

Positioning Women, Mental Health and Depression on Canadian Health Care Agendas

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Abstract

In 2008, substantive equality for women remains an “unfinished agenda” and an integral and critical component of this agenda is the unequal treatment of women’s mental health issues both globally and in Canada. Women and mental health issues are not on the Canadian health care agendas. Depression is a mental health problem that is unique to women and it warrants particular attention; globally and across diverse societies and social contexts women are nearly twice as likely to suffer depression as are men. The World Health Organization (WHO) predicts that depression will be the second leading cause of global burden of disease by 2020 and a sense of urgency is needed to reduce the over representation of women with this mental illness.

A commitment to the inclusion of mental health as a part of the mainstream Canadian public health care system presently exists in Canada. To ensure that the specific mental health needs of women are also included in the mainstream care system, women, mental health and depression need to be on Canadian health care agendas. Positioning women, mental health and depression on the relevant agendas is a pressing issue that all three governments and the recently established Mental Health Commission of Canada should make a priority. A sense of urgency and the development and implementation of a National Mental Health Care Strategy that includes a National Women’s Mental Health Care Strategy as an integral and substantive component will accomplish this outcome.

Lawyers can make a contribution to the development and implementation of these strategies and a contribution to gaining equality for women with mental health problems. They might have a vested interest; studies show both men and women lawyers are almost four times more likely to experience depression than the general population. Vested interest or not, as persons of privilege, power and influence they are uniquely situated to make a difference; they can be leaders in contributing to the completion of the “unfinished agenda” of substantive equality for women including the unequal treatment of women’s mental health issues both within the legal profession and within Canadian society.

“I’d had a miscarriage which caused me to have a breakdown. I didn’t know it was a breakdown but I went to my doctor and explained how I felt. He said there was nothing he could do for me, he had all these patients to see and perhaps the nurse could get me a cup of tea...”¹
Pauline Lee 2004

Introduction

Pauline’s story echoes many women’s stories in the twentieth century and is also representative of women’s herstory about mental health concerns. Herstorically, women with medical health issues have been pathologized and over-medicated or under –recognized, under-treated and undiagnosed. The root of this inequality is in the diagnosis of “hysteria”

¹ Regional Office for Eur., WHO, *Mental health: facing the challenges, building solutions* 93 (Report from the WHO European Ministerial Conference) (WHO Europe 2005); Videotape: Open Up (Mental Health Media’s Anti-discrimination Project 2004) (available at <http://www.openuptoolkit.net/home/index.php>).

during the nineteenth century, which assumed that a uterus and ovaries put women at risk for “nervous disorders”. This flawed biological and scientific finding framed the mental health concerns of women as biological issues, matters of nature rather than issues about human rights and equality. As a result, women suffered inequality in every respect in society.

Feminist scholarship has critiqued “hysteria” and with decades of lobbying has exposed “hysteria” for what it is; overt sexism and bad science. Women were denied basic rights on the basis of “hysteria”.² For example, under the law, women were not considered “persons”, did not have the right to vote or access to educational opportunities. A vision of equality, hard work and vigilance guided the *Famous Five* in 1929 to the highest court in Canada to legally transform women into persons with entitlement to fundamental equality rights.³ These feminists and those who followed stood by their position for women’s equality, even in the face of many losses, to gain the right to vote and access to educational opportunities for Canadian women. More recently, significant strides toward equality have gained inclusion of equality provisions in the *Canadian Charter of Rights and Freedoms*⁴; ratification of international agreements such as the

² Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addiction, *Women, Mental Health and Mental Illness and Addiction in Canada: An Overview 1* (May 8, 2006) [hereinafter *Women Mental Health, Addiction*], <http://www.cwhn.ca/PDF/womenMentalHealth.pdf>.

³ *Edwards v. Canada (A.G.)*, [1930] A.C. 124 (P.C.). Known as “*The Persons Case*”. Five white women from Alberta, women of privilege, power and political influence (known as the *Famous Five*) launched this case and took it to the Supreme Court of Canada. At issue was the interpretation of section 24 of the *British North America Act, 1867* that governed the eligibility of persons for the Canadian Senate. In a unanimous reference decision the Supreme Court of Canada held that women were not qualified to be Senators because they were not “persons” under section 24. The *Famous Five* did not take no for an answer and appealed to the Judicial Committee of the Privy Council, then the highest court in Canada. In a unanimous decision of their Lordships, it was held that women were persons and were entitled to be Senators. Lord Sankey, speaking for the Lordships said: “The exclusion of women from all public offices is a relic of days more barbarous than ours...” Some of the *Famous Five* also helped gain the provincial vote in some provinces in 1916 and the federal vote in 1918 although it is important to note that Asians and First Nation Canadians did not gain the right to vote in federal elections until 1960. The decision also birthed the “living tree doctrine” that still informs the interpretation of the constitution in Canada.

⁴ *Canadian Charter of Rights and Freedoms*, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11 (U.K.).

*Convention on the Elimination of all Forms of Discrimination against Women*⁵ and the right to equal pay for work of equal value.

There is no doubt that there has been significant progress in achieving the notion of equality as a basic human right for Canadian women. At the same time, there is a very real danger that this progress had led many to think that we have achieved substantive equality for women in Canada. This “no problem” perception emanates from the partial fulfillment of the substantive equality agenda for women and operates as a real obstacle to the identification of the unmet equality challenges that presently exist. Substantive equality for all women remains an “unfinished agenda” and the unequal treatment of women’s mental health issues in Canada is an integral and critical component of this agenda.⁶ Women and mental health issues are not on Canadian health care agendas.

Pauline’s story reveals that women continue to be under treated or not treated at all and thereby denied access to the appropriate health care services. A cup of tea has been touted as preventative for all sorts of medical problems⁷ and there is some evidence that green tea helps with depression.⁸ Even so, a cup of tea is an inadequate medical response and a denial to Pauline of the right health care services having regard to her experience in the circumstances of a breakdown.

Whereas Pauline was under-treated and essentially left untreated, those women who are over-treated are equally denied appropriate health care services. A frequent choice of physicians

⁵ Convention on the Elimination of all Forms of Discrimination against Women, Dec. 18, 1979, G.A. Res. 34/180 (entered into force Sept. 3, 1981, accession by Canada Jan. 9, 1982).

⁶ See, e.g., Donna M. Eansor, *Gender, Depression and Women in the Legal Profession: A Population Health Approach* 27 (2007).

⁷ Life Steps Health Protection Program Building a Healthy Life One Step at a Time, *Complementary & Alternative Medicine: Is a Cup of Tea Strong Medicine?* (2004), <http://www.lifesteps.com/gm/Ato z/dc/cen/cam/alert10081999.jsp>.

⁸ About.com: Chinese Food, *The Miracle of Green Tea*, <http://chinesefood.about.com/library/weekly/aa011400a.htm> (last visited May 15, 2008).

and psychiatrists for women with mental health issues is the prescription of psychotropic drugs. Many women are over-medicated or placed on the wrong medication. Thirteen percent of women versus 9% of men consume these drugs and women are twice as likely as men to walk out of a doctor's office with a prescription for anti-anxiety or anti-depressive medication.⁹ Moreover, little research has been conducted about how sex and gender differences affect the metabolism, overall efficacy and side effects of these medications over life courses. The impact on women's health is unclear and there is very little research and data available.¹⁰

Even with "hysteria" firmly behind women's equality struggles, mental health research, promotion and treatment continue to ignore women's experiences of mental health and mental health care. This is the case even though women utilize mental health services more frequently than men, women seek a wider range of treatment and support options that are available than do men, and women experience certain mental illnesses more than men.

Collectively, this evidence suggests that the mental health needs of women are significantly different from those of men and warrant particular attention. To date, this evidence has not been translated into policy and practice in the mental health care system, contributing to treatment inadequacies and less than optimal mental health outcomes for women.¹¹

Women's mental health issues must not be under-treated nor over-treated. Properly addressing each woman's mental health issue requires an individual assessment as every woman has her own story shaped by her herstory including varying degrees of oppression and discrimination affecting racial and ethnic minority women, Aboriginal women, disabled and

⁹ Laila Malik, The Can. Women's Health Network, *Still in the Shadows: Kirby Report Turns a Blind Eye to Women* 1 (July 12, 2006), <http://www.cwhn.ca/resources/pub/shadows/html>.

¹⁰ M. Morrow, B.C. Centre of Excellence for Women's Health Policy Series Report, *Mainstreaming Women's Mental Health: Building a Canadian Strategy* 2-3 (2003), <http://www.bccewh.bc.ca/publications-resources/documents/mainstreamingwomensmentalhealth.pdf>.

¹¹ *Id.* at 1.

aging women, lesbians and immigrant and refugee women. A balanced, diverse and culturally sensitive and nuanced approach that considers all available mental health care options and treatments is needed for every woman who presents with mental health issues.

Both sex and gender differences exist in the rates of specific mental health problems for women and men. For women, depression is a mental health issue that warrants particular attention, as women are nearly twice as likely to suffer depression. This difference runs across diverse societies and social contexts and is one of the most robust findings in psychiatric epidemiology.¹² Depression contributes most significantly to the global burden of disease¹³ and the World Health Organization (WHO) views the reduction of the overrepresentation of women with depression as a matter of urgency, predicting that depression will be the second leading cause of global burden of disease by 2020.¹⁴

Most immediately, a sense of urgency about the reduction of this overrepresentation is needed. This urgency exists in the many reports of WHO¹⁵, in reports of The Canadian Women's Health Network and the Centres of Excellence for Women's Health¹⁶ and in provincial reports from the Ontario Women's Health Council¹⁷ and the British Columbia Centre of Excellence for Women's Health¹⁸ as well as in the writings of academics.¹⁹ Yet, despite all of the data and available evidence, this same sense of urgency is absent from governmental health care policies,

¹² Dep't of Mental Health and Substance Abuse, WHO, *Gender Disparities in Mental Health 2* (WHO 2002) [hereinafter *Gender Disparities*], <http://www.who.int/mentalhealth/media/en/242.pdf>.

¹³ *Id.* at 5.

¹⁴ *Id.* at 12.

¹⁵ *Id.*

¹⁶ *Women Mental Health, Addiction*, *supra* note 2.

¹⁷ Ont. Women's Health Council, *A Literature Review on Depression Among Women: Focusing on Ontario* (Natalie Diaz-Granados & Donna E. Stewart eds., University Health Network Women's Health Program 2006), available at <http://www.womenshealthcouncil.on.ca/English/Health-Reports.html>.

¹⁸ Morrow, *supra* note 10.

¹⁹ Eansor, *supra* note 6.

legislation that impacts on the mental health of Canadians including women and from the minds, practices and expertise of many health care providers.

This paper is divided into five sections. In the first section of this paper, women and depression are examined to explain how problems of diagnosis and recognizing symptoms contribute to the stigmas of depression, which explains Canada's current 'unfinished health care agenda'. Second, the nature of Canada's health care program and the strides Canada has made in relation to mental health is examined; nonetheless, women, mental health, and depression remain an 'unfinished agenda' in Canadian health care. In the third section, three key strategies are looked at that can position women, mental health, and depression on the health care agendas in Canada so that we may work towards achieving substantive equality and equal treatment for women and mental health sufferers. In the fourth and fifth sections, the lawyers are summoned because they are individuals who are uniquely situated to make a difference, and four roles that lawyers can play to contribute to the completion of the unfinished substantive equality agenda for women are examined, respectively.

I — Women and Depression

Women and men experience mental health problems at nearly identical rates,²⁰ although significant differences exist in the patterns and symptoms of these problems. Depression is almost always reported to be twice as common in women compared with men across diverse

²⁰ *Women Mental Health, Addiction, supra* note 2, at 5-6. Overall rates of mental health problems are almost identical for men and women but significant gender differences exist in the patterns of mental disorders. In examining the role of gender, a distinction needs to be made between low-prevalence and severe mental disorders such as schizophrenia and bi-polar disorder, where no consistent gender differences in prevalence rates have been found, and the high-prevalence disorders of depression and anxiety, where large gender differences in rates have been consistently reported.

societies and social contexts. A recent study across 29 countries revealed that in none of these countries are males more likely to be depressed than females.²¹

In Canada, depression affects 5% of Canadians.²² Individuals with lifetime and 12-month (having had an episode in the past year) prevalence rates of major depressive disorder are estimated at 12.8% to 16.6% (16.5% of women, 8.9% of men) and 3.9% to 6.7% (5.0% of women, 2.6% of men), respectively. Among employed individuals 15.7% (19.5% of women, 11.4% of men) met lifetime criteria for major depressive disorder and 8.6% (10.2% women, 5.9% men) met 12-month criteria.²³

Depression is a serious mental health problem that is both under-diagnosed and misunderstood even by many health care providers. It is as disabling or more disabling than several other chronic medical conditions with respect to social functioning, physical functioning, role functioning and days spent in bed. Individuals with a physical condition as well as depressive symptoms are at a very high risk for disability.²⁴

Although depression produces symptoms of feeling alone, it is often not the only disorder that women experience. Comorbidity—the occurrence of more than one disorder concurrently—with depression as a common factor, is a characteristic finding of many studies on women's mental health. Nearly one half of all individuals with depression also have at least one, and most often three or more, disorders at the same time. Depression and anxiety are the most

²¹ Rosemary L. Hopcraft & Dana B. Bradley, *The Sex Difference in Depression Across 29 Countries*, 85 *Social Forces* 1483, 1483 (June 2007), available at <http://muse.jhu.edu/login?uri=/journals/socialforces/v085/85.4scott.html>; Dep't of Gender, Women and Health Family and Cmty. Health, WHO, *Gender in Mental Health Research* 14-17 (WHO 2004), available at <http://www.who.int/gender/documents/en/mentalhealthlow.pdf>.

²² *Gender Disparities*, *supra* note 12, at 18.

²³ Emma Robertson Blackmore, Stephen A. Stansfeld & Iris Weller, *Major Depressive Episodes and Work Stress: Results from a National Population Survey*, 97 *American Journal of Public Health* (2007). Data were derived from the Canadian Community Health Survey, 2002. Depressive episodes were assessed using the Composite International Diagnostic Interview; See also *Women Mental Health, Addiction*, *supra* note 2, at 5-6; See *Gender Disparities*, *supra* note 12, at 1.

²⁴ *Gender Disparities*, *supra* note 12, at 3.

common disorders but concurrent disorders include many of those in which women predominate, including agoraphobia, panic disorder, somatoform disorders and post traumatic stress disorder. For example, a strong link exists between panic attacks, panic disorder and depressive disorder. The combination of these disorders is severe as well as long lasting and is connected to a higher rate of suicide for women. In addition, women have higher prevalence rates than men of both lifetime and 12-month comorbidity of three or more disorders. The proliferation over the life course of women of psychiatric comorbidity coupled with the presence of three disorders at the same time, burden women with the heightened risk of disability, increased severity of illness, premature death and higher utilization of health care services.²⁵

Depression is, in general, caused by individual vulnerabilities interacting with environmental stress.²⁶ Until recently, the bulk of the research about women and depression focused on individual vulnerabilities including the determinant of biology and genetics. The diagnosis of “hysteria” during the nineteenth century is a striking example. Researchers’ penchant for biological explanations eliminated the careful consideration, or any consideration at all for that matter, of the impact of other determinants of health on the mental health of women. Recently released research heavily discounts the role of biology as the causative agent of depression in women and WHO specifically rejects biological vulnerability as the reason for the high rates of depression. Rather, these high rates are attributed to women’s greater exposure to a range of environmental stressors and risks to their mental health.²⁷

In Canada, the mental health of women has been neglected and mental health problems specific to women, like depression, are urgent medical health problems. Even so, women, mental

²⁵ *Id.* at 7-8.

²⁶ Carole Wade & Carol Tarvis, *Psychology* 589 (Prentice Hall 6th ed. 2000).

²⁷ *Gender Disparities*, *supra* note 12, at 17.

health and depression are not on Canadian health care agendas. There are many reasons for this void and some of the most significant reasons are:

- until the early 2000's, the mental health of Canadians was neglected and largely ignored by all levels of government²⁸,
- Canada is the only G8 nation without a national health care strategy that addresses mental illness²⁹,
- mental health research, promotion and treatment continue to ignore women's experiences of mental health and mental health care³⁰, and,
- Canada does not have a National Women's Mental Health Care Strategy.

A more detailed examination of these reasons follow and begins with a general introduction to the present health care system in Canada and an overview of the recent Canadian reports that assessed the health care system and the status of mental health care in Canada beginning in 2002.

II — Canadian Health Care Framework & Recent Canadian Mental Health Reports

The aim of Canada's health care system is to ensure that all Canadians have reasonable access to medically necessary insured services without direct charges. The Canadian constitution does not address health and health care as a single subject nor does it explicitly allocate responsibility to the federal government or to the provincial government. Both provincial and federal governments have varying degrees of jurisdiction over different aspects of the health care system. As a result, it is now accepted that constitutionally, the provinces of

²⁸ Michael J.L. Kirby, The Standing Senate Comm. on Social Affairs, Sci. and Tech. on Mental Health, Mental Illness and Addiction, *A Proposal To Establish A Canadian Mental Health Commission* (Interim Report 4) (Oct. 2005), <http://www.parl.gc.ca/38/1/parlbus/commbus/senate/comm-e/soci-e/rep-e/rep16nov05-e.pdf>.

²⁹ Mental Health Comm'n of Can., <http://www.mentalhealthcommission.ca/keyinitiatives.html> (see under "National Strategy") (last visited May 15, 2008) [hereinafter Mental Health Comm'n of Can.].

³⁰ *Id.*

Canada are responsible for the administration and delivery of health care services. In contrast, Yukon, Nunavut and the Northwest Territories do not have formal constitutional powers over health care, although they have assumed these responsibilities in recent years.

The national health insurance program is achieved through thirteen interlocking provincial and territorial health insurance plans, linked through adherence to national principles set at the federal level under the *Canada Health Act*.³¹ This federal health insurance legislation establishes the national standards that the provinces and territories must meet in order to receive the full federal cash transfer contribution under the Canada Health and Social transfer. Each year the *Canada Health Act* Annual Report is presented to Parliament and it contains a report on how well the provinces and territories are complying with the *Canada Health Act*.³²

The early 2000's marked a critical turning point for the recognition of and the sense of urgency necessary to include the mental health of Canadians in mainstream public health care. In 2001, the Commission on the Future of Health Care in Canada was created by Prime Minister Jean Chretien. Headed by Chair Roy Romanow, the Commission's mandate was to review Canada's health care system. The Commission released its final report "Building on Values: The Future of Health Care in Canada"³³ in November 2002.

The Commission heard from leading experts and organizations that one in five Canadians are directly impacted by mental health problems and the stigma associated with mental health. The discrimination these individuals face in accessing and receiving appropriate health care services were clearly revealed. The economic, social and employment implications for

³¹ Canada Health Act, R.S.C., ch. C-6 (1985).

³² Health Can., *About Health Canada* (2008), http://www.hc-sc.gc.ca/ahc-asc/index_e.html; Minister of Health, Health Can., *Canada Health Act Annual Report 2006-2007* (2007), http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/chaar-rales-0607/chaar-rales-0607_e.pdf.

³³ Roy Romanow, Comm'n on the Future of Health Care in Can., *Building on Values – The Future of Health Care in Canada* (2002).

Canadians with mental health issues were highlighted as was the result - the marginalization of these Canadians. On the basis of this evidence, the Romanow Commission described mental health as the “orphan child” of health care in Canada and recommended that it be brought into the mainstream of public health care.³⁴

The government of Canada responded with a commitment to address this reality and in 2006, *Out of the Shadows At Last* was released by the Canadian Standing Senate Committee on Social Affairs, Science and Technology.³⁵ This report recognizes the real need for profound change if persons with mental health problems are to receive the appropriate health care services they both need and deserve. Much praise for *Out of the Shadows at Last* is earned as the Committee has taken significant strides toward illuminating the neglected state of mental health services, as well as providing information for raising awareness and education and for policy development and reform of health care delivery systems in Canada. In addition, the Report specifically recognizes that the mental health care system has been neglected for many years that pervasive problems surrounding mental health exist and addressing this neglect is both complex and urgent.³⁶

³⁴ *Id.* at 32.

³⁵ Can. Senate Standing Senate Comm. on Social Affairs, Science and Tech., *Out of the Shadows At Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Interim Report, 38th Parliament, 1st Session) (May 2006) [hereinafter *Out of the Shadows at Last*], <http://www.parl.gc.ca/39/1/p/arlbus/commbus/senate/com-e/soci-e/rep-e/pdf/rep02may06part1-e.pdf>. The Standing Committee received a mandate from the Senate to study the state of mental health services and addiction treatment in Canada and to examine the role of the federal government in this area. See also The President’s New Freedom Comm’n on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (July 2003), <http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf>. In the U.S., the New Freedom Commission on Mental Health received a mandate from President Bush in 2002 to study the mental health service delivery system, and to make recommendations that would enable adults with serious mental illness and children with serious emotional disturbance to live, work, learn, and participate fully in their communities. The Report recommends a fundamental transformation of the nation’s approach to mental health care. The Report contains six goals as the foundation for this transformation. The goals are intertwined and all must be achieved to transform the mental health care delivery system. Goal 3 of the Report is the elimination of disparities in mental health services.

³⁶ Kirby, *supra* note 28.

Out of the Shadows at Last contains 118 recommendations many of which, if implemented, will benefit Canadians and make a difference in the delivery of health care services. The recommendations have the potential to positively impact affected individuals as well as their families and improve the overall quality of their lives with a focus on hope and recovery, compassionate care benefits, housing, and employment opportunities. Most importantly, specific initiatives to eliminate stigma and discrimination will restore and preserve dignity and mark a significant move toward the equality that every Canadian living with mental health problems both deserves and is entitled to. Some of the most far reaching and significant recommendations include: the establishment of the Mental Health Commission of Canada, an anti-stigma and anti-discrimination campaign, a national strategy (as Canada is currently the only G8 nation without a national strategy to address mental illness) the creation of a Knowledge Exchange Center³⁷, the adoption of the population health approach and a commitment from the federal government for 25 million dollars for mental health research.³⁸

At the same time, the Report is uninformed and largely silent in several key and significant respects.³⁹ The recommendations address the special needs of First Nations and Inuit peoples⁴⁰, children and youth⁴¹, seniors⁴² and immigrant and refugees⁴³ yet it is virtually silent about Canadian women and has been described as “Gender Blind”.⁴⁴

³⁷ Mental Health Comm’n of Can., *supra* note 29, at 1-2. The Mental Health Commission of Canada was created in 2007. See Press Release, Canadian Alliance on Mental Illness and Mental Health, National Coalition of Mental Health Groups Enthusiastic About Budget Announcement of National Mental Health Commission (Mar. 19, 2007), available at [http://www.nnmh.ca/files/camimh%20press%20release%20marc h%2019%20e.pdf](http://www.nnmh.ca/files/camimh%20press%20release%20marc%20h%2019%20e.pdf).

³⁸ See *Out of the Shadows at Last*, *supra* note 35, at 471.

³⁹ See *Women Mental Health, Addiction*, *supra* note 2, at 3.

⁴⁰ See *Out of the Shadows at Last*, *supra* note 35, at 287.

⁴¹ *Id.* at 135.

⁴² *Id.* at 157.

⁴³ *Id.* at 339.

⁴⁴ Malik, *supra* note 9. Report calls for future empirical research to assess the effectiveness of culturally competent practices.

This blindness is significant as across Canada a large percentage of women report unmet mental health care needs.⁴⁵ And it is a deafening silence, in light of the facts previously discussed including the fact that the mental health needs of women are significantly different from those of men and warrant particular attention.⁴⁶ The opportunity to break this silence and bring visibility to these issues presently exists in Canada as there is both will and momentum to bring mental health into the mainstream of public health care. Women and their specific mental health needs will be an integral component of this mainstreaming process provided that the issues are visible and part of the conversation. At the outset then, the initial challenge is to position women and their specific mental health needs on the relevant agendas. Three key strategies are necessary to accomplish this outcome: first, a sense of urgency is needed, second, the development and implementation of a National Mental Health Care Strategy that includes, third, a National Women's Mental Health Care Strategy as an integral component.

III — Positioning Women, Mental Health And Depression On The Health Care Agendas In Canada

(i) A Sense of Urgency

When going forward to advance the equality of women on any particular issue a commitment to equality is not enough. A sense of urgency, persistence and hard work is always needed. The challenge of positioning women on the relevant mental health care agendas is not an exception and the development and implementation of a National Mental Health Care Strategy and a National Women's Mental Health Care Strategy in conjunction with this sense of urgency will do much toward the accomplishment of this objective.⁴⁷

⁴⁵ See also Ont. Women's Health Council, *supra* note 17, at 154. Eighty percent of Ontario women reported unmet mental health care needs.

⁴⁶ Morrow, *supra* note 10, at 1.

⁴⁷ *Gender Disparities*, *supra* note 12, at 2.

(ii) Developing and Implementing a National Mental Health Care Strategy

The Mental Health Commission of Canada, a key recommendation from *Out of the Shadows at Last*⁴⁸, was established and officially launched in August of 2007.⁴⁹ The creation of the Commission heralds a new era in mental health in Canada as for the first time there will be a body that can direct institutional and financial resources at a national level to Canadians with mental health problems. The Commission will undertake critical tasks at the national level and maintain a needed national focus on mental health issues working to improve the health and social outcomes of Canadians living with mental illness.

One goal of the Commission is to act as a facilitator, enabler and supporter of a national approach to mental health issues and one of their three key initiatives is the promotion and development of this strategy. Canada is currently the only G8 nation without a national strategy to address mental illness.⁵⁰ The lack of a national approach to mental health issues is a significant national deficiency that prevents implementation of concrete initiatives at a national level that would benefit Canadians living with mental health problems.⁵¹

The Commission has the potential to develop and implement this strategy. It is a national organization, not a federal one and is funded by the Government of Canada. All three levels of government have endorsed the Commission although the provinces and territories remain

⁴⁸ *Out of the Shadows at Last*, *supra* note 35, at 432. The Government of Canada, along with all provincial and territorial Ministers of Health, with the exception of Quebec, agreed to the creation of the Commission at a meeting of the federal/provincial/territorial Ministers of Health on October 23, 2005. Steven Fletcher, health critic for the Conservative Party in the 38th Parliament, expressed support for the establishment of a National Mental Health Commission as well.

⁴⁹ Press Release, CTV News, PM officially launches mental health commission (Aug. 31, 2007), *available at* www.ctv.ca/servlet/ArticleNews/story/CTVNews/20070831/mental_health_070831.

⁵⁰ Mental Health Comm'n of Can., *supra* note 29. The G8 (Group of Eight) is an international forum for the governments of Canada, France, Germany, Italy, Japan, Russia, the United Kingdom and the United States. The group's activities include year-round conferences and policy research, including an annual summit meeting attended by the heads of government of the member states. The European Commission is also represented at the meetings.

⁵¹ Mental Health Comm'n of Can., *supra* note 29, at 2.

responsible for the organization and delivery of health care services. It operates at arms length from the governments and a majority of its board of directors come from outside government.⁵² Eight Advisory Committees including a Mental Health and Law committee provide advice to the Board and support the Commission in keeping it engaged with the broader stakeholder community.⁵³ The development and implementation of an effective and productive national health care strategy will be accomplished through inter-ministerial collaboration at all three levels of government as well as national-provincial-municipal partnerships working together with the Mental Health Commission.

With the Commission established and focused on the creation of a National Mental Health Care Strategy the next task will be the determination and assembly of the substantive components of this strategy. The focus of this discussion is on one such component: a National Women's Mental Health Care Strategy.⁵⁴ The development of this strategy will make visible the specific mental health needs of women and ensure that these issues are on relevant health care agendas. The next part of the discussion provides seven recommendations to inform the development of a National Women's Mental Health Care Strategy.

(iii) Developing and Implementing a National Women's Mental Health Care Strategy

The seven recommendations that follow provide all three levels of the government, the Mental Health Commission of Canada and all other stakeholders with a concrete plan of action for the development and implementation of a National Women's Mental Health Care Strategy.

⁵² *Id.* at 1-2.

⁵³ *Id.* at 1. The other seven advisory committees are: Child and Youth; Seniors; First Nations, Inuit and Métis; Workforce; Family Caregivers; Service Systems and Science.

⁵⁴ Target Groups Project of Statistics Can., Statistics Can., Women in Canada: A Gender-based Statistical Report 21 (Colin Lindsay & Marcia Almey eds., 5th ed. Mar. 2006), <http://www.unece.org/gender/publications/Canada/WomenCanada2006.pdf>.

(1) - Expansion of Mental Health Services without Direct Charge

The first recommendation is that more mental health services be available without direct charge and that all three levels of government commit the resources needed to provide these services. As the “orphan child” of health care, mental health care services have historically received a very small portion of federal, provincial and territorial health care dollars. One consequence of this is that only psychiatric health services are directly funded even though there is a wide range of mental health care options available. As a result, only Canadians with financial resources can access other options and that is problematic for the mentally ill. Unemployment for persons living with serious mental illness is estimated to be as high as 90%⁵⁵ and as women suffer more poverty than do men it is likely that more women are unemployed and without adequate financial resources to secure appropriate mental health care.

(2) - Federal Government Mandate Provincial and Territorial Resources for Women

The second recommendation is that the federal government should mandate provincial and territorial resource allocations for mental health services and supports for women with mental illness. This recommendation is critical as women access the mental health system more frequently, receive treatment more often and have higher rates of hospitalization for psychiatric problems. Additionally, all jurisdictions need to develop interdisciplinary mental health teams with strong connections to community support for women. Funds should be allocated for women-specific services like women’s centres, transition houses, and women’s addiction treatment programs; key supports that require ongoing funding.

⁵⁵ *Out of the Shadows at Last*, *supra* note 35, at 171.

(3) - A Balanced, Diverse, Culturally Sensitive and Nuanced Individual Assessment of Each Woman's Mental Health Needs

The third recommendation centers on the way in which mental health care providers should assess women's mental health. As we have seen, in the current health care system, women are under-treated, under-diagnosed, over-treated and even left untreated. A balanced, culturally sensitive nuanced individual assessment would improve the quality of treatment received by women as a group and as individuals.

Women experience different types of mental illness, cope with stress and life events and signal distress in very different ways than do men. In addition to these differences that have implications for diagnosis and treatment, factors such as race, ethnicity, sexual orientation, age, class, physical ability, and gender identity might impact on an individual woman and the state of her mental health. Other relevant factors including addictions, poverty, homelessness and sexual violence are also assessment considerations because they are all linked to poor mental health.⁵⁶

(4) - Funding for Research By All Three Levels of the Government

The fourth recommendation is a commitment by the federal government as well as the provincial and territorial governments to provide adequate and appropriate funding for the national collection and dissemination of existing mental health data and for future research into women's mental health. Governmental collaboration and partnerships with existing research institutes such as the Canadian Institute of Health Information (CIHR) and the new and developing Knowledge Information Exchange, an initiative of the Mental Health Commission of Canada, will facilitate a more careful exploration of existing data and expand the national

⁵⁶ Morrow, *supra* note 10, at 1-5. Many Aboriginal women live with culture discontinuity and oppression and in impoverished living conditions; the product of colonization and residential schooling. These women experience the highest prevalence of depression, alcoholism, suicide and violence. Immigration also affects the mental health of women while lesbians and bi-sexuals face hatred and are often victims of hate crimes. The consequences are dire as these women commit suicide at rates that are higher than the general population.

evidence base by gathering sex-disaggregated data as well as culturally sensitive disaggregated data on mental illness. The Commission can lead the way through the creation of a center for women within the Knowledge Information Exchange and CIHR. As well, Statistics Canada can support research, collect the data on a regular basis and make this information available to all Canadians on their websites and through a comprehensive database for use by researchers and governments.

Some future research priorities include a systematic examination of existing mental health legislation as well as other legislation, including disability legislation, human rights code provisions and Worker's Compensation legislation utilizing the population health approach analysis and a gender-based analysis.⁵⁷ Research about mental health in the workplace is another priority as 58% of all women aged 15 and over are currently part of the paid work force⁵⁸ and these women report the highest levels of work-life conflict and discrimination, which are predictors of stress and poor mental health, including depression. Future research should also address the gaps in our understanding of the specific types of mental health issues that women experience at rates higher than men and the side effects of psychotropic medications including their impact on the long-term health of women.⁵⁹ Further research that examines women's differing social experiences such as racism, poverty, violence and homophobia is also needed as is an examination of the connection between mental illness, addictions, poverty, homelessness and violence.

The collection and dissemination of existing research and further research that addresses voids in our understandings will provide the foundation for the assessment of the way in which the differing mental health needs of women might be met through policy, service delivery, and

⁵⁷ See *Healthy Living Strategy*, *infra* note 63; see also *What Determines Health?*, *infra* note 65.

⁵⁸ Target Groups Project of Statistics Can., *supra* note 54, at 105.

⁵⁹ Malik, *supra* note 9, at 1.

treatment. Funding commitments to accomplish these objectives as well as collaboration and partnerships with existing research institutes, all levels of the government and the Mental Health Commission is a critical component of a National Women's Mental Health Care Strategy.

(5) - Mechanisms to Involve Canadian Women and their Families in the Conversation

The fifth recommendation, of significant importance, is that appropriate mechanisms be developed for the involvement of Canadian women and their families in the process of policy-making and the development of diagnosis, treatment and health care option women centered models. Most of the provinces and territories in Canada do consult with mental health consumers in the policy-making process and a significant aim of the Mental Health Commission is consultation with all Canadians.⁶⁰ Every conversation about the mental health of Canadian women is no conversation at all without the input of these women and their families. Their real life experiences reveal the specific needs of these women; their involvement should be a critical goal of all mental health care systems in Canada.⁶¹

(6) - Creation of a Working Group by the Federal Government

The sixth recommendation of a National Women's Mental Health Care Strategy is for a federally created working group. Representation from provincial and federal mental health organizations including representatives from Health Canada, the Women's Health Bureau, the Canadian Alliance for Mental Illness and Promotion and advocates in each province and territory

⁶⁰ Mental Health Comm'n of Can., *Moving Forward Together: Stakeholder perspectives on the priorities of The Mental Health Commission of Canada* (Oct. 9-17, 2007), http://www.mentalhealthcommission.ca/documents/MHCC_StkhldrRprt.pdf. The Commission held consultations with the mental health stakeholder community; seven stakeholder consultation sessions in six cities: Halifax, Saint John, Toronto, Winnipeg, Edmonton and Vancouver.

⁶¹ Morrow, *supra* note 10, at 7.

will assist with and oversee the development of an effective and meaningful informed National Women's Mental Health Care Strategy.⁶²

(7) - Adoption by the Mental Health Commission and All three Levels of Government of the Population Health Analysis Approach and a Gender-Based Analysis Approach

The seventh and last recommendation is the adoption, by the Mental Health Commission and all three levels of the government, of two key tools to assist policy-makers, health planners and researchers. These two tools are: the population health approach analysis⁶³ and the gender-based analysis.⁶⁴ The purpose of the population health approach is the identification of sources of poor mental health and specific mental health needs of groups of individuals including women. Once specific needs are identified, the gender-based analysis is employed to assess governmental policies, legislation and other governmental actions that address mental health problems specific to women. The adoption and application of these approaches will produce the information that is necessary to ensure that the mental health care system includes women centred health care options, treatments and service models.

The population health approach maintains that individual and community well being is determined by complex interactions between social and economic factors, physical environment and individual behaviour.⁶⁵ Mental health is intricately interwoven with physical health and is a function of the interrelationship between and among determinants of health that impact people's

⁶² *Id.* at 9.

⁶³ See Eansor, *supra* note 6, at 13. See also The Secretariat for Intersectoral Healthy Living Network, Minister of Health, *The Integrated Pan-Canadian Healthy Living Strategy* (2005) [hereinafter *Healthy Living Strategy*], http://www.phac-aspc.gc.ca/hl-vs-strat/pdf/hls_e.pdf. The strategy was approved by Federal, Provincial and Territorial Ministers of Health in October 2005. The strategy includes the population health approach. Recommendation 103 of *Out of the Shadows At Last*, *supra* note 35, at 421, calls for the inclusion of mental health as an immediate priority health issue in the strategy.

⁶⁴ See *Women Mental Health, Addiction*, *supra* note 2.

⁶⁵ Public Health Agency of Can., *The Population Health Approach—What determines health?* (2004) [hereinafter *What Determines Health?*], <http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/determinants.html>; See WHO, *The World Health Report 2001—Mental Health: New Understanding, New Hope* 14 (WHO 2001) [hereinafter *New Understanding, New Hope*]; See also *Out of the Shadows at Last*, *supra* note 35, at 412-413. *Out of the Shadows At Last* adopted these determinants at 412-413.

living, lifestyles and working circumstances.⁶⁶ Addressing the determinants of health and their interactions in a given population or sub-population is a key element of the approach and the goal is to “frame” health issues in terms of their causes.⁶⁷

Scientists have discovered that the health of any population can be improved by addressing the determinants of health, as they are amenable to change. Thirteen determinants of health are presently recognized and include: sex, gender, income and social status, employment/working conditions, social environment, health services, social support networks, education, physical environments, personal health practices and coping skills, health child development, and culture.⁶⁸ There is a paucity of population health approach research about women and specifically about women and depression. At the same time, collected data from many reports and sources have drawn a link between women and the following determinants of health.

Sex and gender interact with income and social status, and deficient health services resulting in a higher prevalence of mental health problems in poor women. Women constitute more than 70% of the world’s poor.⁶⁹ Older women, Aboriginal women and single mothers are disproportionately poorer than other women and than men. Treatment, program development and policy in our health services do not address these inequities and this contributes to the severity of the mental illness these women experience. The safety of these women is also

⁶⁶ Public Health Agency of Can., *The Population Health Template Working Tool* (July 2001) [hereinafter *Population Health Template Working Tool*], http://www.phac-aspc.gc.ca/ph-sp/phdd/pdf/template_tool.pdf. The population health approach consists of eight elements. One of the key elements is the examination of the determinants of health and their interactions in a population or subpopulation. Once risks to mental health are identified, workplace intervention strategies can be developed and implemented. The Public Health Agency acknowledges that not all eight key elements will be addressed at the same time and by the same individuals and agencies. Research that addresses any of the elements is a contribution to gaps that exist in current knowledge.

⁶⁷ *Id.* at 2.

⁶⁸ *Id.*

⁶⁹ *Gender Disparities*, *supra* note 12, at 12.

jeopardized as ⁷⁰ poverty is often integrally connected with increased risk of violence and abuse for women with mental illness. Depression can also be predicated as a function of the interrelationship between and among these determinants. As we have seen, women are overrepresented with depression and poor women who lack social status, income and employment opportunities are overrepresented amongst women in the general population experiencing depression.

Globally, women experience discrimination and inequality in all facets of their lives. The connection between inequality and mental health problems including depression has yet to be fully explored by researchers; however health scientists have made some important findings to date. These scientists have linked poor mental health with the stress that is generated by current, sustained and recurring patterns of direct and systemic discrimination within the workplace and within the family and the community. ⁷¹ For example, in her 1998 piece “Legal and Ethical and Legislative Issues and Women’s Health in Canada” Karen Capen attributes inevitable and serious health consequences directly to the inequality and discrimination that women sustain.⁷²

Clearly, the most disadvantaged in our society are most likely to experience poor mental health resulting from the interaction of the determinants of health. Interestingly, however, the negative effects generated by the interaction of determinants of health are not confined to this group. Rather, there is a strong “social gradient” of health whereby the negative effects have been shown to “run across society”, reoccurring within sub-populations or groups of individuals such as employed professional women.⁷³

⁷⁰ Morrow, *supra* note 10, at 3.

⁷¹ WHO Eur., *Social Determinants of Health. The Solid Facts* 13 (Richard Wilkinson & Michael Marmot eds., 2d ed. 2003) [hereinafter *Social Determinants of Health*], <http://www.euro.who.int/document/e81384.pdf>.

⁷² Karen Capen, Health Can., *Legal and Ethical and Legislative Issues and Women’s Health in Canada* ¶ 2 (Women’s Health Forum: Legal, ethical and legislative issues 1996), http://www.hc-sc.gc.ca/hl-vs/pubs/women-femmes/can-usa/can-back-promo_13_e.html.

⁷³ *Social Determinants of Health*, *supra* note 71, at 10.

For example, among employed women, a clear connection between work-life conflict and mental health problems, especially depression, is revealed in existing data. Work-life conflict occurs when the cumulative demands of paid work and non-paid work are incompatible, so that participation in one role is made more difficult by participation in the other role. The conflict is conceptualized to include role overload, defined as having far too much to do and too little time to do it in. Women report work-life conflict⁷⁴ and correspondingly very high levels of stress at much higher rates than do men.⁷⁵ Current as well as persistent and sustained stress correlates with depression.⁷⁶ Stress impacts on self-esteem and produces “a sense of loss and defeat, entrapment, and humiliation denoting devaluation and marginalisation,” all of which are predictors of depression.⁷⁷ Distress is also generated by stress and research shows that distressed women are four times more likely to experience depression.⁷⁸

A population health approach analysis of women in the legal profession illustrates the social gradient of health and reveals the causes that might increase the risk and incidences of mental health problems in this group of women. Data available about women lawyers and their integration into the legal profession⁷⁹ allows for the consideration of the following determinants

⁷⁴ Eansor, *supra* note 6, at 22.

⁷⁵ Deborah L. Rhode, ABA Comm'n on Women in the Profession, *The Unfinished Agenda: Women and the Legal Profession* 17 (2001), <http://www.abanet.org/ftp/pub/women/unfinishedagenda.pdf>. *The Unfinished Agenda* is a comprehensive contemporary review of the status of American women in the legal profession. This report seeks to identify both the progress made in eradicating the difficulties that women face, and the work that still needs to be done to achieve equality for women in this field.

⁷⁶ *Social Determinants of Health*, *supra* note 71, at 12-13.

⁷⁷ *Gender Disparities*, *supra* note 12, at 12.

⁷⁸ Thomas Stephens, Corinne Dulberg & Natacha Joubert, *Mental Health of the Canadian Population: A Comprehensive Analysis*, 20 *Chronic Diseases in Canada* 118, 122 (1999), available at <http://www.phac-aspc.gc.ca/publicat/cdic-mcc/pdf/cdic203e.pdf>.

⁷⁹ The data is contained in three recent reports: two from Canada and one from the United States. The first of the two Canadian reports is: Merrill Cooper, Joan Brockman & Irene Hoffart, Law Society of Alta., *Final Report on Equity and Diversity in Alberta's Legal Profession* (Jan. 26, 2004), http://www.lawsocietyalberta.com/files/reports/Equity_and_Diversity.pdf. The second of the Canadian reports is: Fiona M. Kay, Paula Curry & Cristi Masuch, The Law Society of Upper Can., *Turning Points and Transitions: Women's Careers in the Legal Profession* (Sept. 2004), available at http://www.lsuc.on.ca/media/oct2604_turning_points.pdf. The report from the United States can be found at: *see* Rhode, *supra* note 75.

of health: sex, gender, income and status, employment/working conditions, social environment, social support networks and physical environments. The consideration of these determinants revealed that women lawyers:

- face pervasive direct and systemic discrimination within the legal profession;
- earn less income and occupy fewer partnership positions than do their male counterparts;
- are less likely to be in positions of seniority or supervision;
- experience low levels of autonomy and have little policy decision-making power;⁸⁰
- do not enjoy a presumption of competency whereas male lawyers do;
- are assumed to lack the commitment required for partnerships and senior partnerships if they are mothers, unlike male lawyers who are fathers;⁸¹
- are outsiders in the legal profession with inadequate access to informal support networks and formal support networks including mentors in legal work settings;
- continue to be sexually harassed and this results in a hostile work place and undermines positive collegial relationships;⁸²
- report the highest levels of work-life conflict.⁸³

Presently, research is ongoing in Canada at the University of Windsor, a joint project of the Faculty of Law and the Department of Psychology, about these risks as potential causes of mental health problems among women who engage the law.⁸⁴ An examination of women's levels of depression and anxiety, as well as whether women's levels of resistance moderate the impact of negative workplace experiences will emerge from the collected data. Whether women lawyers are resistant to mental health problems like depression or whether they are more likely to be candidates to experience higher incidences and rates of mental health problems like depression will make an equal and valuable contribution to the research about employed women and mental health problems. If incidences and rates of depression are higher than those of the

⁸⁰ See Eansor, *supra* note 6, at 15-16.

⁸¹ *Id.* at 18-19.

⁸² *Id.* at 19-21.

⁸³ *Id.* at 21.

⁸⁴ The Canadian Bar Association, Law for the Future Fund, approved funding for a project entitled: *The Mental Health of Women in the Legal Profession: Incidence, Causes and Consequences*. This project aims to examine features of the working lives of women in the legal profession and to assess their impact on indicators of mental health. The survey instrument is based on existing psychometrically sound measures of workplace characteristics and outcome measures of stress, depression and anxiety. This survey has been administered to a large random stratified sample of women in the legal profession in Canada. Work on the project commenced in January 2007.

general population, the results will fill gaps that currently exist in our understanding about mental health risks for women in the paid workplace and the strategic interventions necessary to promote good mental health. If women lawyers are in fact resistant to these stresses and incidences and rates of mental health problems are consistent with those of the general population the focus of further inquiry will shift to a search for the sources of that resilience and capacity for good mental health that women lawyers' possess.⁸⁵

The application of the population health approach analysis to poor and unemployed women as well as employed women, specifically women lawyers, reveals causes that increase the incidences and rates of mental health problems for these women. A common thread between and among these women is gender and its importance is the focus of the gender-based analysis approach. This approach assesses the design, implementation and impact of all government action, including government health strategies through a gender lens. Such an examination ensures that the diverse needs of women, including their unique mental health needs are accounted for and addressed as an integral component of government policies. Health care policy will be positively impacted with the adoption of this analysis by all relevant branches of government.⁸⁶ A legislative mandate for gender equality that requires governmental bodies to employ the analysis would promote the process and the Government should move quickly to legislate this mandate in accordance with the suggestion of the Standing Committee on the Status of Women.⁸⁷

Thus far, we have three key strategies for positioning women on relevant health care agendas: recognizing the sense of urgency, developing and implementing a National Mental

⁸⁵ See Eansor, *supra* note 6, at 6.

⁸⁶ *Id.* at 12.

⁸⁷ Georgina Steinsky-Schwartz et al., The Expert Panel on Accountability Mechanisms for Gender Equality Final Report, *Equality for Women: Beyond the Illusion* 10 (Dec. 2005), http://www.swc-cfc.gc.ca/resources/panel/report/report_e.pdf.

Health Care Strategy and a National Women's Mental Health Care Strategy. With three key strategies in place, the next part of the discussion focuses on the way in which lawyers might contribute to the development and implementation of these strategies and explores other ways in which lawyers might contribute to the eradication of the inequality of women with mental health problems in fulfilling the many roles they occupy within Canadian society.

IV — Enter The Lawyers

It appears that all lawyers, both men and women have a vested interest in the development and implementation of both a National Mental Health Care Strategy and a National Women's Mental Health Care Strategy. A number of scientific studies between an individual's occupation and higher incidences and rates of mental health problems show a clear relationship between lawyers and elevated mental health risks. In fact, these studies show that lawyers topped the list of over one hundred occupations with incidences and rates of depression.⁸⁸

Vested interest or not, lawyers have an obligation and responsibility to work to complete the unfinished substantive equality agenda for Canadian women and the unequal treatment of women's mental health issues in Canada as an integral and critical component of this agenda. Like the *Famous Five*, lawyers are persons of privilege, of power and of influence. With privilege comes responsibility and lawyers are uniquely situated with knowledge, expertise and legal skills to take on the formidable tasks outlined thus far. In the next and final part of the discussion, four roles of lawyers are explored with a goal of identifying ways in which lawyers who occupy these roles can constructively contribute to gaining equality for Canadians including women with mental health problems.

⁸⁸ See Eansor, *supra* note 6, at 3.

V — Summon The Lawyers—Engaging Lawyers In Mental Health Issues And The Law

A law degree provides lawyers with many opportunities to engage the law and as a result, lawyers occupy many different roles and functions in Canadian society. Four roles demonstrate the way in which lawyers might contribute to the completion of the unfinished substantive equality agenda for women and the unequal treatment of women's mental health issues in Canada as an integral component of this agenda. These four roles are: Lawyers as Employers, Lawyers as Legislators and Policy Makers; Lawyers as Advisors and Advocates; and Lawyers as Lobbyists.

(i) Lawyers as Employers

Law firms and universities are major employers of lawyers and legal academics as well as many other employees who comprise the necessary support staff to operate these organizations. Lawyers also act in the capacity of in-house counsel to corporations and to government employers all of which have employees, some in trade unions and some not. All Canadian employees are affected by their work environment and the management practices specific to these workplaces. Moreover, management practices include the legal obligation of employers to accommodate employees with special needs including mental health problems. As a result, lawyers who are employers have the opportunity to make a positive impact on the lives of their employees with mental health problems through the development and implementation of comprehensive workplace intervention strategies that eradicate those risks that can potentially generate mental health problems in employees.

The development of workplace intervention strategies that are sensitive and accommodating to the needs of employees with mental illness is a formidable challenge for

employers. Research about mental health and the workplace is sparse and disparate and the issues are complex and multifaceted. There is little data on the prevalence of mental illness in the workplace⁸⁹ and there is a clear absence of scientific consensus on how to define and measure a high-risk psychosocial work environment. Although much more research is needed, existing data clearly shows that the quality of workplaces or lack thereof, impacts on the mental health of employees. It is known that the workplace can contribute positively to mental health, well being and recovery from mental illness. At the same time, work environments can contribute to the development of mental health problems, including stress, depression and anxiety. A consult to the *Out of the Shadows At Last* committee summed it up as follows: “Therein we have one of the fundamental paradoxes we face today. Work is good for your mental health and work can make you crazy.”⁹⁰

Employers can focus on the quality of their workplaces and work toward the development and implementation of comprehensive workplace intervention strategies in two key ways: primary prevention measures aimed at eliminating factors in the workplace that have a negative impact on the mental health of employees, and secondary intervention strategies crafted to reduce the effects of a stressful work situation by improving the ability of employees to manage stress. Primary prevention has the greatest potential to create longer-lasting effects than secondary prevention. However, the existence of both primary and secondary prevention

⁸⁹ See *Out of the Shadows at Last*, *supra* note 35, at 176.

⁹⁰ *Id.* at 171. Workplaces sensitive to the mental health needs of employees are more productive and the investment into a quality workplace that reduces mental health risk factors just makes good business sense. There is a considerable amount of evidence about the cost of mental disability to employers and to Canadian society. Disability claims attributable to mental illness is the fastest-growing area of disability costs in Canada accounting for 60% to 65% of all disability insurance claims among employers. Mental illness ranks among the first two types of disability in Canada and, of the ten leading causes of disability worldwide, five are mental disorders: unipolar depression, alcohol use disorder, bipolar affective disorder, schizophrenia and obsessive-compulsive disorder. As the cost of mental disorders fall mostly on employers and employees, there is a persuasive economic case that exists for employers to improve the quality of their workplaces. See *id.* at 177.

measures guarantee a quality workplace that will at a minimum reduce mental health problems in employees.

Primary Prevention Measures – Well-Structured Organizational Approach

The most effective primary prevention measure that an employer can create is a management practice in the form of a well-structured organizational approach that identifies work-related causes for mental health problems and reduces or eliminates stress. As discussed earlier, stress is a predictor of mental health problems including anxiety and depression. Key to the success of this measure is support from senior management, the involvement of employees in crafting the practices, as well as full implementation of the practice including on-site management.

Empirical evidence has identified management practice or behaviours that can precipitate or aggravate mental health problems in a work environment.⁹¹ Other research has suggested the existence of at least seven key environmental stressors that can elevate the risk of an employee experiencing mental health problems. These environmental stressors include: occupying low rank positions, low levels of control over and input into working circumstances, low levels of autonomy and decision making, the absence of social support networks and mentors at work, inadequate pay, work-life conflict and discrimination. All of these stressors are determinants of health and amenable to change. As a result, a well structured organizational approach that crafts management practices to eliminate the existence of these stressors in the workplace will diminish the rates and incidences of mental health problems among employees.

Secondary Prevention Measures- Workplace Management Programs

⁹¹ See *Out of the Shadows at Last*, *supra* note 35, at 181-182.

Workplace disability management programs target recovery and return to the workplace following an illness. Presently most programs focus only on employees with physical disabilities and should be expanded for application to employees with mental health issues. This expansion is challenging as the mental health care system and the workplace differ in significant respects; different cultures, languages, practices and priorities create delays in returning to work for these employees. What are needed are common goals, a shared understanding and a common language that will allow information to be shared and knowledge to be disseminated across these two very different environments. Employers as well as mental health providers can accomplish these objectives and integrate the environments with leaders, “boundary walkers” who are educated in both mental health and employer issues.⁹²

A critical component of all workplace disability management programs is the legal duty of employers to accommodate employees with mental health problems and provide equitable treatment for these individuals.⁹³ Accommodation is a critical issue for all individuals with mental health problems and it is particularly so for women as issues of disability intersect with issues of sex, gender and family status creating a complex analysis of what constitutes accommodation in each individual case.

Accommodation refers to ‘any modification of the workplace, or in the workplace procedures that makes it possible for a person with special needs to do a job.’⁹⁴ Employers are required to accommodate individual employees sharing the characteristics of the mentally ill employee to the point of undue hardship. The law does not require the imposition of undue

⁹² *Id.* at 18.

⁹³ Canadian Human Rights Act, R.S.C., ch. H-6 (1985); Ontario Human Rights Code, R.S.O., ch. H.19 (1990). Section 2(1) of the Ontario Human Rights Code states that accommodation provides that “[e]very person has a right to equal treatment with respect to the occupancy of accommodation, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status, disability or the receipt of public assistance” [emphasis added].

⁹⁴ See *Out of the Shadows at Last*, *supra* note 35.

hardship on an employer and thus, what will constitute an undue hardship in any given case will rest on an assessment of the resources and of the exact nature of the business of the employer.⁹⁵

In order to accommodate employees with mental health problems an individual and specific needs approach is warranted. Delineating the parameters of legal accommodation in this way is requisite for at least two reasons. First, mental disability intersects with the specific individual characteristics and circumstances of the employee. Issues of gender, sex and family status for example are particularly relevant to the accommodation assessment for women employees. As a result, the assessment of the individual's mental health problem involves the consideration of factors in the workplace as well as factors specific to the individual that might exist outside of the workplace.⁹⁶ Second, the episodic nature of mental illness makes accommodation a more complex determination than a determination for example that accommodates a physically disabled employee who requires consistent and continual accommodation including wheelchair access. Employees with mental illness are not usually continuously ill. Rather, illness is cyclical; the employee experiences periods of illness and wellness. When well, productivity at work is maintained. When ill, many employees are not able to function at a level necessary to maintain regular employment on a part or full-time basis.⁹⁷

The individual and specific needs approach as well as the parameters of what constitutes undue hardship have been recently tested in the case of *Syndicat des employées et employés de techniques professionnelles et de bureau d'Hydro-Québec c. Hydro-Québec*.⁹⁸ The Supreme

⁹⁵ B.C. (Pub. Serv. Employee Relations Comm'n) v. B.C. Gov't and Serv. Employees' Union (B.C.G.S.E.U.) (Meiorin Grievance), [1999] 3 S.C.R. 3, 176 D.L.R. (4th) 1.

⁹⁶ See *Out of the Shadows at Last*, *supra* note 35, at 171-173.

⁹⁷ *Id.* at 174.

⁹⁸ *Syndicat des employées et employés de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ) c. Hydro-Québec*, 2006 QCCA 150, *rev'd*, [2004] J.Q. no 11048 QUICKLAW (Super. Ct. Oct. 21, 2004).

Court of Canada heard and reserved judgment in the case in January of this year.⁹⁹ The Quebec Court of Appeal determined that Hydro-Quebec had not met the legal duty to accommodate a mentally ill employee to the point of undue hardship.¹⁰⁰ The employee, Ms. Manon Laverriere, had been employed by Hydro-Quebec for 24 years and was dismissed in 2001 for an exceptionally high rate of absenteeism as well as her current and future inability to regularly and reasonably perform her job. The company based the latter evaluation on the opinions of psychiatric experts who concluded that Ms. Laverriere's attendance problems at work would unlikely improve in the future.

Over the course of her employment, Ms. Laverriere was absent from work for many days. For example, over a seven year period she was absent for 850 days due to injury, inter-personal conflict, depression and two suicide attempts. In 2000, Ms. Laverriere was absent 210.5 days often offering no explanation to Hydro-Quebec. She was diagnosed by many doctors in 2000 and 2001 as suffering from a personality disorder although the doctors did not agree on whether there was a solution to the attendance problems and whether she could perform her job in the future even with accommodation.

In arbitration and at trial, Hydro-Quebec demonstrated that the only way to fully accommodate Ms. Laverriere would be to consistently and continuously provide her with new working environments, supervisors and colleagues.¹⁰¹ The arbitrator and the trial judge found that the repeated creation of new work environments transcended the legal duty to accommodate as this imposed undue hardship on Hydro-Quebec.¹⁰²

⁹⁹ Syndicat des employées et employés de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ) c. Hydro-Québec, [2006] C.S.C.R. no 129, leave to appeal granted.

¹⁰⁰ See *Hydro-Quebec*, 2006 QCCA 150 at ¶ 102.

¹⁰¹ *Id.* at ¶ 46.

¹⁰² Syndicat des employé-e-s de techniques professionnelles et (de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ) c. Corbeil, [2004] J.Q. no 11048 QUICKLAW (Super. Ct. Oct. 21, 2004), at ¶ 52.

The Quebec Court of Appeal disagreed holding that Hydro-Quebec had not met the legal duty to accommodate even though the company had made many efforts to accommodate Ms. Laverriere including providing her with an opportunity to transfer to another location when her job became redundant in 1998.¹⁰³ The court was of the view that a business the size of Hydro-Quebec ought to be able to create a position and schedule to suit the very specific needs of Ms. Laverriere.

The individual and specific needs approach adopted by the Quebec Court of Appeal is well suited to address the issues of accommodation for employees with mental health problems. Each employee must be individually assessed and the Canadian Psychiatric Association has developed recommendations upon which accommodation can be built through positive arrangements.¹⁰⁴ Other research provides a non-exhaustive list of mental health accommodations that operate as a starting point to the determination of appropriate accommodation in each individual case. Examples include, flexible scheduling, changes in supervision, in training, modification of job duties and of work space including the option of working from home.¹⁰⁵ Whether the individual and specific needs approach will become law in Canada and the parameters of undue hardship will become clearer when the judgment of the Supreme Court of Canada is released.

Secondary Prevention Measures – Employee Assistance Programs

¹⁰³ See *Hydro-Quebec*, 2006 QCCA 150 at ¶¶ 20, 120.

¹⁰⁴ The Standing Senate Comm. on Social Affairs, Sci. and Tech., *Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada* 124 (Interim Report 1) (Nov. 2004), <http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/report1/repintnov04vol1-e.pdf>. These positive arrangements include: creating an environment in which arrangements are made in relation to the individual needs of each employee; respecting the employee's desire for confidentiality; the willingness of employers and employees to engage in joint problem solving; voluntary arrangements for the employee that are subject to ongoing review to meet changing needs; employer flexibility in enforcing traditional policies; and identifying and crafting written, concrete and specific accommodation policy and practices. See also *Out of the Shadows at Last*, *supra* note 35, at 184-185.

¹⁰⁵ See *Out of the Shadows at Last*, *supra* note 35, at 185-186.

A second significant secondary intervention strategy is Employee Assistance Programs that are employer-sponsored. Between 60% to 80% of employees in medium-sized or large companies (500 employees or more) have access to such a program. Thus, at the outset, smaller organizations and corporations need to provide equivalent programs to their employees. Evidence shows that these programs are effective as they have become the primary vehicle through which many employees get their first access to mental health care. The programs are not without their limitations however and one consistent limitation is the number of counselling sessions that are offered through these programs. An increase of counselling sessions is needed, as is the establishment of these programs among smaller employers.¹⁰⁶

Lawyers as employers can work to develop primary and secondary intervention strategies in collaboration with the Mental Health Commission of Canada and in close collaboration with the Knowledge Exchange Centre. They can employ ‘boundary walkers’ to foster a common language between the health care system and its providers and employers and their employees.¹⁰⁷ In addition, employers can work in partnership with the federal government through the Opportunities Fund for Persons with Disabilities to help people find and retain jobs.¹⁰⁸

(ii) Lawyers as Legislators and Policy-Makers

At the outset, lawyers who legislate and make policy must bring a population health approach analysis as well as a gender-based analysis to the crafting of legislation and policy.¹⁰⁹ As previously discussed, these tools are critical if laws and policy are to address and respond to

¹⁰⁶ *Id.* at 186-188.

¹⁰⁷ *Id.* at 182-188.

¹⁰⁸ *Id.* at 192.

¹⁰⁹ For a full discussion, see *What Determines Health?*, *supra* note 65; see also *Population Health Template Working Tool*, *supra* note 66.

the mental health needs of Canadians and specifically the mental health needs of Canadian women.

A priority for legislating and policy-making lawyers should be the systematic review of all mental health legislation as well as legislation that impact all Canadians. An example of legislation that impacts all employed Canadians is workers' compensation legislation. All provinces and territories have workers' compensation legislation to deal with workers' related health claims. The current legislative schemes across Canada are disparate and inadequate and the underlying policy as well as the legislation as it relates to mental health claims is in need of significant reform.

Mental health claims are most often categorized as occupational stress yet the content of what constitutes occupational stress varies between and among the boards across Canada, which is the direct result of the different legislative frameworks that exist in each jurisdiction. A consult to the *Out of the Shadows at Last* committee articulated the dilemma:

....It is not reluctance on the part of the boards to provide the benefit, because the board do what the legislation tells us to do. We are the body that gives life to the legislation....That variability goes back to the responsibility of the legislators to design legislation that is response to the social, political, economic, cultural and historical values that are inherent to that jurisdiction. Whether it is right is not for the boards to say. It is our job to administer than legislation...If the legislation says that we cover it, then indeed it would be covered by us.¹¹⁰

¹¹⁰ See *Out of the Shadows at Last*, *supra* note 35, at 192-193.

An additional problem exists regardless of differences in the legislative schemes. Workers' compensation boards determine what disabilities will be recognized utilizing an occupational disease model that is rooted in the legislative language of the respective legislation. Across Canada, disability is based on continuous exposure to hazardous conditions related to an individual's employment. Thus, proving the genesis of a physical illness, the result of exposure to toxins for example fits neatly within the disability paradigm.

On the other hand, the genesis of a mental illness when framed as an occupational stress claim does not fit neatly within the disability paradigm. Occupational stress claims result from workplace stress in combination with other factors, including determinants of health, that are both work related and non-work related. Demonstrating a continuous exposure to hazardous employment conditions as the root of the illness is much more difficult as factors in the workplace interact with factors outside of the workplace to generate the illness.

A co-ordinated effort by legislators and policy-makers across Canada is necessary to accomplish a national legislative approach to occupational stress. What is needed is a consistent definition of occupational stress and this will require a re-thinking of the current disability paradigm. This approach is consistent with a National Mental Health Care Strategy and a National Women's Mental Health Care Strategy. In order to draft appropriate legislation, research is needed and at a minimum, legislators need to move quickly with a sense of urgency to require each jurisdiction to collect data about occupational stress. The number of claims, the nature of the claim (episodic or chronic) and the compensation that was paid in each case is the starting point to collecting the necessary data for legislators and policy-makers to accomplish effective national legislative change.

(iii) Lawyers as Advisors and Advocates

Practicing lawyers act daily as client advisors and engage the judicial system as advocates in the courts, at tribunals and in mediation. In these capacities, lawyers have the opportunity to bring knowledge and expertise about the mental health of Canadians and the mental health of women to venues where law can be reformed and new law made. A clear understanding of the needs of Canadians with mental health problems including Canadian women is needed if stigma and discrimination is to be eradicated and the legal system informed and reformed to adequately respond to the mental health care needs of Canadians.

One avenue to inform and reform the law that is arguably effective is constitutional challenges to legislation that impact on Canadians with mental health problems. Such constitutional challenges have the potential to impact on all Canadians in contra distinction to smaller groups of Canadians, like employees. Moreover, whether successful or not, these challenges often spark public discussion raising awareness about mental illness, about stigma and about the discrimination that individuals with mental health issues experience and as well motivate governments to legislate to produce fair outcomes.

In Canada, section 15 of the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*¹¹¹ provides that every individual is equal before and under the law and has the right to equal protection of the law without discrimination on the basis of race, nationality or ethnic origin, colour, religion, sex, age or mental or physical disability. These rights are guaranteed unless the government can demonstrate that the discrimination is a reasonable limit demonstrably justified in a free and democratic society

¹¹¹ Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11 (U.K.), § 15.

Hospital emergency rooms and the procedure utilized to prioritize patients is one area of the law that might be reformed as it relates to mental health patients and their constitutional rights. Hospital emergency rooms are the point of first access to mental health care for many Canadians.¹¹² This is the case for a number of reasons: there is a shortfall in psychiatrists resulting in long patient waiting lists; other health care professionals such as psychologists are not paid for by the Canadian health care insurance program; there is a disparity in access to and availability of doctors and clinics between and among communities both within individual provinces and nationally; there is considerable stigma and discrimination that exists in Canada with respect to mental health, even among health care providers limiting access and appropriate treatment; over 50% of individuals presenting at emergency rooms are indeed emergencies; and, they are in a crisis that might jeopardize their safety and or the safety of others.

Canadian emergency rooms are filled beyond maximum capacity and long waits are a reality. In order to prioritize patients, the *Canada Health Act* mandates hospitals to implement a five level triage scale known as the CTAS.¹¹³ The triage nurse determines where a patient will be placed in priority to other patients in accordance with these guidelines. A careful assessment of these guidelines reveal discriminatory treatment for patients with mental health problems and specifically for women as it is women who access health care services, such as emergency rooms, in higher numbers than do men.¹¹⁴

The CTAS guidelines differentiate between patients with physical problems and patients with mental health problems. They operate to adversely affect mental health patients in a number of ways resulting in discriminatory treatment of these patients in accessing the mental

¹¹² See Ont. Women's Health Council, *supra* note 17, at 156.

¹¹³ Canada Health Act, R.S.C., ch. C-6 (1985).

¹¹⁴ Ont. Women's Health Council, *supra* note 17, at 151.

health care system and to obtaining appropriate treatment. The following two examples are illustrative of this point.

First, the guidelines are written to provide for a heavy reliance on patient-communicated symptoms. This is problematic for patients with mental health problems as they are generally reluctant to disclose symptoms, even to health care professionals, because of the stigma and discrimination that is more often than not associated with mental health. As a result, triage personnel who follow the guidelines, as indeed they are trained to do, are not equipped with appropriate guidance to illicit those symptoms that a patient with mental health problems is experiencing. As a result, whether a patient is in a crisis that might be life threatening may not be observable by triage personnel.

Moreover, an assumption that experienced triage personnel might fill the guideline gaps is misplaced. Research shows that even health care providers are ill informed and undereducated about mental health problems¹¹⁵ and are as likely as other Canadians to stigmatize and discriminate against individuals with mental health problems, even if only on an unconscious level. Therefore, a triage system that heavily relies on patient-identified complaints and symptom disclosure discriminates against individuals who are unable to articulate their symptoms.

Second, the CTAS guidelines, as written, provide lengthy descriptions and instructions for triage personnel for largely physical problems, yet are vague and limited in their description and instructional guidance on mental health problems. As a result, mental health patients are triaged at lower levels. The level of triage determines at what point in time a patient will be reassessed while they wait to see a doctor and how long that wait will be.

This is a critical void in the law for mental health patients. Since these patients are normally triaged at a lower level they are also reassessed less frequently than patients triaged at a

¹¹⁵ *Id.* at 156.

higher level. These reassessment times present a disproportionate burden upon those with mental illness as many flee the hospital without notice and without seeing a doctor for diagnosis and treatment.¹¹⁶

These two examples demonstrate the way in which the CTAS guidelines discriminate against individuals with mental health problems and offend their dignity as Canadians. Reform of the guidelines to address this discrimination can be accomplished with minor revisions that require minimal resources or a reallocation of existing resources to provide better access to care and appropriate treatment. For example, the existing guidelines provide a panel of questions for triage personnel that do not in any way address mental health issues. The Canadian Psychiatric Association has suggested that direct questioning would be effective in overcoming the challenges mental health patients face in disclosing symptoms and impact significantly on the triage level that these patients are placed at in emergency rooms. An amendment to the guidelines in this respect is a low cost solution to the present and significant void in these guidelines.¹¹⁷ In the end, the government should be required to respond with appropriate guidelines and a section 15 challenge to this legislation to require this response will speak volumes whether it is a successful challenge or not.

(iv) Lawyers as Lobbyists

Lawyers are involved in all three levels of government. They are mayors, municipal counsellors, members of parliament, members of senate, and employees in many governmental departments including the Department of Justice. The mental health legislative scheme in

¹¹⁶ *Id.* at 150.

¹¹⁷ The Canadian Psychiatric Ass'n, *Clinical Practice Guidelines: Treatment of Schizophrenia*, 50 *The Canadian J. of Psychiatry* 1S, 11S (Nov. 2005), available at http://ww1.cpa-apc.org:8080/Publications/Clinical_Guidelines/schizophrenia/november2005/cjp-cpg-suppl1-05_full_spread.pdf.

Canada is maintained primarily by lawyers including lawyers to the existing boards such as the Consent and Capacity Boards. Nationally, lawyers are present on the Mental Health Commission of Canada and in fact one of the eight advisory committees to the board of the Commission is titled Mental Health and the Law. Lawyers work at legal aid clinics, poverty clinics and for mental health organizations and are in daily contact with Canadians suffering from mental health problems.

In short, lawyers occupy many diverse roles throughout Canadian society and they interact with Canadians with mental health problems and engage issues that call for a consideration of mental health. Lawyers are uniquely situated and their legal skills are empowering; as no matter what role a lawyer might take on in Canadian society, a legal degree and the unique skills that accompany it make her or him an individual of privilege, of power and of influence. As a result, each of these lawyers has the opportunity to raise awareness about mental health in Canada and ensure that the mental health of Canadians and the mental health of women are on every relevant agenda. Each of these lawyers can make a positive contribution to informing and reforming the law as well as society, so that each is more responsive to the needs of Canadians with mental health problems. And, in this way, whether directly or indirectly, every lawyer can contribute to the development and implementation of a National Mental Health Care Strategy and a National Women's Mental Health Care Strategy.

Conclusion

In 2008, substantive equality for women remains an “unfinished agenda” and an integral and critical component of this agenda is the unequal treatment of women's mental health issues both globally and in Canada. Women constitute 70% of the world's poor and poverty is

connected with increased sexual violence, addictions and homelessness. Moreover, sex and gender intersect with race, ethnicity, sexual orientation, age, class, physical ability and gender identity impacting on the mental health of every woman. Women with mental health problems likely constitute the majority of Canada's unemployed and many women who are employed are concentrated in lower wage work sectors and in part-time employment. All of these factors are predictors of poor mental health including depression.

Even among employed women, including professionals like lawyers, substantive equality has not been accomplished and these women's mental health needs remain unmet. Women lawyers report the highest levels of work-life conflict and pervasive discrimination, both direct and systemic in the legal profession. These environmental stressors combined with others impact on the mental health of women lawyers and it might be that these women are one of the most high risk groups in Canada to experience mental health problems like anxiety and depression.

Women and mental health issues, including depression, are not on the Canadian health care agendas. The reasons for this are many and the most significant reasons are: until the early 2000's, the mental health of Canadians was neglected and largely ignored by all levels of government; Canada does not have a National Mental Health Care Strategy that addresses mental health; mental health research, promotion and treatment ignores women's experiences of mental health and mental health care; and, Canada does not have a National Women's Mental Health Care Strategy.

Three key strategies for positioning women, mental health and depression on the health care agendas in Canada are proposed in this discussion: A Sense of Urgency; the development and implementation of a National Mental Health Care Strategy; and the development and

implementation of a National Women's Mental Health Care Strategy as one of the integral components of Canada's national strategy. Seven foundational recommendations for a National Women's Mental Health Care Strategy include: Expansion of Mental Health Services without Direct Charge; A Federal Government mandate of Provincial and Territorial Resources for Women; A Balanced, Diverse, Culturally Sensitive and Nuanced Individual Assessment of Each Woman's Mental Health Needs; Funding for Research from all three levels of government; Mechanisms to Involve Canadian Women and their families in all processes; a federally created working group and; the adoption by the Mental Health Commission and all three levels of government of the population health approach analysis and a gender-based analysis approach.

In the end, we are left with a critical question: Who will take carriage of implementing these strategies and working toward the completion of the "unfinished agenda" for substantive equality for women that include the critical component of mental health equality? The establishment of the Mental Health Commission of Canada is a step in the right direction and collaboration with all three levels of government and all stakeholders including Canadian women with mental health problems and their families will be instrumental in the development of a National Mental Health Care Strategy and a National Women's Mental Health Care Strategy. The development and implementation of these strategies will put women's mental health issues on the health care agendas in Canada and this is critical to the task of attaining mental health equality.

Lawyers can also play a significant role in the implementation of these strategies and the attainment of equality. They might have a vested interest, both men and women lawyers, as studies have shown that lawyers top the list of occupations with incidences and rates of depression. Vested interest or not, like the *Famous Five*, lawyers are persons of privilege, power

and influence and this uniquely situates them to make a difference. Privilege carries responsibility: “With privilege comes responsibility and commitments to equality are not enough. A sense of urgency, a clear vision of equality...as well as constant vigilance and hard work are necessary....”¹¹⁸

A law degree provides lawyers with many opportunities to engage the law and lawyers occupy many different roles and functions in Canadian society in which they engage with Canadians with mental illness and with mental health issues. There are multiple ways in which lawyers can contribute and specifically four roles of lawyers have been explored to demonstrate this: Lawyers as Employers; Lawyers as Legislators and Policy-Makers; Lawyers as Advisors and Advocates; and Lawyers as Lobbyists. Lawyers are individuals of privilege, power and influence who enjoy membership among the keepers of the justice system; they can be leaders in contributing to the completion of the “unfinished agenda” of substantive equality for women including the unequal treatment of women’s mental health issues both within the legal profession and within Canadian society.

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