not speak directly to the questions of whether the child is at risk.

Fourth, psychology and psychiatry believe that what is observable or obvious in human functioning is not necessarily a complete version or even a reliable version of what a person is really thinking, feeling or likely to do. Michel Foucault describes psychiatric predictions of dangerousness in criminal matters as "strange mixed discourse" where the only thing that matters is danger to society. He points out that:

The law has never pretended to punish someone because he is 'dangerous', but because he was a criminal. But in the realm of psychiatry the question isn't any more meaningful: as far as I know 'danger' is not a psychiatric category, nor is the concept of 'rehabilitation'. "The Anxiety of Judging" in *Foucault Live (Interviews 1966-84)* (New York: Semiotexte, 1989) at 174-175.

This idea is the foundation of the psychoanalytic version of theory. Repression (as unconscious forgetting) and sublimation (as positive use of otherwise socially unacceptable impulses) are central concepts in this school of thought. The idea has extended to psychiatric diagnosis and into popular culture. It is not foreign to think of the "passive aggressive personality", "compensation for weaknesses" or socially acceptable outlets for darker instinctual tendencies.
merely "the tip of the iceberg." However, the hidden portion of a person’s motivation, feeling or thought is often viewed to be the darker, more negative aspect of personality which is at odds with the person’s superficial appearance. At first blush, this idea seems inconsistent with psychology/psychiatry’s reliance on assessments and observations to make predictions about people. But in actual fact this apparent contradiction increases the mystification of psychological or psychiatric practice. What is submerged in the iceberg is not apparent to just anyone, but it can be detected by a psychologist or a psychiatrist who has the requisite knowledge and power. The psychiatrist or psychologist is specially trained to understand why a person’s description of an inkblot\textsuperscript{105} is important, what it means, whether it indicates something worrisome about a person’s tendencies and what, if anything, can be done about any problems disclosed by a person’s response. To the untrained person, a person’s comments about an inkblot would not have any special significance.

2. The Ideology of Motherhood

My objective in this section is to outline certain aspects of the ideology of motherhood and point out the ways that psychological thinking reinforces these ideas under the cover of objectivity, making them all the more insidious. Although what we think

\textsuperscript{105} See \textit{supra} note 95.
constitutes ideal "mothering" varies with the times, and each culture constructs motherhood in a particular way in a given historical epoch, there is a prevalent belief in our society that some universal definition of "good" mothering exists. The elements of the mainstream psychological paradigm dovetail with the ideology of motherhood\(^{106}\) in a way that leads to a firmer, more scientifically entrenched conception of what distinguishes a "good" mother from a "bad" mother.

The first component of the ideology of motherhood is that being a mother is an essential part of being a woman.\(^{107}\) This means that to be a personally fulfilled and socially acceptable woman, one must have children or want to have children. Minimally, women are expected to take the question of motherhood seriously and to answer it. Motherhood then, cannot easily be a "non-issue" for a woman in our society regardless of whether we are mothers or not. The important caveat however, is that women are required to be mothers only if they are deemed to be "fit". Precisely who is fit or unfit has varied with history. In the modern era, single mothers, First Nations mothers, lesbian mothers, mothers working outside of the home, and women with a number of sexual partners, continue to struggle with a

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\(^{106}\) I am relying here in large part on aspects of the ideology described by B. Wearing, *The Ideology of Motherhood: A Study of Sydney Suburban Mothers* (Sydney: Allen & Unwin, 1984) c. 4; also Kline, "Complicating", *supra* note 31.

defined view of fitness and morality as obstacles for them. Women with disabilities are commonly faced with the presumption that they are "unfit" to be mothers. In addition to their experience with the child protection system, women with disabilities have had a painful history with dangerous experimental contraceptives, non-consensual sterilizations, and coercive abortions. This wide-ranging interference with fertility, pregnancy and parenting attests to the social presumption that women with disabilities are not fit mothers.

According to a second element of the ideology, legitimate motherhood assumes a heterosexual and able-bodied nuclear family. Based in an ideology of domesticity

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108 See references supra note 31.


110 See, The Disability Rag Resource (May/June 1993) for an overview of consumers discussing parental rights and their experience with law and state apprehensions. See also, M. Fine and A. Asch (eds.) Women with Disabilities, supra note 33: especially H. Rausso, "Daughters with Disabilities: Defective Women or Minority Women?" at 139 and A. Asch and M. Fine, "Shared Dreams: A Left Perspective on Disability Rights and Reproductive Rights" at 297. For an example of a baby-protection regulation that is insensitive to mothers with disabilities, see K. Blackford, "The Baby Crib and Other Moral Regulators of Mothers with Disabilities" in Stewart et al. (eds.) The More We Get Together supra note 22.

111 Gavigan, "Paradise", supra note 3.
and privacy, the law presumes the natural healthy family to be a private, self-reliant unit. Whenever there is a need for assistance from the state, the family is considered less than ideal regardless of whether the requisite help is financial or emotional. Through 'socialized legal coercion,' the courts readily interfere with families that do not fit the dominant model and child protection decisions often refer disapprovingly to the family's reliance on state resources.

The third ideological component of motherhood is that being a mother is difficult, but the rewards are great and intrinsic. However, while mothering is an important job in

112 Chunn, "Rehabilitating", supra note 7 at 138.

113 The privatization of the nuclear family has important consequences not only for women but also for children. With few exceptions, the options for children in Western culture are seen to belong in a parental-familial framework or the state-as-alternative parental framework. A relational rights analysis recognizes the complicated dynamic relationships between children, family and the state. The child has the right to call on the state and breach family privacy thereby effecting a direct relationship between the child and the state, but also has the right to be protected from state intrusion by the protection of parental authority as well as the right for state support for autonomous decisions. M. Minow, "Rights for the Next Generation: A Feminist Approach to Children's Rights" (1986) 9 Harvard Women's Law Journal 1.

114 See Chunn, "Rehabilitating", supra note 27 at 138.

115 See, for example, the comments that focus on individual responsibility in Re: Brown (1976), 9 O.R.(2d) 185, 21 R.F.L. 315 at 316 in awarding wardship to the Crown, the court noted that the family had received "massive attention from various agencies and resources" but without sufficient effect. The court describes giving up one's children as the ultimate sacrifice for their benefit.
our society, it has little status. Because the ideal says that wanting to be a mother springs from within a person, and the ability to be a good mother stems from loving one's child, the "skills" associated with mothering are not comparable to those required to do a good job in the marketplace. Part of the ideology is that whatever the unpleasant aspects of mothering, these are always more than compensated for by the good parts.

Fourthly, according to the ideology, mothers must put their children first. To be a good mother means being entirely unselfish and being more or less always available to meet a child's physical, emotional or intellectual needs. In particular, young children need their mothers to be constantly attentive. This complete selflessness may involve extreme self-sacrifice for the benefit of the children. In Re: Brown et.al the court commented on parental sacrifice of children to the state in a child protection case.


The undervaluing of mothers is revealed not just through anecdotes, but also by hard facts. According to the U.S. Department of Labor, the skill level needed to be a homemaker, childcare attendant, or nursery school teacher is rated at 878 on a scale of 1 to 887 where 1 is the highest skill level. On this scale, the rating for a dog trainer is 228.

Rich, Of Woman Born, supra note 4.
procedure by saying:

Perhaps, out of their love for these children someday will come an understanding that this sacrifice was made for their benefit. Sometimes love demands extreme sacrifice; the mother who uses her body as a shield to protect her young ones from the bombs of war, the parents who endure starvation in order to feed their children.\textsuperscript{118}

However, exactly which mothers are expected to give up their children to a "better" parent, who is the state, may depend on race or other differences between women along which different conceptions of ideal mothering are constructed.\textsuperscript{119} Associated with this selflessness is a view of an ideal motherly temperament which is patient at all times and never angry. This devotion is especially important with children who are particularly difficult, demanding or who have other special needs.\textsuperscript{120}

\textsuperscript{118} Supra note 116, p.322
\textsuperscript{119} Kline, "Best Interests", supra note 31.
\textsuperscript{120} This, of course, fails to take into account the stress generated by parenting as described in the classic A. Rich, Of Woman Born, supra note 4. See also Luxton, Rosenberg and Arat-Koc, Through the Kitchen Window, supra note 117 and the increased stress associated with being a parent to a child with a disability. See for example, J. Hoyle, "Stress in Mothers of the Disabled" (1991) 12 Canadian Woman Studies 6771 and B. Lawson, "Mothering a Disabled Child: Challenge for Today, Hope for Tomorrow, In Stewart et. al. (eds.) The More We Get Together, supra note 22. See also the role of mother to a child with a disability from the perspective of the child: R. Cepko, "On Oxfords and Plaster Casts" in Saxton and Howe (eds.) With Wings, supra note 33 at 56.
In combination, the elements of motherhood prescribe and "interiorize" the ideal mother. I use the term interiorize to evoke two ideas about internal life simultaneously: certain mandatory rich internal requisites that constitute a proper motherhood psyche coexisting with a completely neutral, blankness about personal life or self-interest with the possible exception of mental energy that must be devoted to working outside the home. The internal psychical requisites include a natural desire to be a mother, love and spontaneity which spring from within, and infinite unspecified internal resources to remain always attentive and interested. At the same time as demanding this complicated interior resource for the benefit of the child, the ideology requires an absolute bareness as self. The bare self may not be filled with aspirations, feelings or especially, point of view.\textsuperscript{121}

3. Intersection of Psychology/Psychiatry with the Ideology of Motherhood

The rise of the "psy" disciplines is linked to their claims to scientific "truth".\textsuperscript{122} A

\textsuperscript{121} See Arnup, "Mothers Just Like Others", supra note 31 indicating that courts are especially troubled about custody matters by lesbians who are "out" or politically active.

\textsuperscript{122} Foucault suggests that accounts of current history will show that it is possible to write the history of feelings, behaviour and the body and that "the history of the West cannot be dissociated from the way 'truth' is produced and produces its effects." In L. Kritzman (ed.) \textit{M. Foucault: Politics, Philosophy, Culture} (New York: Routledge, 1988) at 112. See also Donzelot, \textit{The Policing
fundamental tenet in the ideology of science is that it is possible to systematically identify, diagnose, treat and prevent pathology which produces deviance. Since proper mothering is seen as the critical influence on normal development it follows that there is growing legitimacy to the idea that women cannot mother without "expert" advice. Ideas about motherhood have been produced and are reinforced in two major ways by psychological knowledge and this input has a very specific impact on women with mental health disabilities. First, mothers are held primarily responsible for any mental disturbance in their children, a tendency that other writers have referred to as "mother-blaming." Second, the denial of subjectivity has an ambiguous and particularly controlling effect on women in their roles as "good patients".

Because mothers are expected to be the most important and constant influence on their child's development, any problem in a child's development becomes causally linked to the kind or constancy of mothering. While there may be some minor commentary

See also, P. Chesler, Women and Madness (New York: Avon Books, 1972) at 73 who expresses the widely held view of feminists writing about the paradoxical view of psychiatry on the subject of mothering:

Clinician-theorists share the idea that women need to be mothers and that children need intensive and exclusive female mothering in order for both to be mentally "healthy." The absoluteness of this conviction is only equalled by the conviction that mothers are generally "unhappy" and inefficient, and are also the cause of neurosis, psychosis and criminality in their children.
on how fathers affect their children's development, there is simply no male equivalent for "the schizophrenic mother" or "the overprotective mother," because raising children is not seen to be the primary responsibility of fathers. Although widely held ideas of mothering may account for motherblaming in general, mental health professionals engage in "mother-blaming" because of certain fundamental aspects of the psychological paradigm in which they work. The combined effect of psychology's and psychiatry's basic roots in individualism, its precept that early experience is determinative of adult development and the idea that mothers must be constantly available to young children means that anything less than a mother's complete attentiveness will lead to problems for her child in adulthood. By relying on empirical data generated by a "scientific method", a critical element of the ideology of science, psychiatry concludes that "maternal deprivation," is an objective answer to why children are maladjusted.

124 The schizophrenic mother has been defined as inadequate, domineering, more involved in pursuits outside the home, cold, emotionally detached. The overprotective mother is seen to be as rejecting of her child as the schizophrenic mother but just demonstrates her hostility in another way by coddling or pampering the child.

125 See P.J. Caplan and I. Hall, "Mother-blaming in Major Clinical Journals" (1985) 55 American Journal of Orthopsychiatry 345, a review of the large number of ways that mental health professionals blame "mothering".

126 For a review of the ways in which psychological and psychiatric theories of motherhood have explained and blamed mothers for such diverse things as asthma, schizophrenia and autism see P.S. Penfold and G.A. Walker, Women and the Psychiatric Paradox (Montreal: Eden Press, 1983) at 124-140.
Early work on attachment and maternal deprivation is still used to criticize daycare for young children despite the flaws that have come to light about this research. Although John Bowlby’s work was extremely influential and based on a scientific model, the "scientific" thinking and ultimate applications are somewhat bizarre. For example, the work which he carried out at the end of World War II used children who had experienced long-term hospitalization as subjects on the effects of mothers and early attachment processes. His conclusions were rather overreaching by his suggestion that maternal deprivation meant anything less than full-time, not working outside the home mothering. He further concluded that families failed because fulltime employment of the mother was on a par with such conditions as the death of a parent, imprisonment of a parent, social calamity, war or famine.\(^{127}\)

The host of social variables that affect what sort of person the child becomes are given little attention in the dominant psychiatric paradigm. The tendency for psychiatry to "blame the victim",\(^ {128}\) in this case the mother, is a consequence of an abstracted, 

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asocial and ahistorical view of the individual or the mother. When something is "wrong", the problem is seen as a "defect" in the individual or the mother. Even when there is some recognition that social factors are relevant, the focus remains on personal weaknesses albeit within a difficult social structure. The individual is held responsible for not shifting whatever social factors or systems would improve the particular situation, reasoning that is common in child protection cases. In *P.E.I. (Director of Child Welfare) v. H.(D.)* the court found the mother's psychiatric diagnosis was consistent with evidence adduced at the hearing and stated:

The defendant's inability to find more suitable accommodation for herself and

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130 See I. Prilleltensky, "Psychology and the Status Quo" (1989) 44 *American Psychologist* 795. Prilleltensky examines the ideology of psychology and its limited role in promoting social change. In reviewing the "organic perspective" of psychology which informs the eugenics movement, he says:

"The clear conforming message in that theory [sic Darwinian, adaptive] was and still is, that human suffering is predominantly the result of a deficient organism. From this viewpoint, environmental factors such as poor nutrition, detrimental living conditions, and unemployment are thought to be 'caused' by the inability of those people to help themselves. To the extent that functionalism in psychology assisted in the dissemination of this theory, it collaborated with the ruling ideology in disguising social injustice as biological or psychological inferiority." p.798

Along with the tendency to hold mothers responsible for any problems that their children encounter, is psychiatry’s denial of the subjectivity of motherhood. While feminist theory has begun to address this omission by articulating the ways in which the varieties of "experiencing" motherhood have been left out of the construction of motherhood, psychological thinking necessarily denies the experience of being a mother because the focus is on the child’s experience. The peculiar interiorization requires that, in order to be selfless, a mother is required to deny any interest of her own so that she can defer completely to her child’s interests. Judgments about mothering become assessments of how well a mother meets her child’s demands rather than analysis of the mother-child-society arrangement as relational and dynamic.

Ibid.


See, for example J. Benjamin, *The Bonds of Love: Psychoanalysis, Feminism and the Problem of Domination* (New York: Pantheon, 1988) at 23-24, who
As a result of psychology’s concentration on how mothers affect child development, the process of interest in research is almost always the infant’s attachment. However, there is some indication that in mother-infant pairs where the infant is disabled, the focus is more often on the mother’s attachment than the infant’s. A disability rights perspective would note that the focus shifts from the disabled member of the pair, (the infant) toward the able member of the pair, (the mother) even within the powerful ideology of motherhood where the experience of mothering is so much less important than the experience of being mothered. The absence of the disabled infant’s perspective exemplifies the social experience of disabled people in rendering them less personal, less visible, less privileged in any social interaction.

Denying the legitimacy of subjectivity or point of view as an essential condition of motherhood poses an especially difficult problem for women with psychiatric

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argues that psychoanalytic theory is based in the Oedipal conflict which depends on denying a mother’s subjectivity and that the perception of mother in psychology is principally to meet her child’s demands, a view that has been deeply imbedded in our culture.

See the classic psychological research on infant monkeys attachment to real and surrogate mothers. The surrogates were either made of wire or made of cloth. H. Harlow and R. Zimmerman, "Affectional Responses in the Infant Monkey" (1959) 130 (No. 3373) Science 421.

A. Harris and D. Wideman, "The Construction of Gender and Disability in Early Attachment" In Fine and Asch (eds.) Women with Disabilities, supra note 33 at 120.
disabilities. By defining a psychiatric problem, psychiatrists highlight the existence of a woman's subjectivity because of its pathology. The particular woman's thoughts, feelings or attitudes are "abnormal" and need to be changed through therapy. Put another way, the mother has a point of view, not necessarily because the woman asserts it, but because the psychiatrists say it needs changing. What is important for mothers with a mental health problem is that an expert has determined that the very existence of her particular subjectivity is inconsistent with "good" mothering. By definition, women with psychiatric disabilities are actually troubled or, at least have been assessed as troubled by psychiatrists. As a condition that is defined externally and professionally, the woman's experience constitutes a defect. Until the defect is resolved, that is the point of view is made invisible, the woman cannot truly be "selfless" and considered to be an appropriate candidate for motherhood. By this time the legal process has probably denied her the opportunity.

To complete the special conundrum for women with psychiatric labels, the demands of being a good patient are inconsistent with being a good mother. The classic "sick role" exempts people from blame for their deviance but the exemption is temporary and depends on the person actively seeking to recover.137 To be a "good" patient a woman must put some effort into getting "well" and that means concentrating on

herself. But this requirement of therapy specifically defines a self-interest that is not permitted in good mothers. The therapeutic process may also mean disclosing a woman's true, ambivalent and perhaps not-very-nice-feelings about her children and her role as mother, but admitting these is fatal to the woman as a "good "mother. This dilemma alone places psychiatry in an enormously powerful position in relation to a woman trying both to restore her mental health and re-gain custody of her children.

In child welfare matters, state action has very specific effects on women who are labelled with a psychiatric diagnosis. Women with psychiatric diagnoses experience all of the same personal intrusions and requirements of public accountability to public authorities as other women whose "fitness to mother" is being scrutinized-- questions about cleanliness, management of finances, life-style choices. But a psychiatric label and its concomitant therapy authorizes even further inquiry to a woman's deepest and most intimate thoughts, feelings, and motivations. As a result, it is extremely difficult for a woman to retain any vestige of privacy, except perhaps through her own "madness" as the only personal and private sphere of existence outside the reach of state authorities.

4. Radical/Critical Psychiatry: An Alternative Perspective

Radical or critical psychiatry has a different orientation than the psychiatry and
psychology described here.\textsuperscript{138} My objective in this section is to present an alternative psychology/psychiatry, not as an alternative expert discourse to speak to the best interests of the child, but which, if considered, would encourage judicial skepticism in the "truth" of psychiatric opinion. The problem however, is that with the "scientific" underpinnings of psychiatry removed from the discourse (as they are in radical psychiatry) the courts cannot defer to an "objective" "apolitical" expert. In other words, radical psychiatry is not of assistance to the courts in child welfare matters in the same ways as other psychiatry because it does not share the mutually reinforcing assumptions of the ideology of science and the ideology of motherhood and therefore it cannot provide legitimacy to judicial decision-making in the same way.

Despite the current trend in natural science to admit the influence of values and cultural biases,\textsuperscript{139} social scientists, especially psychologists, have been reluctant to acknowledge the influence of values on a scientist's ability to make objective observations and to construct socially untainted theory.\textsuperscript{140} The insights of radical psychiatry are exemplified by the sources in \textit{supra} note 34.

\begin{itemize}
  \item \textsuperscript{138} What I mean by radical psychiatry is exemplified by the sources in \textit{supra} note 34.
  \item \textsuperscript{139} Prilleltensky, "Psychology and the Status Quo", \textit{supra} note 131 at 797 citing D.N. Robinson's, \textit{Philosophy of Psychology} (New York: Columbia University, 1985).
  \item \textsuperscript{140} See: D.R. Fox, "Psychological Jurisprudence and Radical Social Change" (March 1993) \textit{American Psychologist} 234 at 239. See also Fox, "Social Science's Limited Role in Resolving Psycholegal Social Problems" (1991) 17 \textit{Journal of Offender Rehabilitation} 159 at 165. Occasionally psychologists will
\end{itemize}
psychiatry are helpful both in explaining the attraction of mainstream psychiatry/psychology as accounts of mental illness and as influencing the course of child welfare matters.

For the purposes of this thesis I characterize radical psychiatry as containing two dominant ideas about mental health, both of which challenge the mainstream approach: a political-historical idea of mental illness and a subjective-adaptive idea of mental illness. The first idea emphasizes the social function of psychiatrists as keepers, excluders, controllers and agents of surveillance. Psychologists and psychiatrists are seen to act more like conjurers than doctors. The coercive and carceral elements comment on the limits of their own approach and the centrality of scientism:

American psychology’s emphasis on the individual is longstanding. It is not that psychology ‘decided’ that such an emphasis would be more profitable than other directions. For our purposes it is sufficient to say that the direction taken seemed right, natural, and proper. Besides, it seemed to allow psychology to make fruitful use of scientific methodology and, therefore, to justify its separation from philosophy. For almost a century this emphasis has been productive, permitting its severe limitations to go relatively unnoticed. Recognition of these limitations is very recent.


In the *Manufacture of Madness* (New York: Harper and Row, 1970), T. Szasz describes the similarities between witch-hunts and diagnosing and treating mental illness. The "swimming test" determined whether a person was a witch by completely tying her up and throwing her in the water. If she floated she was guilty, innocent if she sank and three tries were allowed. Szasz says, at
of mental health are the important aspects and the focus is the process of being institutionalized or psychiatrized. Sociological work has looked at the mental hospital as an example of a total institution and the stigmatizing effect of psychiatric hospitalization with institutionalization in a mental hospital involving a greater deprivation of liberty than imprisonment.\textsuperscript{142} Psychiatry and any concomitant mental health law is a powerful tool of social control for those who do not conform to social norms. Labelling theory\textsuperscript{143} says that mental illness is no more than the attribution of it and although everyone does things that could acquire the label, the label is given to some people and withheld from others since the designation of mental disorder is used for social control. Once a person has acquired the label, the individual may well behave more like the label itself.

Unlike mainstream psychology and psychiatry, critical psychiatry, especially in the

\begin{quote}
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The aims and results of several methods of psychodiagnosis resemble closely the ordeal by water. One is the use of projective tests—like the Rorschach or the Thematic Apperception Test. When a clinical psychologist administers this test to a person referred by a psychiatrist, there is the tacit expectation that the test will show some pathology.
\end{quote}


\textsuperscript{143} Scheff, \textit{Being Mentally Ill}, supra note 34.
work of Foucault, incorporates an understanding of mental illness as an historical process. The concept of mental illness and especially confinement of the "mad" developed along with capitalism and served capitalist ends. By isolating certain people, society could forget about certain problems such as unemployment and capital could make use of cheap labour during their confinement. According to this sociological view within critical psychiatry:

No medical advance, no humanitarian approach was responsible for the fact that the mad were gradually isolated, that the monotony of insanity was divided into rudimentary types. It was the depths of confinement itself that generated the phenomena; it is from confinement that we must seek an account of the new

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144 This kind of analysis has demonstrated how confining mental patients to asylums or houses of correction followed the confinement of enormous numbers of lepers. Once the institutions were emptied because leprosy was nearly eradicated, Western society showed a rather easy acceptance of a new form of illness. In M. Foucault, *Madness and Civilization, supra* note 34 at 6.

What doubtless remained longer than leprosy, and would persist when the lazar house had been empty for years, were the values and images attached to the figure of the leper as well as the meaning of his exclusion, the social importance of that insistent and fearful figure which was not driven off without first being inscribed within a sacred circle.

145 Using people with disabilities as a cheaper labour source survives in the modern era in the form of sheltered workshops. See *Fenton v. British Columbia (Forensic Psychiatric Services Commission)* (1992) 56 B.C.L.R. (2d) 170, where the court ruled that the work performed in a work-rehabilitation program by patients in a forensic setting did not fall under the *Employment Standards Act.*
A second idea in critical psychiatry, mainly in the work of R.D. Laing looks more directly at the experience of madness. While locating the experience of madness within a social structure and defining sanity as a social construct emanating from power rather than a medical illness, this type of anti-psychiatry arises from an existentialist tradition and is more concerned with the actual feelings and thoughts of a person who is considered insane. From the idea that crazy responses may be the most sensible reaction to a crazy world or family, the internal world of madness as a mode of resistance is paid considerable respect. Laing says:

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146 Foucault, *Madness and Civilization*, supra note 34 at 224.

147 See for example R.D. Laing, *The Divided Self* (New York: Pantheon, 1970) at 41-42 who distinguishes the "ontologically secure person" who "may experience his own being as real, alive and whole; as differentiated from the rest of the world in ordinary circumstances so clearly that his identity and autonomy are never in question..." from the "ontologically insecure person" who "in the ordinary circumstances of living may feel more unreal than real; in a literal sense more dead than alive..

See also Laing, *The Politics of Experience*, supra note 34 at 90:

Psychiatrists have paid very little attention to the experience of the patient. Even in psychoanalysis there is an abiding tendency to suppose that the schizophrenic's experiences are somehow unreal or invalid; one can make sense out of them only by interpreting them; without truth-giving interpretations the patient is enmeshed in a world of delusions and self-deception. (emphasis in original)
In over 100 cases where we have studied the actual circumstances around the social event when one person comes to be regarded as schizophrenic it seems to us that without exception the experience and behaviour that gets labelled schizophrenia is a special strategy that a person invents in order to live in an unlivable situation.\(^{148}\) (emphasis in original)

While Laing's work has considerable appeal, feminists have found it problematic. Although radical psychiatry has bequeathed to the women's movement 'a vocabulary of protest',\(^{149}\) feminists have criticised it as placing the causes of mental difficulties directly within the family and invariably with the mother. The tendency toward mother-blaming in mainstream psychology is not clearly overcome by radical psychiatry. Laing's schizophrenic voyage has been called a male "heroic fantasy"\(^{150}\) and his case studies described as emanating from a male voyeuristic position. Radical psychiatry challenges the "science" of the dominant paradigm, but fails to consider the practical difficulties of women's lives and the facts and figures that science generates about women.\(^{151}\) For example, some empirical work suggests that women do not typically report being cajoled or coerced into entering hospital by police or medical

\(^{148}\) Laing, *The Politics of Experience*, *supra* note 34 at 95.


\(^{151}\) Showalter, *ibid.* at 231.
authorities and many indicate that they have come to hospital voluntarily. Family responsibilities are a large reason for admission.\textsuperscript{152} "Official" mental health statistics say that more women than men become mentally ill\textsuperscript{153} and that male deviance results in contact with the criminal justice system. This gender difference in the mental health/criminal justice statistics generally fails to consider the role of professionals in diagnosis and treatment.\textsuperscript{154} Doctors, especially psychiatrists have tended to pathologize women and to treat them as child-like,\textsuperscript{155} and the social work view of child neglect tends to be that the mother is immature or has other qualities usually

\textsuperscript{152} However, women did not necessarily reject conventional female roles in the family, but simply wanted a rest from them. They viewed release with some apprehension because returning to the family meant returning to stress. See B. Miedma and J. Stoppard, "Asylum, Bedlam or Cure? Explaining Contradictions in Women's Experiences of Psychiatric Hospitalization" in Stewart et al. (eds.) \textit{The More We Get Together}, supra note 22.

\textsuperscript{153} The ways in which psychiatric knowledge has been organized by men in a particular mode and how that epistemology results in a disservice to women is explained in D.E. Smith, "The Statistics on Mental Illness (What they will not tell us about women and why)" in D. Smith and S. David (eds.) \textit{Women Look at Psychiatry} (Vancouver: Press Gang Publishers, 1975). For other useful theoretical work on the subject of women, mental illness and its patriarchal ideology see Ussher, \textit{Women's Madness: Misogyny or Mental Illness}, supra note 99.

\textsuperscript{154} D. Chunn and R. Menzies, "Gender, Madness and Crime: The Reproduction of Patriarchal and Class Relations in a Psychiatric Court Clinic" (1990) 1 \textit{Journal of Human Justice} 33.

\textsuperscript{155} See Showalter, \textit{The Female Malady}, supra note 151.
attributed to children such as being impulsive, pleasure-seeking or infantile.\textsuperscript{156}

But the dominant discourse in psychology/psychiatry has survived any challenge of critical ideas.\textsuperscript{157} In matters concerning children and motherhood, the impact of radical psychiatry has been minimal, especially in the legal realm of child protection. In my review of judicial decisions in these cases, I found no reference to psychiatric opinion that takes up the ideas I have described as radical, or critical psychiatry. In marshalling evidence for its case to remove a child from a mentally ill mother, the state would be unlikely to seek an expert who gives evidence that is based on assumptions that psychiatry is a form of social control or that bizarre behaviour might be quite sensible. In these circumstances the psychiatric point of view is conveyed as monolithic knowledge unlike the case of private custody disputes where the form of psychiatric opinion may play out as a disagreement among experts.


\textsuperscript{157} P. Chesler, "Twenty Years Since Women and Madness" (1990) 11 The Journal of Mind and Behavior 313.
CHAPTER 4: PSYCHIATRY/PSYCHOLOGY: JUDICIAL DECISION-MAKING IN CHILD PROTECTION PROCEEDINGS

1. General

To this point I have described the ideological basis for the powerful influence of the dominant paradigm in psychiatry and psychology, and the ideas about motherhood, along with the stark power held by mental health personnel. In this system mothers themselves may be convinced that it is best to give up their child without a hearing and the state may be able to remove a child from a mother with a mental health diagnosis without resorting to the court process. Yet some cases do reach the courts where judicial decision-making is a final stage in risk assessment.

My objective in this section is to explore the general tendencies in judicial decision-making in child welfare matters where the mother has a mental health history. Because the cases are usually depicted as fact-specific and therefore disclosing little in general legal principles, I use the cases to demonstrate trends rather than to explicate the law. Specifically I will examine the tendency of judges to accept the underlying tenets of psychology and the elements of the ideology of motherhood that

158 I have not included cases where mental handicap is the issue unless the woman has a dual diagnosis because cases involving mental handicap raise separate issues about such matters as predictability and dangerousness.
I have described earlier in this thesis.

Child protection cases where the mother has a psychiatric disability tend to be decided overwhelmingly against the mother. Predictably these cases are characterized by the court's deference to the views of psychiatrists, psychologists or social work authorities.\textsuperscript{159} The deferential trend is consistent with Isabel Grant's work which points to the general tendency of Canadian courts to adopt a paternalistic model in mental health cases rather than an explicit social control model that characterizes

\textsuperscript{159} There is a strain in American law that explicitly suggests judicial deferral to psychiatrists in mental health cases. In \textit{Parnham v. J.R.} (1979) 442 U.S. 584, 99 S.Ct. 2493, 61 L.Ed. 2d 101, the U.S. Supreme Court restricted the right to procedural due process for children admitted to mental health hospitals and focused on these decisions as "essentially medical". The Court concluded that "the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real" at (442 U.S. 584) 609. See also \textit{Youngberg v. Romero} (1982) 457 U.S. 307 at 321, 102 S. Ct. 2452, 73 L.Ed.2d 28, where the court set an extremely high standard for judicial review of professional decision-making and held that it would be inappropriate "for the courts to specify which of several professionally acceptable choices should have been made." Even more extreme is the decision in \textit{Washington v. Harper} (1990) 494 U.S. 210 where the issue was the non-consensual administration of psychotropic drugs to mentally ill, but competent prisoners. Here the court found that the decision to medicate was probably better made by the medical profession than the judiciary and that due process requires no more than an administrative review by medical decision-makers to override a prisoner's decision not to accept drug therapy. But see also the cases in which a higher standard of due process protection is contemplated where a liberty interest is at stake: \textit{Re Gault} (1967) 387 U.S. 1, 18 L.Ed. 2d 527; \textit{Wyatt v. Stickney} (1971) 325 F. Supp. 781; and \textit{Addington v. Texas} (1979) 441 U.S. 418, 60 L.Ed. 2d 323.
The paternalistic attitude of the courts however, is inevitably connected to the advice of experts who act like legal agents of social control in their roles both before and during the court process. One explicit judicial statement that pronounces a paternalistic model in mental health cases states:

...the objects and purposes of criminal law and mental health legislation are so different that cases in one area will be of little guidance in the other. A protective statute and a penal statute operate in dramatically dissimilar contexts. Strict and narrow criteria for the detention of persons in a criminal law context reflect our society’s notions of fundamental justice for an accused person and protection of the public is a foremost consideration. But in the field of mental health, the same criteria would defeat the purpose of the legislation which is to help seriously mentally ill people in need of protection.

Underlying the paternalistic model is a view that all of the legal actors are seeking a solution in the best interests of the individual. Since there are no competing interests recognized by this model, the sensible approach would seem for judges to defer to those with the greatest expertise, the mental health professionals. The American courts have deferred to psychiatric opinion when an issue is interpreted as peculiar to the mental health context, such as non-consensual treatment order, but may take a "rights" approach on other issues brought by persons labelled mentally ill. Canadian courts

160 I. Grant, "Mental Health Law", supra note 60.

161 McCorkell, supra note 58.
have taken a similar view.\footnote{162} Grant points out for example, that psychiatric patients have generally lost their Charter challenges, but the few successful Charter challenges are cases where the court can analogize to some more familiar principle of law such as principles of administrative law or employment law.\footnote{163} That is, the court can view the case, not as a "mental health" case where psychiatric and psychological knowledge may be more significant but as a question of "statutory interpretation" or "fairness" where judicial knowledge is more immediately and obviously pertinent.

I argue that the courts adopt a paternalistic model in deciding child protection cases as they do in deciding mental health cases. Just as there are no competing interests recognized by a paternalistic model in deciding mental health cases, there is seen to be a common interest among the legal actors in a child protection proceeding, that is the welfare of the child. For similar reasons judges tend to defer to the opinions of psychiatrists when the issues are defined as specific to the child protection context such as mental health or child development questions. A "rights" approach may be more likely if the issue is defined outside the specific child welfare context and judges can analogize to some other area of law where psychiatric knowledge is not seen as

\footnote{162} \textit{Fleming v. Reid} (1991), 82 D.L.R. (4th) 298 is a notable exception in which the Ontario Court of Appeal held that it was unconstitutional for the review board to make treatment decisions on the basis of a person's "best interest" rather than the position expressed by the person while competent.

superior.

The background to this analysis was a review of 128 Canadian child protection decisions decided since 1980 where the mental health of the mother was an issue. The number of cases on which this analysis is based is a sample of 61 decisions. While the sample is not large enough to perform statistical analysis, the numbers are sufficient to suggest trends. Cases originally reviewed were not subject to further analysis either when the decision was too brief to analyze the issues, or where the case was framed around a principle that was unrelated to the mother’s mental health. Cases were gathered through standard library research and through computer-generated searches. The sample contained cases from each of the provincial jurisdictions in Canada except Quebec and consisted of both unreported and reported cases.

An example of a case that was rejected because of brevity is *Child and Family Services of Central Winnipeg v. Poiron* [1989] M.J. No 651 (Man. C.A.) where the actual reasoning of the judgement was five lines long. An example of a case that was rejected because the issue of the case was completely separate from the mother’s mental health was *Catholic Children’s Aid Society of Metropolitan Toronto v. C.M.* (1991), 37 R.F.L. 202 (Ont. Ct. of Justice (Gen. Div.)) where the issue was around the appointment of counsel for the child and the child’s instructions to counsel.

Cases were not reviewed from Quebec simply because I am not fluent in French. Not all unreported judgements are available on computer data bases. I would speculate that many of these cases are short paper judgements at the Registry which are never picked up by the data base.
Of these cases, very few reach the provincial Courts of Appeal\textsuperscript{166} and most cases are unreported.\textsuperscript{167} Access to lawyers has historically been a matter of economic privilege and poor people have not exercised their rights of appeal in legal matters. Despite the existence of legal aid, there are still few appellate decisions on any welfare matter. The low number of reported cases in this sample probably indicates that the people who decide which cases to report view these cases as fact-specific and not reflecting any important general legal principles.

Of the 61 judicial decisions in child protection matters, disclosure of psychiatric records was the central issue in 14 cases and the court ordered disclosure in 11 of these 14 cases. I have discussed the records cases earlier in Chapter 2 and have defined the remaining 47 cases as "unsuccessful" or "successful" on the basis of the custody disposition at the end of the hearing. For the purpose of this analysis a case is defined as "unsuccessful" when the mother loses custody of her child at the conclusion of the hearing. "Successful" cases are decisions that result in the mother retaining custody or re-gaining custody of her child at the conclusion of the

\textsuperscript{166} 3 cases or slightly less than 5% of 61 cases.

\textsuperscript{167} Of the sample, 40 cases or almost 66% were unreported. I think that the number of reported cases in this sample is inflated because I did not contact Court Registries directly to obtain judgements that would not be picked up by computer data bases.
2. Unsuccessful Cases

In deciding these cases, judges are almost always presented with the evidence of mental health professionals about both the mother and the child. The particular opinions sought from the psychiatrist are usually how long the mother's problem is likely to last, how independent the mother can be as a parent and the degree of support that she would require.\textsuperscript{169} Inherent in such evidence are the postulates that inform psychiatric research and practice discussed in Chapter 3: a focus on the individual, the objectivity of (social) science, confidence in assessment, the predictive value of diagnosis and the unreliability of lay observations of human behaviour. By accepting psychiatric evidence without serious scrutiny of the underlying assumptions and basic research leading to conclusions by psychiatrists and psychologists, the courts tend to remove children from mothers with mental health histories on the basis of psychiatric

\textsuperscript{168} In this sample, 29 of the 47 cases were unsuccessful, 10 of the cases were successful and 8 could not be categorized. Of the 10 successful cases, the mother retained or re-gained custody without conditions in only one case.

opinion that is not tested in the same ways as other expert evidence.\textsuperscript{170}

Psychiatric opinions of what is in the best interests of the child are strikingly grounded in a medical model of mental disorder. Since judges seem to accept the general premise that psychiatrists know best what choices people with psychiatric diagnoses ought to make, the courts accept the medical model. The "right" choice for people with mental illnesses is to do what the psychiatrist has recommended. As a consequence, mothers with psychiatric diagnoses do poorly in court when mental health professionals report that the women have refused to accept their advice. In \textit{P.E.I. v. H(D)m}\textsuperscript{171} for example, the Court was especially concerned that the mother had missed a number of counselling appointments and had terminated counselling although the counsellor thought that counselling should continue. Courts are far more

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\textsuperscript{170} Courts have traditionally been reluctant to allow expert opinion on the "ultimate issue". The reason given is a concern that the allowing such evidence would usurp the function of the trier of fact. Courts continue to be reluctant to admit this evidence in that the closer the opinion gets to the ultimate issue, the more likely it will be rejected. The "ultimate issue" phraseology is no longer really used but the reasoning is generally the same. The evidence will be rejected if the trier of fact does not need assistance in reaching a conclusion on the point in question [which will generally be the case with the 'ultimate issue']. \textit{R. v. Graat} (1980), 55 C.C.C. (2d) 429, 17 C.R. (3d) 55, 30 C.R. (2d) 247, 7 M.V.R. 163, 116 D.L.R. 143 (C.A.) aff'd [1982] 2 S.C.R. 819, 2 C.C.C. (3d) 365, 3 C.R. (3d) 289, 18 M.V.R. 284, 144 D.L.R. (3d) 267, 45 N.R. 451. The insanity defence is an exception to this pattern where courts almost always rely on psychiatrists on the ultimate issue.

\textsuperscript{171} \textit{Supra} note 132.
\end{flushleft}
persuaded by a psychiatric view that treatment is needed than by a mother’s view that it is not. The medical model of mental illness is also clearly reflected in the decisions by the emphasis on drug therapy. Refusing to take medication is frequently mentioned in the reasons for the state to permanently remove a child, as is a mother’s “resistance” to treatment. In W. (C.A.) although the court recognized a mother’s right to refuse psychotropic medication, it decided that the refusal deemed her incapable of caring for a child. An identical concern about medication is very frequently the focus of hearings about releasing involuntary patients under mental health legislation.

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175 See: Hoskins v. Hislop, supra note 58 where the intention to discontinue medication was a primary consideration in the decision not to release. This is certainly consistent with my experience in representing people at tribunals.
An especially ironical situation is demonstrated in the case of *L. (K.)*\textsuperscript{176} Here a mother diagnosed as a manic depressive was advised by her psychiatrist to discontinue lithium treatments during her pregnancy because the drug could harm the fetus. She stopped taking the drug while she was pregnant and consequently developed symptoms of shakiness and mood swings after the birth of the child. Because of these symptoms the psychiatrist recommended the child be placed in care until the mother's condition could be stabilized. Without any objection from the mother, the child was apprehended and found in need of protection. The mother consented to the child remaining in care awaiting the expected stabilization. Eventually, the mother withdrew her consent and a hearing was required to decide the question of whether the child was in need of protection and if so, what was in the child's best interests. The court decided that there was no need to make a fresh finding that the child was in need of protection and that it was in the child's best interests to be permanently apprehended in order to be adopted. Here the mother had followed her psychiatrist's advice precisely concerning medication. She also cooperated fully with the legal process. Regardless of the fact that the mother cooperated with psychiatric officials, she lost her child. If she had not cooperated with her doctors and continued to take lithium during pregnancy or had objected to the child being in care while she stabilized, one would expect exactly the same result.

Although the issue of child welfare is obviously intertwined with the fitness of the custodial parent, the courts tend to re-orient these cases remarkably easily to make the central question the mother's mental health diagnosis. Exactly how a mother's diagnosis relates to a child's best interests is largely unexamined by the court. Regardless, the question in the hearing may become the mother's mental health rather than the child's best interests. Often applications for a mother's mental health records are made in child welfare cases without any argument as to how the records would answer the best interests question. In *C.L.M.*\(^{177}\) the court ordered psychiatric disclosure of a mother's records because it was "essential in the interests of justice."

The Crown wardship application involved an application that the mother was unfit because of schizophrenia. The court found that psychiatric disclosure is essential when:

"(1) The patient's psychiatric state is the main issue being litigated and;

(2) That issue cannot be determined through other evidence adduced."(emphasis added)

Besides generally accepting the medical model of mental illness, courts rely on the specific assumptions of the psychological paradigm. Judges accept the predictive value

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\(^{177}\) In *Re: C.L.M.* (1982), 29 R.F.L. (2d) 460 (Ont.Prov.Ct.(Fam.Div.,)) Note this case is used to demonstrate the point here although it is included in the discussion in Chapter 2 of patterns in records cases. It is categorized as one of the 14 records cases.
of psychiatric diagnosis in child protection proceedings without seriously analyzing the assessment that led to the diagnosis and despite the existing evidence that psychiatrists are poor assessors of risk.\textsuperscript{178} Not only is the psychiatric diagnosis of the mother accepted relatively easily by the courts, children are assessed, labelled and linked to the mother’s label. In \textit{W. (C.A.)}\textsuperscript{179} the mother’s diagnosis of personality disorder was linked to the assessment of learning disabilities in her children, thereby blaming the pathologically labelled mother for her children’s label of pathology.

The psychiatric diagnosis itself often serves as the pivotal point of the decision, even when the behaviour that led to psychiatric involvement in the woman’s life has disappeared. Repeated apprehensions of a child or apprehensions of children born later occur because of a lingering psychiatric label. In \textit{N.B. v. C.(N)}\textsuperscript{180} a woman’s paranoid delusions resulted in apprehension of two of her children shortly after their births. After her third child was born, this child too was permanently removed although this mother demonstrated no psychiatric symptoms at this time and the diagnosis had changed from paranoid schizophrenia to schizoid personality disorder,

\begin{itemize}
  \item \textsuperscript{178} See \textit{supra} note 103.
  \item \textsuperscript{179} \textit{Supra} note 173.
  \item \textsuperscript{180} \textit{Supra} note 173.
\end{itemize}
considered a less severe condition. However, the psychiatric expert said that the mother's symptoms were "lurking just below the surface" and this led to the permanent removal of the child. In addition to accepting the "truth" value of psychological prediction and assessment of an individual, judges are influenced by the psychological idea of the "iceberg" nature of personality, that a person's motives, and potential behaviour may be hidden behind a seemingly harmless exterior, especially in persons who are mentally ill.

According to the standard rules about opinion evidence, expert evidence is only necessary if the opinion tells the court something it would not otherwise know. In these circumstances it is only helpful to the court in making a decision if a diagnosis can lead to more accurate predictions about a mother's future behaviour. In *P.E.I v. H(D.)* the medical diagnosis of "borderline personality disorder" for example, meant that the mother had "difficulty dealing with the problems of day-to-day life," "appears impulsive" and "unable to establish priorities." While not stated in the case, this diagnosis is situated in a taxonomy or classification scheme shared by the psychiatric establishment. Borderline personality disorder is not considered

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181 See Rosenhan, "On Being Sane in Insane Places" *supra* note 97.

182 *Supra* note 132.

183 S. Kaysen, *Girl Interrupted* (New York: Turtle Bay Books, 1993) gives an account of her own hospitalization and treatment for mental illness. She discovered with the help of a lawyer to obtain her hospital records that she was
particularly amenable to therapy. As a result, the psychiatric prediction is that this woman is not likely to change. However, the judgement discloses no attempt to test the evidence or its context. For example, there is no indication of the basis of the assessment, no questioning about the research indicating that therapy is unlikely to work, and no empirical research to link the diagnosis to more general conclusions. In short, the more standard techniques of testing evidence in court or testing the basis of expert opinion seem not to be used in these circumstances. Regardless, judges seem willing to accept psychiatric opinion as superior knowledge in these cases.

2. The "Successful" Cases

While mothers with mental health histories lose in the majority of cases, it is useful to look closely at the nature of the "success" in the relatively few cases where the

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diagnosed as having a Borderline Personality. She needed to find a copy of the Diagnostic and Statistical Manual of Mental Disorders to "see what they really thought of me." She writes at 150 - 151:

What does borderline personality mean anyhow? It appears to be a way station between neurosis and psychosis: a fractured but not disassembled psyche. Though to quote my post-Melvin psychiatrist: 'It's what they call people whose lifestyles bother them.'

He can say that because he's a doctor. If I said it, nobody would believe me.
court decides in favour of the mother. Despite the apparent victories, these decisions reveal two important themes that point to the overarching influence of the psychological view in the judicial process. First, these decisions indicate a tendency to disagree with psychological or psychiatric evidence in limited circumstances, these being only when the child protection authorities have demonstrated flagrant disregard for the required process. Secondly, judges are extremely reluctant to decide the question without arranging for an ongoing watchful eye of the psychiatrist or psychologist to attend the mother and/or child.

In *J.P.*184 the mother had a vaguely described mental disability that suggested aspects of mental handicap and mental disorder. The British Columbia Court of Appeal quashed an order awarding permanent custody to the Superintendent because the statute required the court to consider whether the condition was likely to be remedied.185 The appellate court was not satisfied that the lower court had before it an appropriate assessment to make the determination according to the statutory requirement. In quashing the order, the court invited the Superintendent to request a deemed apprehension of the child so that proceedings could begin again.

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184 *Supra* note 170.

In *Children’s Aid Society of Hamilton-Wentworth v. M.M.*\(^{186}\), a two year old child was apprehended on the basis of rather vague allegations of anticipated abuse. This case is somewhat exceptional in that the court examined the values underlying the psychological assessment. The mother was young, with a tendency to alcoholic binges. There were questions about her intellectual abilities and hints of mental health issues. Psychologists were called by both the CAS and the mother, and each gave evidence of their assessments of both the mother and the child. Here the court describes a number of serious irregularities of process in this case. There was no indication that the mother was informed of her right to counsel at the beginning of the proceeding. The case took 24 months to come to trial, a delay that was primarily the fault of the CAS.\(^{187}\) A further statutory breach occurred because CAS service providers did not ensure that the interests of the parents were represented at meetings where important decisions were made about their child. In considering the psychological evidence, the


\(^{187}\) *Ibid.* Judge Beckett was clear that the delay was attributable to the authorities:

Delays in cases of this type are rarely in the best interests of the child or the family and almost always have an extremely serious deleterious effect on the child and the family. Certainly that is so in this case. It is not necessarily my function in this case to analyze the reasons why this case has taken so long to come to trial. The Unified Family Court and its system must bear part of the responsibility. However, the CAS had carriage of the case and the best interests of the child required the Society to move the case forward with dispatch. Certainly the CAS must bear the primary responsibility for the unconscionable period of time that has elapsed from apprehension to trial.
court decided that the main allegations about the mother reflected middle class biases and were insufficient to make a wardship order.

As a matter of principle and social policy, family integrity should be maintained wherever it is reasonably possible. As I have already indicated, much of the criticism made with respect to M. seems to have been made from the perspective of middle class values without sensitivity to the fact that Marsha, as do thousands of others, lives in what for her has been perpetual poverty and deprivation. Added to this is her unfortunate cognitive disability. However, we have not reached the day, in our society when being poor or homeless or unintelligent or unemployed can be viewed as a reason to send a child for adoption in a so-called normal, middle-class home. It may be argued that the child would be better off in a more affluent, socially-acceptable home. That is not the test. 188

The Court ordered that the child be returned to the mother but with certain important conditions, almost all of which necessitated a continuing relationship between this mother and child and mental health professionals. These conditions included that the CAS supervise the case for twelve months; the CAS provide assistance in finding subsidized housing and necessary furniture; the child be enrolled in a daycare program, preferably a therapeutic daycare program where the mother could participate; the child be examined monthly by the family doctor and these reports be sent to the CAS and the mother; and the mother arrange counselling for her own problems and any deficiencies in parenting.189

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Ibid.

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Other conditions were that no third party reside with her without the written consent of the CAS and the child not to be left alone with certain male family members.
In *Children's Aid Society of London (City) and Middlesex (County) v. H. (T.)*, a Crown expert gained access to a mother's psychiatric records despite the fact that the mother had refused consent. The Children's Aid Society secured the records for this purpose by obtaining consent from the grandmother who had interim custody of the child and the CAS expert completed his report for trial with this information included. The mother successfully applied to exclude all of the evidence of this expert. The court was struck with "the flagrant and wilful breach of T.H.'s rights" and viewed "as of cardinal importance the protection of privacy of individuals such as T.H., who enter into a treatment facility for assistance to allow themselves to be questioned and assessed." The Court admonished counsel for the CAS further because "the striking aspect of this fact situation is the number of other techniques available to the Society to have obtained the same information about T.H. in an entirely legitimate way."

The first theme of the "successful" cases is that courts tend to decide in favour of the mother, not usually on the grounds of merit, but because the state authorities showed

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191 CAS obtained a release from the mother for her psychiatric records, but the mother did not consent for these records to be used in a psychological assessment.

192 But see *infra* note 195.
flagrant disregard for procedure. Where mothers have a mental health history the courts tend to seize on dramatic procedural or technical irregularities that have occurred in the child protection process much as they have in the Charter challenges in child protection matters generally.\textsuperscript{193} Although the courts give child protection authorities considerable latitude in their practice,\textsuperscript{194} these cases represent situations

\begin{quote}

Two of the three successful Charter challenges in child protection law were decided primarily on procedural issues: first, imposing a 12 month inflexible time limit for temporary custody was arbitrary and violated the rights of the child under section 7 of the Charter and was not saved under section 1.\textit{(See R.A.J. (Re) [1992] Y.J. No.126. The provision was not stuck down, but the court merely exempted the application of the section to the child in question.)} Second, authorizing warrantless searches without restriction for children in need of protection was too general and authorized searches too often. Section 15(1) of the \textit{Family and Child Services Act} R.S.P.E.I. 1974, c.F-2.0) was found to contravene section 8 of the Charter and was held to be of no force and effect (See \textit{M. (H.) v. Director of Child Welfare for Prince Edward Island} (1989), 22 R.F.L.(3d) 399, 79 Nfld. & P.E.I.R. 274, 246 A.P.R. 274 (P.E.I.S.C.(T.D.))

In \textit{Re: C.P.L.} (1988) 215 A.P.R. 287, 70 Nfld. & P.E.I.R. 257 (Nfld.U.F.C.), the only Charter decision that has been decided on substantive issues, the court held that the lack of notice of apprehension and granting consent to medical treatment without consultation with the parents deprived the baby of its right to liberty and security of the person. Here the court was appalled, not by a disregard for procedure, but by the procedures themselves:

As can be seen from the evidence in this case total control is left in the hands of a medical practitioner. All he need do is call the Director or somebody who is a social worker and request that consent be given for treatment of a child. The consent may be given without further consultation....This effectively keeps the parents out of the picture. In this case it was not what was actually done but how it was done, which was the denial of the child’s rights.

See for example \textit{Re: Clarke Institute of Psychiatry and Catholic Children’s Aid}
where it appears to the judge that a critical line has been crossed, that the authorities have gone "out of bounds" and the judge must exercise judicial responsibility to avoid a public perception that:

the state agency could act, unguoverned by law, to obtain evidence against a respondent in a child protection trial and that, although the legislature can impose rules to protect people, those rules could be completely disregarded by an applicant Society in the prosecution of its case. I think a reasonable individual would be stunned by the prospect.195

A dramatic example is the case of Re Pamela M..196 The Court ordered costs against the Society although such an order is acknowledged to be very unusual in custody matters "at least where there has been good faith on the part of the contestants" and even more "delicate" when one party is mandated by statute to protect children. Here the Court found that the actions of the agency constituted exceptional circumstances

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Society of Metropolitan Toronto (1981), 31 O.R. (2d) 486 (H.C.) where the mother who was a patient in a psychiatric facility and her child was apprehended shortly after birth. Her mental health records were subpoenaed under the child welfare legislation although the process to release psychiatric records as outlined under the Mental Health Act was not exhausted. The authorities characterized their application as urgent in order to complete a quick investigation of child abuse under the Child Welfare Act because of the "adoptability" of a ten month old baby. The court found that although it "may have been preferable to complete the process contemplated by the Mental Health Act, application by the Society under the Child Welfare Act does not amount to an abuse of process."

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Supra note 187 at 195.

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Re: Catholic Children's Aid Society and Pamela M. (1982), 36 O.R. (2d) 462 (Ontario Provincial Court (Family Division)).
because not only was the original decision to apprehend "a questionable exercise of state power but the conduct of the case thereafter is noteworthy as well." The Court commented on the "feeble attempt" by the social worker to make important contacts prior to the apprehension. Of great concern to the court was the Society's apparent manipulation of the court process. Despite court orders to the contrary, the Society retained custody of the child throughout the proceedings. At the initial hearing, a judge who was well-acquainted with the family decided after three days of hearing that the original apprehension was not justified and the child should be returned home. In response, the Society appealed the decision and moved to stay the order and filed:

a rather selective and biased representation of the facts and in the context of the whole of the evidence it is misleading as to the nature of the risks to Pamela.\(^\text{197}\)

The Society never proceeded with the appeal of the order and the trial was commenced. With one witness remaining, the trial judge anticipated the child's return home, made an access order for the mother to accelerate the proceedings and prepare for the child's return. The Society did not comply with the access order and appealed it but did not proceed with the appeal. In final argument, counsel for the Society informed the court that it intended to proceed the way it had throughout the process, that is to file an appeal of the decision and to keep the child in care pending the outcome. At the conclusion of the trial the evidence was essentially the same as it was at the initial presentation hearing.

\(^{197}\) \textit{Ibid.} at 463.
The second theme that characterizes the "successes" in these cases is judges' tendencies to turn back the important matters in this area to the realm of psychiatry and psychology. In these circumstances, mothers have definitely not been deemed fit by the court, but are simply diverted to a different system which is likely to have more complicated dynamics for these women than the judicial system. Whereas a woman's experience with the courts is finite (although these experiences may certainly be repeated), her connection to the mental health system and related agencies is ongoing and perhaps permanent. The resulting "victory" for women is a judicial endorsement of the need for psychiatry to monitor them as mothers and a prescriptive mandate for monitoring to continue. Implicit in this trend is a message to a woman that she must conform to the ideology of motherhood as incorporated in psychiatry or psychology to retain her privilege as a mother or face further process to remove her as the guardian/custodian of her child.

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198 The important point in these cases is that the court tends to impose an order to explicitly involve the mental health professionals. It is actually quite common that the return of children in child protection proceedings is accompanied by an order requiring continuing state involvement.

199 See M. Molloy, "Citizenship, Property and Bodies: Discourses on Gender and the Inter-War Labour Government in New Zealand" (1992) 1 Gender and History 301.
For example, the pivotal issue in *J.P.*\(^{200}\) is assessment, one of the basic premises of the psychiatric paradigm. Although the British Columbia Court of Appeal overturned the trial decision on a point of law, the court said that the trial judge did not have proper psychological evidence, or enough of it to make a permanent order. In its suggestion that the authorities could immediately re-apprehend the child to begin the process anew, the court gives a clear message that an appropriately comprehensive assessment could well be sufficient. In *CAS of Hamilton-Wentworth v. M.M.*\(^{201}\) there is considerable language acknowledging the value-laden ideals of motherhood and the order returns the child to the mother. However, the court coincidentally returns the mother to the control and surveillance of psychologists and psychiatrists. In short, these cases conclude with orders where the authorities are directed to provide better and further assessment or the mother is ordered to comply with conditions subjecting her to further psychiatric scrutiny so that the appropriate part of the taxonomy of pathology may be invoked, after which the court may comfortably make its decision.\(^{202}\)

\(^{200}\) *Supra* note 170.

\(^{201}\) *Supra* note 187.

\(^{202}\) An incidental but potentially important consequence of an approach where the court requires more and better psychiatric/psychological evidence is the effect on the mental health system itself. Although I argue here that returning child protection questions to psychiatrists and psychologists makes the mother a further captive of the mental health system, it also puts the system on notice that it must be accountable, even if only on its own terms.
Taken together, these two themes of the "successful" cases represent a tacit division of responsibility between judges and psychologists/psychiatrists in child protection matters where a mother has a psychiatric label. Psychiatrists and psychologists are in charge of the substance of the matter while the judge is to monitor the process, especially any serious abuses of the process.

Drawing on Grant's argument that the courts are more likely to act independently when a mental health matter can be characterized as involving some other legal principle, the question here is problematic for the courts because the most important issues all seem peculiar to the hybrid mental health-child protection proceeding and demand psychological answers rather than answers from law. The specific questions reduce to the stability of the mother and the intellectual/social/emotional development of the child. Occasionally however, the issue in a child protection matter may be constructed outside this frame, most commonly as a question about procedure. If the authorities have ignored or sabotaged required procedures, the legal issues resemble questions of natural justice or contempt. In these cases the courts will be more comfortable in disagreeing with psychiatrists/psychologists because they are confronted with issues analogous to more familiar areas of law. However, this level of comfort rarely extends to releasing the mother/child from additional involvement with the "helping" professions. The inferences regarding credibility normally applied to non-

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203 The tendency of Canadian courts to adopt a paternalistic model and defer to "experts" I. Grant, "Mental Health Law", supra note 60.
expert witnesses are not applied here. That is, the flagrant abuse of known process by these professionals is not used to question the diagnoses offered in their evidence.

Women with mental health histories who are also involved in the child protection system are inundated by mental health and other social welfare professionals. Since these persons are deemed experts and so personally involved with the woman, and their opinions are derived from a set of beliefs that are hegemonic in our society, the woman may well decide that the best thing she can do for her child is to sacrifice him/her. Therefore, it is not surprising that there are so few formal decisions in these cases. Besides, when she gets to court she is likely to confront a formal legality that has already appropriated other methods of social control, well-entrenched in the woman's life. She is not likely to be surprised that:

In the past the guidelines have been based on common knowledge and experience; today courts are beginning to apply principles based on research in psychology, the social sciences and medicine.\(^204\)


The purpose of this chapter is to analyze the ways that two alternate legal standards may effect mothers with mental health histories: the best interests of the child and the presumption of the primary caregiver. The current central concept in judicial decision-making in child welfare law is the best interests of the child. The power of this idea comes from believing that judges can impose this test in a fair, benevolent way. Despite the fact that this test purports to impose a general standard, the test has a differential impact on various families and mothers.

Feminists have suggested the presumption of the primary caregiver as an alternative to the false idea that the "best interests" test is a neutral standard that can be applied in an even manner in custody disputes regardless of such variables as the nature of the family unit, cultural context and social location of the mother. This strategy has been developed in the context of private custody matters where two parents demonstrate their histories of caring for a child. Arguably, the question of the primary caregiver is irrelevant to contests between mothers and the state about her fitness. My concern is that the presumption of the primary caregiver presents an image and a standard that bolsters the ideology of motherhood and the concomitant psychological precepts. Because the image of the primary caregiver is consistent with the existing ideologies in child welfare law, it is an image that is easily transferred from the private custody
context to the child welfare domain. A mother who does not fit the newly advanced image of the primary caregiver may be viewed as even more of a risk to her children according to the new test. The impact is especially negative for women with disabilities because their disability may disqualify them as primary caregivers.

1. The Best Interests Test, Expertise and Credibility

The leading decision on the best interests test creates considerable space for the special status of psychology/psychiatry. Because the best interests test requires that decisions be made on individual situations, it appears to acknowledge that what might be best for one child in all of the circumstances may not be best for another in all of those circumstances. According to King v. Low the best interests of the child are not restricted to economic circumstances, but should consider all other relevant factors such as general psychological, spiritual, and emotional factors. The court is to choose the alternative that will best equip the child to be a "mature adult," yet another

However, what is in the best interest of the child is clearly based on social definitions. The individualistic interest that forms the basis of the best interest test has been criticized as ignoring a collective or community interest, most notably in the way that best interest test has been applied in the apprehension of First Nations children who are then fostered by or adopted out to white families. See for example: Kline, "Best Interests" supra note 31 and P. Monture, "A Vicious Circle: Child Welfare and the First Nations" (1989) 3 Canadian Journal of Women and the Law 1. Woods v. Racine, supra note 43 states that bonding is more important than cultural heritage.

Supra note 43.
malleable concept. While the list of factors in *King v. Low* clarifies that the best interests of the child is not to be determined on exclusively materialistic grounds, the list is not of great assistance because of its level of generality. But the expansion of an already malleable conception of the child's best interests promotes greater reliance on psychological and psychiatric opinion to determine the questions. Because psychiatrists and psychologists are viewed as the most important experts in child development and mental health matters, judicial deference to psychiatric opinion on the ultimate question may seem consistent with the meaning of best interests.

In determinations of best interests questions, women with mental health histories are not likely to be believed. With the special role ascribed to psychologists and psychiatrists, women face a particularly difficult problem advancing their own credibility. The existence of a psychiatric diagnosis or mental health history is used often to discredit women.\(^{207}\) When the evidence of a psychiatrist or psychologist conflicts with the evidence of a mother who has been diagnosed as mentally ill in a child protection proceeding, there is really no contest.\(^{208}\) Any suspiciousness a woman might express about the helping professionals in her life is frequently

\(^{207}\) Anita Hill's alleged psychiatric disorders were raised to discredit her testimony on sexual harassment in the Hill/Thomas case. See Perlin, "On Sanism", *supra* note 29.

\(^{208}\) There is an unequal relationship between psychiatrists/psychologists and the people they assess/treat generally. Men too are subject as assessees to the differences in power and class from the assessors.
interpreted as further indications of the paranoia that characterizes her mental illness. Similarly, what might otherwise be considered an intensely "motherly" comment may be considered further evidence of irrationality and unfitness in the context of a psychiatric diagnosis. In *H. (D.)*, for example, the mother's evidence was interpreted through the lens of a psychiatric diagnosis rather than heard as the expression of any number of mothers who might describe their feelings:

She further stated that she would kill herself if she lost F., she had nothing else to live for. She considers suicide to be a rational act on her part because "F" is her life.

Even when a judge hears evidence from a mother who has been labelled mentally disordered and the evidence seems to indicate that she would be fit, the hegemony of psychology/psychiatry in our culture suggests that what you hear or see from a person who is mentally disordered, is not the whole picture. In *Children's Aid Society of Niagara Region v. W. (C.A.)* the mother gave evidence over the better part of three days, and clearly impressed the judge, "had a wide vocabulary and was well-able

In my experience as a mental health lawyer representing people at civil commitment hearings, persons who express distrust of their "treatment team" are likely to be labelled as even more "paranoid".

*Supra* note 132.


*Supra* note 173.
to express herself," "handled the strain very well", and rejected drug therapy although she would accept other help. Nevertheless, her evidence that she was depressed because of separation from her child was outrightly rejected by the trial judge who preferred the evidence of the expert psychiatrist and psychologist. They said that her condition was not situationally determined but indicated symptoms of an underlying mental disorder.

In the rare cases that a particular mental health professional confirms the mother's evidence to the court, but the state's evidence is that she is unfit, the court may make some effort to integrate this mental health professional's view with the overall state psychiatric evidence. In *New Brunswick (Minister of Health and Community Services) v. N.J.C.* 213 a newborn child was apprehended from a mother who had been diagnosed as paranoid schizophrenic. The psychiatrists who gave evidence for the Minister had not had any contact with the mother for more than four years before the hearing but said the mother's underlying condition was irreversible although her symptoms could be treated with medication. A psychiatrist who gave evidence for the mother had been summoned to the hospital immediately after the birth.214 As well, this psychiatrist had seen the mother recently after she left hospital. Although the evidence of this psychiatrist evidence included recognition of some suspicious and

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213 *Supra* note 173.

214 The decision gave no indication of why the psychiatrist was called.
histrionic behaviours, and some reluctance of the mother to accept help, the psychiatrist stated "....the nurse informed me that the patient had shown no abuse or neglect of her baby, but on the contrary was loving and protective of her and was nursing the child". When this witness was asked directly about the mother’s capacity to care for the child, she answered:

Well, I don’t think she has ever been given the chance to show what her capability is from my understanding because all her children have been taken into custody. So I really am not-don’t have any knowledge of what her capability would be...  

The court took this evidence as confirming the "somewhat stale evidence" of the psychiatrists who gave evidence for the Minister and granted a permanent order of custody to the Minister.

Unlike the more typical situation where judges make decisions about events that have already occurred, judges in a protection proceeding are faced with a situation where they are obliged to make a decision that looks to the future in which the task is to assess present risk and prevent future harm. In this process "mental disorder" becomes a master status and all other characteristics or attributes are subsumed. These decisions are about what is likely to happen to a child given the child’s current development and the likely course of a mother’s mental health. In order to properly understand the

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215 Supra note 173.
significance of a mentally disordered person’s evidence and to place that evidence in an appropriate prognostic framework with a view to the child’s future, the court relies on the psychiatrist or psychologist. These are experts who can officially look beyond an unremarkable exterior.

Psychiatrists, after all, are medical men, trained to search for the pathology—the dark lesions, the hidden microbial spores— which lie under the healthiest exterior. As they peered into the rosy picture of the mother–child relationship with the X-ray vision of psychoanalytic insight, a core of hideous pathology revealed itself and came to dominate mid-twentieth century child-raising theory. (emphasis added)

Making psychiatrists and psychologists the official "interpreters" of the woman’s evidence in the courtroom-re-visits, and further complicates, the issue of the subjectivity of motherhood. Not only is psychiatrically/psychologically defined pathology a problem because it constitutes a defined self-interest that must be eliminated for good mothering to be possible, but the meaning and significance of the interest must be communicated to the court by an intermediary. The woman is disallowed from legitimately expressing her own point of view, precisely because of the psychiatric construction of her point of view as pathological. Often the central feature of her diagnosis is "lack of insight." It follows that the mental health professionals responsible for the diagnosis have the requisite insight to describe the

216 Ehrenreich and English, Own Good, supra note 14 at 203.
woman's subjectivity.\textsuperscript{217} The mental health professional then is the legitimate source to tell the court what a woman is really thinking and feeling and its significance, especially if the woman conveys a different version of her own reality. It is difficult to imagine a situation that is more totally silencing. Clearly the best interests test operates in very specific ways and negative ways for women with mental health histories. In the next section I argue that the feminist alternative of the presumption of the primary caregiver may be equally problematic.

2. Presumption of the Primary Caregiver

The presumption of the primary caregiver is a specific suggestion that provides an advantage to the parent who presents better evidence of the history of caring for a

child in contests between private parties. In *Garska v. McCoy*, West Virginia became the first state to adopt the primary caregiver as the sole determinant in custody disputes involving children of tender years and the case includes an extensive list of factors that comprise the test. The critical caveat is that the primary caregiver must be found to be "fit" by the court.

From the perspective of the judiciary, the promise offered by the presumption of the primary caregiver is to provide a more certain standard than the best interests test as well as avoiding protracted expert evidence at trial. As well, the presumption ensures that the relationship between the child and the person who has been the primary caregiver will not be severed. To feminists, the goal of the presumption is to establish a test in custody matters that does not disadvantage women. Recent trends in custody matters such as preferences for joint custody, the "best interests test" and the "friendly

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219 The "caring" and "nurturing" duties that the trial court must determine include *inter alia*: (1) preparing and planning of meals; (2) bathing grooming and dressing; (3) purchasing, cleaning and care of clothes; (4) medical care, including nursing and trips to physicians; (5) arranging for social interaction among peers after school i.e. transporting to friends' houses or, for example to girl or boy scout meetings (6) arranging alternate care i.e. babysitting, daycare etc. (7) putting child to bed at night, attending to child in the middle of the night, waking child in the morning; (8) disciplining, i.e. teaching general manners and toilet training; (9) educating, i.e. religious, cultural, social, etc; and (10) teaching elementary skills, i.e. reading, writing and arithmetic."
parent rule have all been problematic for women.

So far, the presumption of the primary caregiver has been raised in private custody disputes in the context of a privileged and inherently heterosexist nuclear family form. Clearly, the presumption of the primary caregiver is not directly applicable in child protection matters because there are not two private parties who will demonstrate differing care histories of a child. Despite the differences in a dispute between private parties and a dispute with the state however, I argue that the thinking behind this concept may increase the difficulties women with mental health histories face in their cases with the state around questions of their fitness as mothers. My concern is that the image of the primary caregiver will spill over into the ideology of motherhood in influencing child protection decisions. That is the "constantly attentive-always responsible" aspects of the ideology of motherhood will be reinforced by advocating the primary caregiver assumption.

Three facts are important in tracing how the idea of the presumption of the primary

\[ \text{The Divorce Act, in sections 16(10) and 17(9) specifies that the court is to take into account whether the parent is willing to facilitate contact with the other. The premise is that it is in the best interest of the child to have contact with both parents. One major criticism of this rule is that it imperils women and children who have been the victims of father's violence. See J. Zorza, "'Friendly Parent' Provisions in Custody Determinations" (1992) 28 Clearinghouse Review 921.} \]
caretaker evolved. First, most mothers now work outside the home. Second, the increasing number of mothers in the paid labour force has not changed the fact that women remain primarily responsible for the care of children. Finally, judges have begun to assume incorrectly, a new reality of domestic equality in caring for children because more mothers work outside the home. Therefore, the idealized naturalized view of mothering now exists without serious attention to what is involved in caring, our ideas about caring and the gendered division of labour in our society. The gendered division of labour in our society usually means that the mother is the primary caregiver and often the only caregiver to children, although she most often also works outside the home.

Besides the misconceptions about who is doing what in parenting, the literature on the complexities of parenting complicates matters further by dividing caring functions (albeit artificially), into two categories: physical labour and nurturing functions.

221 According to Statistics Canada, The Labour Force 1992 (Ottawa: Statistics Canada, 1992), 64% of women with children under 6 work outside the home.


223 H. Rosenberg, Through the Kitchen Window, supra note 117 uses three categories: housework, motherwork and wifework to describe the domestic labour of married women.
broadly along the lines of mental/emotional and manual labour. Housework comprises the physical labour but mothering must include nurturing work such as:

the touching, rocking, smiling, reassuring, feeding, teaching, diaper-changing, playing with, disciplining, and all the literally countless other activities required for the emotional and physical health of infants and...children. 224

As the language and apparent practices of taking care of children have been "de-gendered", "parenting" has replaced "mothering," and is consistent with custody decisions in private matters that have started to make false assumptions about who does what in child rearing.

The feminist critiques point out that women are doing almost the same amount of work inside the home that they ever have, in addition to being employed in the labour force. In response to the current thinking of the courts in custody decisions that undervalue women's caring work, feminists suggest that there be a presumption in custody decisions awarding custody to the parent according to a principle of who has been the "primary caregiver." 225 Usually that would be the mother. But the potential gains for some women under the primary caregiver presumption cannot be expected for all


women. The presumption has specific problems for women with disabilities who may need someone else, some of the time, to do what is considered as primary caregiving.

In its recent brief on Child and Access Policy, the Canadian Advisory Council on the Status of Women supports in principle the presumption of the primary caregiver in Canada.\textsuperscript{226} The report makes a serious effort to recognize differences among women and the cultural differences among families. The recommendation is for the primary caregiver to operate as a true legal presumption, rebuttable in only the rarest circumstances to prevent a child from serious and imminent harm and for the presumption to operate beyond the "tender years."\textsuperscript{227} Anticipating the way that the "fitness" question may become a "gaping hole"\textsuperscript{228} in the strategy, the report recommends that the presumption not be based on a "list of tasks" as in \textit{Garska v. McCoy}, but should take into account "all of the physical, emotional, social and relational tasks of parenting". This departure from the list of factors approach is in part, to avoid undervaluing the parenting work that women with physical disabilities


\textsuperscript{227} \textit{Ibid.}, Recommendations at 46-47.

perform in managing others who carry out certain tasks.

Nevertheless, the suggestion of the primary caregiver presumption exemplifies a lack of attention to the connections between child welfare law and child custody law. In addition, the recommendation underscores the minimal consideration our theories and strategies give to women with disabilities. The problem is especially acute in considering how differently the presumption may operate for mothers with physical disabilities and mothers with mental disabilities.

Women with disabilities are less likely to be employed than women who are not disabled,\textsuperscript{229} and women with disabilities have had a more complex experience with traditional gender roles. For those who have constantly been denied access to what could be constructed as the goals of being female, achieving them might constitute success.\textsuperscript{230} While the feminist movement has criticized the nuclear family and feminine roles as oppressive, these role requirements may still be extremely powerful

\textsuperscript{229} According to Statistics Canada, \textit{The Health and Activity Limitation Survey}, Ottawa, June 1993, as of 1986, 41\% of women with disabilities are employed. This is in comparison with 66\% of non-disabled women who are employed, and 73\% of the general population (including both men and women and people with or without disabilities). Probably the employment rates of women with disabilities are more inflated than other categories because the statistics are based on being ready and available to work in the labour force.

\textsuperscript{230} N. Begum, "Disabled Women and the Feminist Agenda" (1992) 40 \textit{Feminist Review} 70.
Caring—whether for husbands and children, or for those outside the nuclear family is far from trivial and insignificant. It is moreover, an activity where questions of success are constantly raised, and women can feel 'unsexed' by failure.  

Although the physical-nurturing caring divide may seem somewhat bizarre in real life, its existence at the conceptual level has specific effects on women with disabilities and is even more problematic because of its differing impact on women with physical disabilities and those with mental disabilities. Social work agencies deal with neglect in three ways: through protection, supplementary care and substitute care. Using the physical-nurturing distinction of caring work, women with physical disabilities might successfully argue that supplementary care would be

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232 What you "do" as work in caring for children is obviously inseparable from the intimacy and other unobservables that are connected to the more functional tasks. Tying a child's shoelaces, giving the child breakfast and driving the child to school are all physical labours but the emotional/cognitive/social elements between the parent and child are inextricably connected to the more concrete behaviours.

sufficient for their needs and in fact, women with physical disabilities could oversee the physical work. That is, women with physical disabilities can make a case that, so long as the physical aspects of caring are done through supplementary care, their disability has no effect on their abilities to provide the most important part of caring, that is the nurturing component. This means that the woman with a physical disability just might get over the dissonance between her situation and the ideal of the self-reliant family. She may keep her child with state assistance because supplementary care, a legitimate function of social work, can be a discrete answer to a specific need. The same is not true of mental disability. If the psychiatric evidence suggests that the mother has a chronic problem, the courts seem less anxious to find that it is the best interests of the child to live with a mother. The prescription to look for evidence of primary care-giving will likely have the same result. For this reason women with mental disabilities are more likely to find that agencies will act in their capacity to protect children or to find a substitute care-giver, the most severe reactions to concerns about caring rather than the more moderate action of providing supplementary care.

In child welfare cases the woman is already viewed as a suspect mother. Even if she is already the primary and only caregiver, the state argues that she should not be. Despite the CACSW's explicit recommendation that the primary caregiver presumption not be rebuttable by reason of a parent's "having received psychiatric care," the unitary, blunt understanding of mental disability means that a woman with the label of mental disability will have more difficulty convincing state authorities both that she
is not neglectful and that a more creative and perhaps more complicated type of assistance could alleviate any concerns. The reason for the increased difficulty is that women with mental disabilities are viewed as incapable of providing proper nurturing and modelling in caring for children even if they are able to perform the physical labour. Regardless of whether the particular symptoms or diagnosis logically bears any relationship to caring, women with psychiatric labels are seen to be less capable of the constancy, depth or range of emotional responses that are necessary in caring for children. Agencies are unlikely to provide supplementary assistance because whatever help is required is poorly understood and not obviously discrete. In short, suggesting the "primary caregiver" presumption might be an appropriate and politically useful strategy for some women, but this idea is at odds with arguments that women with disabilities can be good mothers.

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235 See American neglect cases that forbid a presumption that a physical disability creates an inadequacy but do not apply the same rule to mental disability. In Re Jeannie Q. 31 Cal. App. 3rd 709 [2nd Dist Ct. App. 1973].

236 For example, in Supt. of Child Welfare v. P. (J), supra note 169, the British Columbia Court of Appeal referred specifically to the necessity to consider the cause of the condition, the prognosis and whether or not treatment would assist.

See also Winnipeg South Child and Family Services Agency v. W. (J.G.)[1987] M.J. No. 72 (Q.B.) where the mother had a long history of psychiatric problems and had made several suicide attempts. Although the two boys who were in foster care showed no sign of damage, the court awarded a permanent guardianship because the mother was seen as being incapable of bringing about the necessary changes in her own life within a reasonable period of time.
CHAPTER SIX: CONCLUSION

Being a good mother is a weighty responsibility. When the state apprehends one's child, the state declares that this woman is a bad mother. Because the symbolic content of motherhood is so strong, losing a child means failure as a woman. Combined with the real loss, sadness, or grieving that women experience when a child is taken away from them, the route to a woman's own "madness" becomes more direct.

In this thesis I have analyzed the trend in judicial decisions, but I suggest that these matters may be determined in the main, long before trial. Future research should examine the pre-court process in two ways. First, hearing the voices of the mothers in these circumstances is essential. As Linda Gordon demonstrated, women do resist state power, often not successfully, but they are not simply passive victims. The links between the denial of subjectivity in the ideology of motherhood, the heightened attention to pathology and requirements for remedial action by the woman, along with the interpretative quality of professional discourse make for a tight social construction invalidating the mothers' opinions so that we know little about what these mothers think or say. Lengthy interviews with women who have been through this process would give us an invaluable perspective, including their strategies of resistance to state

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power. Second, examining the records of the relevant state agencies would help to
"track" the pre-trial process more effectively. Exactly when and why concerns were
raised about the woman as a mother and as a mental health risk, by whom, and how
information crossed systems, would all be important information.

How does psychology maintain such a tenacious grip on explanations of child
development, fitness to mother and judicial pronouncements in child welfare cases?
I have argued that the combined ideas of the self-reliant family, the interiorization of
motherhood with an obliterated subjectivity, pave the way for the importance of the
"expert," so that in

this incredibly enclosed world of the nursery, the expert looms larger
and more authoritative than ever before--yet over time even he ceases
to represent an 'objective' external standard, scientific or industrial. It
is as if he himself were drawn into the intense, interiorized life of the
family, to become the pivotal figure in the new mid-twentieth century
drama of the Mother, the Child and the Expert.238 (emphasis added)

The courts' reliance on the framework of psychiatry and psychology to decide these
matters is ironic because there is evidence that the assistance of these experts is not
particularly helpful in deciding the difficult cases.239 Some research suggests that

238
See Ehrenreich and English, Own Good, supra note 12 at 190.

239
S. Rush Okpaku "Psychology: Impediment or Aid in Child Custody Cases?"
(1976) 29 Rutgers Law Review 1117 at 1141 discusses the methodological
this sort of expert may be no more competent to make predictions than a layperson and perhaps, less so.\textsuperscript{240} Besides, cultural assumptions about mothering and best interests considerations are themselves imbued with the thinking from these disciplines. Put another way, there is some question of whether anything additional is gained by the input of these professionals.\textsuperscript{241} Judges like the rest of us, are products of our own cultural biases and they too are influenced by psychological theory through the medium of culture. Little of substance is probably added by formal recognition of the opinion of the experts. Because the legal model of a child protection proceeding is somewhat peculiar, and the disciplines of psychology and psychiatry seem so pertinent, judges tend to defer to the opinions of psychiatrists on the substantive matters and intervene only where the authorities appear to have flagrant disregard for legal process.

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deficiencies in the empirical research in child custody matters:

Overall, the empirical research to date has focused on concerns too remote from issues in custody litigation to be of any help to judges deciding difficult cases.

There is a significant risk to the integrity of the decisions in child custody disputes due to the vagueness and generality of psychological formulations.

\textsuperscript{240} See references \textit{supra} note 103 and Bersoff, "Judicial Deference", \textit{supra} note 97.

\textsuperscript{241} See Menzies, \textit{Survival, supra} note 7 at 109-110 that there is nothing special about medico legal experts (forensic specialists) apart from the discourse that is nested in commonsensical cultural stereotypes. Criteria for clinical decision-making reflect the individual theorizing of the experts and the organizational needs of the agency.
Law then operates here in tandem with psychology and other mechanisms of the state. Much like the modern ethos in criminal law, where the shift is away from ideas of rehabilitation of the individual, but toward the risk the person presents to society, the

"judge thinks of himself as a therapist of the social body, a worker in the field of 'public health' in the larger sense."^242

Simply put, the ideas of psychology and psychiatry represent "truth claims" made through the exercise of power. The tenets of psychiatry then, form an epistemology that functions as the accepted knowledge base for the exercise of power. Psychiatry dominates the legal proceeding partly by defining the substantive questions as matters within its expertise. More obviously perhaps, psychiatrists contribute to a particular outcome, that is mothers losing custody, because these professionals systematically appear to give evidence in support of the state's case. Rarely do child protection cases reduce to a "battle of the experts" as they so often do in private custody disputes where each party retains its own expert. Once a child protection matter reaches the courtroom, state authorities are nearly always prepared with a psychiatrically monolithic case.^243 If the courts were to recognize that there is an alternate view of


^243 Accepting psychiatric evidence in such a wholesale way undermines the adversarial nature of legal processes. See T. Scheff, "Social Conditions for Rationality: How Urban and Rural Courts Deal with the Mentally Ill" in F. J.
psychiatry this would help to promote more serious scrutiny of the specific psychological evidence entered in the proceeding.

In trying to maintain or regain custody of their children, women with a psychiatric diagnosis are faced with a presumption against their fitness. When they argue on the basis of their love for their children, or their subjective view of the relationship that exists between the child and themselves, these opinions are dismissed as self-interested and subjective, and therefore not appropriately objective or ultimately reliable. In any individual case there may be internalization of surveillance so that often the "mad" woman scrutinizes herself and finds herself wanting as a mother with the result that she detaches herself both emotionally and legally from her child so that the court proceedings are unnecessary. Women with mental health histories continue to lose their children to the state through some combination of moral suasion, legal process, consent and threat, all against a backdrop of the opinions of particular mental health personnel.

Recently I spoke with the advocate at the Downtown Eastside Women's Centre in Vancouver. The centre is located in an area where people are poor and there is a large number of deinstitutionalized psychiatric patients. She told me that most of the women who came to the drop-in centre were on handicapped social assistance benefits, or should be. As well, she told me that most of the women had already lost their children and many were apprehended at birth. I asked whether children were actually apprehended or whether women gave them up. She answered, "A little bit of both."

Does it matter?244

244 Conversation with K. Speirs, Advocate, Downtown Eastside Women’s Centre, November 26, 1993.
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