

WITHIN REACH *Fall 2009*



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PART I: **UPCOMING REACH EVENT OF THE SEASON**

REACH CANADA 29th ANNUAL AUCTION: *An Enchanted Auction*

Presented by TD Bank Financial Group

Reach Canada was founded twenty-nine years ago during the International Year of Disabled Persons. The success Reach generates is the result of support from our volunteers, donors and the expertise of approximately 200 lawyers who donate their time annually. The funds we raise ensure that we continue to provide lawyer referrals and extensive educational programs to the community.

In honour of our 29th anniversary, Reach Canada is delighted to present live and silent auctions. This high profile event will also feature a corporate cocktail reception and dinner. We hope you will join us to ensure that Reach Canada continues to meet its mandate of providing education and raising awareness about the rights of individuals with disabilities.

The Enchanted Events

The REACH CANADA 29th ANNUAL AUCTION presented by TD Bank Financial Group will be held on **Thursday, October 29, 2009** at the **St. Elias Centre** at 750 Ridgewood Avenue. The events of the evening are:

- Silent Auction and Reception sponsored by **Stoneworks Technologies Inc.** and **e18hteen**. This will start at 5:00 p.m.;
- Gourmet Dinner catered and hosted by **Vittoria Trattoria** and sponsored by **Urbandale Corporation**. The dinner will start at 6:30 p.m.;
- Live Auction. The auction will start after dinner; and
- Music is provided by **The Jazz Mutants**.

Admission Prices

Corporate Tables \$1,100

(Seating 8 people: Includes Cocktail Reception, Gourmet Dinner and Wine)

Individual VIP \$115 (Includes Gourmet Dinner, Wine, and Partial Tax Receipt)

Tickets can be ordered online at www.reach.ca or by fax or phone (see below).

More Information

Telephone: 613-236-6636

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(Charitable Registration Number 10788 9297-RR0001)

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PART II: **REACH CANADA UPDATES**

The 28th Annual General Meeting Award Winners

Reach Canada held its 28th Annual General Meeting (AGM) on June 2nd, 2009. As part of this year's AGM, Reach presented volunteer awards to individuals and groups who have shown outstanding dedication to our not-for-profit organization. Reach Canada's President and long-time supporter, Michael Sousa, and Steven Fletcher, M.P., former Reach Honorary Chairperson, were present to hand out the following awards:

- Ramon J. Hnatyshyn Reach Lawyer Volunteer of the Year: *Domenic Crolla,, Gowling Lafleur Henderson LLP*
- Corporate Sponsor of the Year: *Vittoria Trattoria*
- Volunteer of the Year: *Sharon Wilson*
- Student Volunteer of the Year: *Yar Diduch*
- Gift of Appreciation: *Alfredo Garcia*

We are very pleased to honour these outstanding individuals. Their commitment to Reach Canada over the past year has been indispensable to promoting justice and equality for all Canadians.

CONGRATULATIONS!

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Financial Security and Disability Seminar Series

Presented by



Reach Canada is proud to have organized and hosted *The Financial Security and Disability Seminar Series* in the Winter/Spring of 2009. This series was held at Reach Canada, 400 Coventry Road in Ottawa, Ontario. The goal of the seminar series was to learn about making the most of one's money and resources, saving for one's future, and ensuring a loved one's financial security.

Four seminars were presented: (1) Making Sense of the Tax Free Saving Account, the Registered Disability Savings Plan and Henson Trust, (2) Taxes and Disabilities, (3) Personal Injury Law, and (4) The Ontario Disability Support Program.

1. Making Sense of the Tax Free Saving Account, the Registered Disability Savings Plan and Henson Trust

The *Making Sense of the Tax Free Saving Account, the Registered Disability Savings Plan and Henson Trust* seminar was held on Thursday, February 19, 2009 from 12:00 to 2:00 PM. The guest speakers were Robert Real (Financial Advisor, Edward Jones) and Ron Tomosk, LL.B. (Low, Murchison LLP). The two speakers de-mystified these savings vehicles and answered questions related to eligibility, contributions, investment options and impacts on income-tested benefits. The seminar audience included persons with disabilities and their family members and caregivers, as well as community social and health service providers. Many attendees felt that the seminar provided them with a comprehensive understanding of the Registered Disability Savings Plan (RDSP) and Tax Free Saving Account (TFSA). Quote from an evaluation stated that:

“both Robert Real and Ron Tomosk are high calibre speakers, extremely knowledgeable in their fields, and most importantly, excellent communicators to the general public, and they had something useful even for those who know some, and those who know little”.

Overall, a great seminar to begin the series!

2. Taxes and Disabilities

The second seminar in the series took place on Thursday March 19, 2009. The guest speakers were Jeffrey McAvoy LL.B. (Drache LLP), James Gibbons (Certified General Accountant, Canada Revenue Agency) and Edudzi Ofori LL.B. (Drache LLP). The goal of this seminar was simple: to ensure that

attendees know how to get all the tax credits they are entitled to and pay absolutely no more taxes than they have to. Topics included, but were not limited to: (1) The Disability Tax Credit; (2) The Child Disability Benefit; (3) The Medical Expense Tax Credit; and (4) Registered Disability Savings Plan. The audience included persons with disabilities and their family members and caregivers, as well as Federal government employees.

3. Personal Injury Law

The *Personal Injury Law* seminar was held on Tuesday April 21, 2009 from 12:00 to 2:00 PM. The guest speakers were David Hollingsworth, LL.B. (Goldberg Wiseman Stroud Hollingsworth LLP), Laura A. Mullin, B.A., CIP, CSSC (McKellar Structured Settlements Inc.) and Stephen Pauwels, B.A. (Hons.), MBA (BridgePoint Financial Services Inc.). The speakers reviewed regulations related to personal injury settlements and explained a party's rights and obligations when seeking a settlement. The audience was composed of persons with disabilities, their family members and caregivers, community social and health service providers, Federal Employees, and paralegal students from a local college. Attendees described the seminar as:

“An excellent presentation. Good, informative seminar providing valuable alternatives to awards/settlement plans for long-term disabilities associated with injuries. Good information regarding current legislation.”

This was an essential seminar for anyone affected by a personal injury that led to a long-term disability.

4. The Ontario Disability Support Program

The *Ontario Disability Support Program (ODSP)* seminar was held on Thursday May 28, 2009. The guest speakers were Gary Stein, LL.B. (South Ottawa Community Legal Services) and Cherry Visser, Manager (Ontario Disability Support Program). Both Mr. Gary Stein and Ms. Cherry Visser explained how to apply for and navigate through the ODSP process. They also highlighted what to do if your claim for ODSP is refused, including the appeal process. Attendees included persons with disabilities, their family members and caregivers, Federal employees, community social and health service providers, and law students with an interest in ODSP. Many attendees found this seminar to be extremely beneficial and had many personal questions for both Gary Stein and Cherry Visser. In fact, many wished this was not the last seminar in the series and they would benefit from more financial planning advice related to wills and ODSP.

Overall, the seminar series was an enormous success. Many people in the community benefited from the financial information provided by the guest speakers and are looking forward to the Fall 2009 seminars.

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Lawyer Referral: Update



One of the primary ways in which Reach Canada improves the quality of life of persons with disabilities is by offering lawyer referral services.

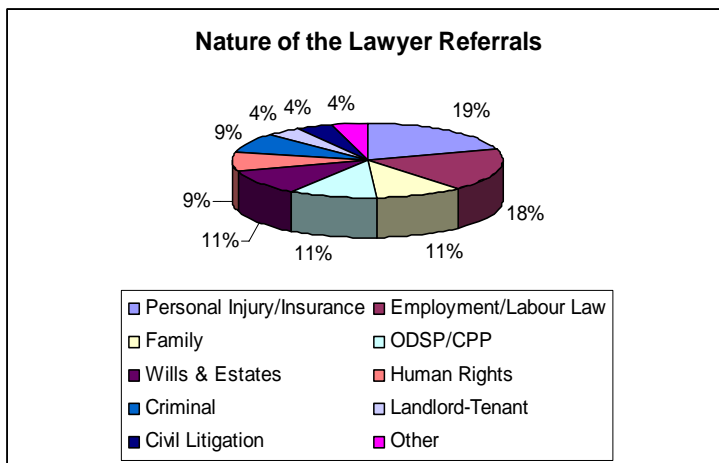
Reach receives hundreds of calls from people with disabilities who contact us for help with various legal issues such as: landlord/ tenant disputes, insurance claims, and employment matters, to name a few.

As a well-established and active organization, Reach mobilizes a network of approximately 200 lawyers in the Ottawa region to help people with disabilities deal with their legal problems.

Our volunteer lawyers provide up to three hours of legal advice, consulting and services on a pro-bono basis (i.e. free of charge). During the first consultation, if more time is required, a fee or continued pro-bono services are discussed between lawyer and client.

From January 1 to August 1, Reach Canada received over 100 requests from persons with disabilities in need of legal assistance. Each client request can take up to five calls to Reach volunteer lawyers to complete the process of matching the client's legal issue to a lawyer.

The clients' legal issues were complex, sensitive, and diverse in nature, encompassing many areas of law:



The most frequent requests were for lawyers in the following five areas of practice: personal injury/insurance, employment/labour law, ODSP/CPP, wills & estates and family law.

If you are a person with a disability and are in need of legal advice, or know such a person, please consult yourself/ refer the person to REACH Canada through the following means:

- Telephone at 613-236-6636/ TTY: 613-236-9478; or
- Visit www.reach.ca and complete a *Get a Referral* Form.

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Reach Canada on Wikipedia!



WIKIPEDIA
The Free Encyclopedia

Reach Canada is proud to announce the launching of a comprehensive article about our organization on Wikipedia in July 2009. Our long-time supporter, Alfredo Garcia, the author of the article, briefly outlines the background and some historical highlights of our organization.

To view the article and learn more about REACH, please visit:
http://en.wikipedia.org/wiki/Reach_Canada

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PART III: **DISABILITY ISSUES**

Disability & the Law: Accessibility for Ontarians with Disabilities Act (2005)

By Jennifer Hiatt
(Common Law Student at the University of Ottawa)

According to Statistics Canada Participation and Activity Limitation Survey (PALS) approximately 4.4 million people in Canada have a disability.¹ Of this total, approximately 1.8 million reside within Ontario.² To ensure that all Ontarians will have full access to goods and services the Government enacted the *Accessibility for Ontarians with Disabilities Act (AODA)* on June 13, 2005.³

The *AODA* is the first legislation of its kind in Canada. The new legislation recognizes the history of discrimination against people with disabilities. It seeks to make all of Ontario fully accessible by January 1, 2025 through the development, implementation, and enforcement of accessibility standards.⁴

What is a Standard?

A standard is “an agreed way of doing something”.⁵ It establishes best practices or requirements in an area. Accessibility standards under the *AODA* will set out rules to make Ontario more accessible. Specifically, businesses and organizations that provide goods and services to people in Ontario will have to meet standards in five important areas: (1) Customer Service, (2) Transportation, (3) Information and Communications, (4) Built Environment, and (5) Employment.

Developing Accessibility Standards

Standard Development Committees (SDCs) will develop and recommend accessibility standards to the Ministry of Community and Social Services.⁶ The SDCs will include individuals from both the private

¹ Statistics Canada, *Participation and Activity Limitation Survey (PALS) 2006* (3 December 2007) at Table 1.1-1, online: <<http://www.statcan.ca/english/freepub/89-628-XIE/2007003/series1-en.htm>>.

² Statistics Canada, *Participation and Activity Limitation Survey (PALS) 2006* (3 December 2007) at Table 2.7-1:, online: <<http://www.statcan.ca/english/freepub/89-628XIE/2007003/series2-en.htm>>.

³ Ministry of Community and Social Services (5 August 2009), online: <<http://www.mcsc.gov.on.ca/mcsc/english/pillars/accessibilityOntario>>.

⁴ *Accessibility for Ontarians with Disabilities Act*, S.O. 2005, c. 11, s.1.

⁵ Ministry of Community and Social Services, “*What is a Standard?*” (5 August, 2009), online: <<http://www.mcsc.gov.on.ca/mcsc/english/pillars/accessibilityOntario/what/standard.htm>>.

⁶ Ministry of Community and Social Services, “*Frequently Asked Questions about the Standards Development Committees*” (5 August, 2009), online: <<http://www.mcsc.gov.on.ca/mcsc/english/pillars/accessibilityOntario/questions/aodo/sdc.htm>>.

and public sectors: school board members, hospital employees, local business owners and employees, representatives of local community organizations, as well as people with disabilities.⁷

The public will also have an opportunity to review and make comments on the accessibility standards that the SDCs recommend to the Ministry of Community and Social Services.⁸ A notice will be posted on the Ministry's website when proposed accessibility standards are ready for review and comment by the public. Following the public review period, the Ministry of Community and Social Services will decide what proposed standards will be recommended to become law.

The Current Status of the Accessibility Standards

The accessibility standards in the areas of customer service, transportation, information and communications, built environment, and employment are at different stages of the development process.

The Transportation standard and the Information and Communications standard have already been released for mandatory public review and the final proposed standards have been submitted to the Minister of Community and Social Services for consideration as law.⁹

The Employment standard has been released for mandatory public review.¹⁰ However, the Employment SDC must still review and consider the input from the public before submitting a final proposed standard to the Minister of Community and Social Services.

On July 14, 2009, the Ontario Government released the initial proposed Accessible Built Environment Standard for public review.¹¹ This standard will be open for public review until October 16, 2009. If you wish to comment on this standard please visit the Ministry of Community and Social Service's website at: <http://www.mcsc.gov.on.ca/mcsc/>.

The accessibility standards relating to Customer Service are the first to come into effect. As of January 1, 2008, customer services delivered in Ontario must be accessible to people with disabilities.¹² Specifically, all organizations providing goods or services to the public are required to implement specific policies, training and procedures as outlined in two Ontario Regulations under the *Accessibility for Ontarians with Disabilities Act, 2005*: Ontario Regulation 429/07 and Ontario Regulation 430/07.¹³ Public sector groups, such as hospitals, school boards, universities, and

⁷ *Ibid.*

⁸ *Ibid.*

⁹ Ministry of Community and Social Services, "*Development of the Accessible Transportation Standard: Where We Are Now*" (5 August, 2009), online:

<<http://www.mcsc.gov.on.ca/mcsc/english/pillars/accessibilityOntario/accesson/business/transportation/>>.

¹⁰ Ministry of Community and Social Services, "*Development of Employment Accessibility Standard: Where We Are Now*" (5 August, 2009), online:

<<http://www.mcsc.gov.on.ca/mcsc/english/pillars/accessibilityOntario/accesson/business/employment/>>.

¹¹ Ministry of Community and Social Services, "*Development of the Accessible Built Environment Standard: Where We Are Now*" (5 August, 2009), online: <

<http://www.mcsc.gov.on.ca/mcsc/english/pillars/accessibilityOntario/accesson/business/environment/>>.

¹² Ontario O. Reg. 429/07, s. 10.

¹³ Ministry of Community and Social Services, "*Development of the Accessible Customer Service Standard: Where We Are Now*" (5 August, 2009), online: <

<http://www.mcsc.gov.on.ca/mcsc/english/pillars/accessibilityOntario/accesson/business/customer/index.htm>>.

municipalities must fully comply with these regulations by January 1, 2010.¹⁴ Private business and non-profit groups must comply with these regulations by January 1, 2012.¹⁵

What do the Customer Service Regulations Require?

All of the requirements relating to the Customer Service Accessibility Standards can be found in Ontario Regulation 429/07 and Ontario Regulation 430/07.¹⁶ In general, these regulations require Ontarians to:

Implement policies and procedures to govern the provision of goods and services to persons with disabilities. These policies and procedures must be consistent with the following principles:

- (1) Goods or services must be provided in manner that respects the dignity and independence of persons with disabilities;
- (2) The provision of goods or services to persons with disabilities and others must be integrated;
- (3) Persons with disabilities must be given an opportunity equal to that given to others in order to use and benefit from the goods or services;
- (4) Have policies that support the use of service animals, support persons or other assistance devices and that require goods and service providers to consider a persons disability when communicating with them;
- (5) Notify customers/clients when services are disrupted provide customers/clients with a way to give their feedback; and
- (6) Every provider of goods or services that has at least 20 employees shall prepare one or more documents describing the policies, practices, and procedures that have been implemented to ensure accessibility for persons with disabilities. The provider of goods and services should be willing to give a copy of this document to any person that requests.¹⁷

Staff training is another requirement under the Customer Service Accessibility Standards. The regulation mandates training for all staff dealing with the public or developing policies, practices, and procedures governing the provision of goods or services to members of the public. The training must include a review of the purposes of the Act and the requirements of the Regulations and instruction about the following matters:

- how to interact and communicate with persons with various types of disability;
- how to interact with persons with disabilities who use an assistive device or require the assistance of a guide dog or other service animal or the assistance of a support person;

¹⁴Ontario O. Reg. 429/07, s. 2.

¹⁵ *Ibid.*

¹⁶ *Supra* note 13.

¹⁷ Ontario O. Reg. 429/07, s. 3.

- how to use equipment or devices available on the provider's premises or otherwise provided by the provider that may help with the provision of goods or services to a person with a disability; and
- what to do if a person with a particular type of disability is having difficulty accessing the provider's goods or services.¹⁸

Every public sector organization and every other goods and services provider that has at least 20 employees shall also prepare a document describing the training policy of their organization. They must also keep records of the training provided to their employees, including the dates on which the training is provided and the number of individuals the training is provided to.¹⁹

Where can I get more Information?

- **For information on the AODA, please visit:**
<http://www.mcsc.gov.on.ca/mcsc/english/pillars/accessibilityOntario/>
- **For information about training available for service and goods providers visit:**
www.reach.ca
- **For a downloadable copy of the AODA visit:**
<http://www.e-laws.gov.on.ca/index.html>

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¹⁸ Ontario O. Reg. 429/07, s. 6.

¹⁹ *Ibid.*

Disability & the Law continued:

New ODSP Practice for Persons with Addictions

First appeared in July 2009 edition of ARCH Alert

By Dianne Wintermute, Staff Lawyer with ARCH

A recent decision by the Divisional Court in the on-going case of *Director v. Werbeski and Tranchemontagne* has had a positive impact on how applications for Ontario Disability Support Program (ODSP) benefits for persons with addictions will be assessed.

In the past, people whose only medical condition was an addiction were excluded from receiving ODSP under the law. However, as was reported in the May 2009 edition of ARCH Alert, in the recent Werbeski/Tranchemontagne decision, the Court said that not only are addictions disabilities, but also to deny people ODSP benefits because their sole condition is an addiction is discriminatory, and contrary to the Ontario Human Rights Code.

The Government has sought leave to appeal this decision to the Ontario Court of Appeal. However, unless leave is granted and the decision of the lower court is overturned, people who may not have previously qualified for ODSP benefits because their only medical condition was an addiction may now qualify for benefits.

If you have already applied for ODSP benefits and have appealed a denial of those benefits to the Social Benefits Tribunal (SBT), you may want to make sure that you have provided enough evidence to both the SBT and the Disability Adjudication Unit (DAU) to show that the addiction is a substantial one that has lasted more than one year and has a substantial impact on your ability to take care of yourself or function in the community or function in the workforce. If you have not applied for ODSP benefits in the past because you were told that you could not, then you may want to apply for benefits now. Unfortunately, it is not clear what will happen to people who applied and whose appeal was denied because in the past, addictions were not considered to be a disability. ARCH is working with other community legal clinics to determine what will happen in those kinds of cases.

All cases that involve addictions and that are scheduled to be heard by the SBT are being adjourned to give the Disability Adjudication Unit an opportunity to develop criteria by which to adjudicate addictions cases. The plan is to have the criteria in place by fall 2009, and then the cases will be scheduled to be heard. The DAU is sending letters to people who have applied, advising them of the postponement of their appeal. However, the letters may be confusing. ARCH urges you to contact your local community legal clinic for assistance with these cases.

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On the Road Again: Accessible Travel Tips and Resources

By Stephanie Swift

(Common Law Student at the University of Ottawa)

With summer winding down and coming to an end, now is the perfect time to start planning that vacation for next summer or the winter holidays. Although people with disabilities face additional challenges and concerns when planning a vacation, there exist ample resources to help make the journey a smooth and safe process. Various transport and governmental agencies have published guides with travel advice and information, while more and more tour groups are geared towards people with disabilities. As no disability is the same, there are multiple organizations and publications tailored towards each traveller's unique situation. What is outlined below is just a sample of the vast information available to someone who has always wanted to travel but has questioned the possibility of doing so.

Planning Ahead

There appears to be common consensus amongst agencies and organizations that preparation and planning is the key to ensuring that your trip goes well with as little disturbances as possible. The Canadian Transportation Agency maintains that it is important to plan ahead and prepare for any bumps along the road. They suggest that travellers know their needs, do adequate research prior to booking and travelling, determine which companies are best suited for specific needs, and obtain written confirmation for all arrangements when booking or reserving.²⁰ Also, when booking with a transportation company, it is important to provide as much notice as possible and inform them of any special needs so that they have ample time to accommodate (usually 48 hours notice).²¹

Scott Rains, a travel writer, suggests that when using equipment, such as a wheelchair or scooter, one should be familiar with it and pack a repair kit along with instructions in case something should break.²² He also suggests knowing how to assemble and disassemble any equipment should storage be required.

In addition to planning in advance, it is also wise get to the airport early and to fly direct if possible.²³ Also, plan for your arrival: have transportation to and from the airport reserved ahead of time (such as accessible taxis) and contact hotels to inquire if their rooms, restaurants, and pools are accessible.²⁴

Important Documentation

When travelling internationally, it is important to bring documentation for any medications; if one uses a service animal, certification, vaccination, and health certificates for the animal may also be required.²⁵ According to the Spina Bifida Association, it is important to save all tickets and receipts,

²⁰Canadian Transportation Agency, "Take Charge of Your Travel: A Guide to Persons with Disabilities," <http://www.cta-otc.gc.ca/doc.php?sid=1021&lang=eng>.

²¹ *Ibid.*

²² Scott Rains, "Travelling with a Disability," E-bility, http://www.e-bility.com/articles/accessible_travels.php.

²³ Spina Bifida Association, "Travel With a Disability: Easier than Ever,"

http://www.spinabifidaassociation.org/site/c.liKWL7PLLrF/b.2700303/k.6FE4/Travel_With_a_Disability.htm.

²⁴ *Ibid.*

²⁵ Canadian Transportation Agency, "Take Charge of Your Travel: A Guide to Persons with Disabilities," <http://www.cta-otc.gc.ca/doc.php?sid=1021&lang=eng>.

and to write down the names of people who have served you (whether at the airport, train station, or hotel) so that they know that they are accountable.²⁶

Have Fun!

There are many tours located around the world that are focused on providing accessible travel to interesting places. While it is recommended to book through a travel agent (as they have numerous resources and contacts available to them to confirm which aspects of the trip are accessible), many tour companies and travel agents have websites with information on accessible tours²⁷:

- <http://www.accessibleurope.com> provides information on tours in more than 18 locations
- <http://www.undiscoveredbritain.com> has information on accessible tours in the UK
- <http://www.accessholidays.ca> is located in Toronto and has information on vacation packages around the world for people with special needs
- And many others!²⁸

After the proper research and planning has been done and all the preparations have been made, you will be ready to leave on that jet plane and have a great vacation!

Important Websites

Here are just a few of the resources available for consultation when planning your vacation:

- The Canadian Transport Agency provides a guide on their website specifically tailored towards travellers with disabilities. “Take Charge of Your Travel: A Guide to Persons with Disabilities” is available at <http://www.cta-otc.gc.ca/>
- Access to Travel (Transport Canada): <http://www.accesstotravel.gc.ca>
- Air Canada: Customers with Special Needs: <http://www.aircanada.com>
- Society for Accessible Travel and Hospitality (SATH): <http://www.sath.org>
- Accessible Adventure Travel for People with Disabilities: <http://www.accessanything.net>
- To find accessible B&B’s: <http://www.1-888-inn-seek.com>
- International Transport Forum: <http://www.internationaltransportforum.org>

Disclaimer: This article is not intended to be legal or travel advice. It is important to conduct adequate research into the country/location you are planning on travelling to and to book through a travel agent who can verify the information obtained.

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²⁶ Spina Bifida Association, “Travel With a Disability: Easier than Ever,” http://www.spinabifidaassociation.org/site/c.liKWL7PLLrF/b.2700303/k.6FE4/Travel_With_a_Disability.htm.

²⁷ Andre Kennedy, “Exploring the Globe,” <http://www.thefreelibrary.com/Exploring+the+globe--who+to+call+if+you+have+a+disability+and+want+to...-a0190050761>.

²⁸ See Kennedy article for further descriptions of travel organizations and their websites.

Disability & Abuse: Towards a Future of Freedom from Maltreatment for Vulnerable Individuals

By Stephanie Swift
(Common Law Student at the University of Ottawa)

The increase of studies in the past two decades on the vulnerability of individuals with disabilities²⁹ reveals that, regardless of type of disability, age, or gender, persons with disabilities are at a greater risk of abuse than persons without disabilities. Ali O'Callaghan, Glynis Murphy, and Isabel Clare observe that there exist many forms of abuse, such as sexual, physical (non-sexual), and emotional, as well as neglect and financial exploitation³⁰. For individuals with disabilities, the range of possible perpetrators is just as large as the range of possible abuses: it could be a caretaker, parent or family member, health care practitioner, fellow service user, and/or a complete stranger³¹. While the picture painted by the above mentioned studies is bleak, experts provide a range of recommendations to aid victims, families, and caretakers in recognizing, reporting, and overcoming abuse. This article will provide a brief overview of the types of abuses faced by individuals with disabilities, the impact of abuse, and expert advice for implementation of much needed resources, training, and counselling.

According to Hilary Brown and Vicky Turk: “while the legal framework for the protection of disabled children and young people runs out when they are 18, the risks of abuse and the need for protection do not”³². While children of all ages with disabilities are more susceptible to sexual abuse and its more serious forms, when compared to children without disabilities³³, the risk does not dissipate with age.

Indeed, research reveals that men, women, and children with disabilities are at a greater risk to be maltreated than non-disabled individuals³⁴. Each individual is susceptible to the same abuse for very similar reasons: age is not a distinguishing factor. Children, whether in day school or institutions, are susceptible to abuse by the very people on which they depend. Similarly, adults with learning disabilities can be abused by staff members, family, and caregivers³⁵ or coerced into sexual activities to which they have not given consent. Women with physical disabilities are at a greater risk of being abused by attendants and health care providers, and for a longer duration, than their non-disabled counterparts³⁶.

²⁹ Ali C. O'Callaghan, Glynis Murphy & Isabel C. H. Clare, “The Impact of Abuse on Men and Women with Severe Learning Disabilities and Their Families” (2003) 31:4 *British Journal of Learning Disabilities* 175 at 175 [O'Callaghan].

³⁰ *Ibid.* See also: Ann M. Sebald, “Child Abuse and Deafness: An Overview” (2008) 153:4 *American Annals of the Deaf* 376 at 377 [Sebald].

³¹ *Supra* note 29.

³² Hilary Brown & Vicky Turk, “Sexual Abuse in Adulthood: Ongoing Risks for People with Learning Disabilities” (1994) 3:1 *Child Abuse Review* 26 at 26 [Brown].

³³ I. Hershkowitz, M. E. Lamb & D. Horowitz, “Victimization of Children With Disabilities” (2007) 77: 4 *American Journal of Orthopsychiatry* 629 at 633 [Hershkowitz].

³⁴ Willi Horner-Johnson & Charles E. Drum, “Prevalence of Maltreatment of People with Intellectual Disabilities: A Review of Recently Published Research” (2006) 12:1 *Mental Retardation and Developmental Disabilities Research Reviews* 57 at 66 [Horner-Johnson].

³⁵ *Brown, supra* note 32.

³⁶ Mary Ellen Young et al., “Prevalence of Abuse of Women with Physical Disabilities” (1997) 78:12 *Archives of Physical Medicine and Rehabilitation* 34 at 34 [Young].

Greater vulnerability of persons with disabilities is due in large part to increased dependency on others for essential aspects of daily life, obstacles in communication, institutional care, and social isolation³⁷. Adults and children with disabilities, either physical or mental, rely for an extended period of time on caregivers for assistance in all areas of daily life³⁸. Their placement in facilities and institutions, even for temporary care, increases the chances that the individual will be abused³⁹. Those who require assistance in daily activities, such as feeding and bathing, are susceptible to threats, rough treatment, and inappropriate touching⁴⁰. In institutional settings, high turnover rates, low wages, and lack of supervision of staff⁴¹ lead to an increased risk of abuse.

Because of their special and vulnerable situation, the abuse is also more likely to be ongoing. For example, children with disabilities may be viewed as “safe targets” by perpetrators because they are dependent and unable to report abuse⁴². Similarly, Andrews and Veronen have postulated that perpetrators of abuse against women with disabilities may feel there is a lesser risk of being discovered⁴³.

Lack of reporting by the victim is a further issue compounding vulnerability to abuse and can lead to prolonged maltreatment. Hershkowitz, Lamb, and Horowitz observe that “people with mental disabilities seldom report their experiences to the police”⁴⁴. Compared to typically developing children, children with disabilities are less likely to divulge information on their abuse, and if they do disclose, they are more likely to delay the time of disclosure⁴⁵. Children’s limited social and communicative skills further limit their capacity to communicate the abuse⁴⁶. Children with learning disabilities may have problems communicating either through signals or verbally⁴⁷. And children who use augmented communication systems face an obstacle in that the systems they use often lack the vocabulary to describe an abusive situation⁴⁸. Children who are deaf or hard of hearing may also face additional challenges in trying to report the abuse⁴⁹.

If the abuse is perpetrated by a caregiver or parental figure (as it often is), the child may also postpone reporting the abuse because of their reliance on the caregiver⁵⁰. Or, a child may feel fear or shame about the experience and so may choose to not disclose it⁵¹. Similarly, a study on women with

³⁷ Rebecca Oosterhoorn & Andrew Kendrick, “No Sign of Harm: Issues for Disabled Children Communicating About Abuse” (2001) 10:4 Child Abuse Review 243 at 244 [Oosterhoorn]; Margaret A. Nosek et al., “Vulnerabilities for Abuse Among Women with Disabilities” (2001) 19:3 Sexuality and Disability 177 at 178 [Nosek]; Alina Paul & Pat Cawson, “Safeguarding Disabled Children in Residential Settings: What We Know and What We Don’t Know” (2002) 11:5 Child Abuse Review 262 at 270 [Paul]. See also *supra* note 36 at 37.

³⁸ Hershkowitz, *supra* note 33 at 630; Young, *supra* note 36 at 35; Nosek, *supra* note 37 at 177.

³⁹ Oosterhoorn, *supra* note 37 at 244; Young, *supra* note 36 at 37. See also Eileen M. Furey, Jill J. Niesen & James D. Strauch, “Abuse and Neglect of Adults with Mental Retardation in Different Residential Settings” (1994) 9:4 Behavioural Interventions 199-211.

⁴⁰ Nosek, *supra* note 37 at 185.

⁴¹ *Ibid.* See also Paul, *supra* note 37 at 272.

⁴² Hershkowitz, *supra* note 33 at 633; Paul, *supra* note 37 at 264.

⁴³ Nosek, *supra* note 37 at 178.

⁴⁴ Hershkowitz, *supra* note 33 at 630.

⁴⁵ *Ibid.* at 629.

⁴⁶ *Ibid.* at 630; Paul, *supra* note 37 at 270.

⁴⁷ Oosterhoorn, *supra* note 37 at 245.

⁴⁸ *Ibid.* at 251.

⁴⁹ Sebald, *supra* note 30 at 378.

⁵⁰ Hershkowitz, *supra* note 33 at 634.

⁵¹ Oosterhoorn, *supra* note 37 at 244.

disabilities indicates that when a caregiver is the abuser, individuals may feel that they have to endure the abuse as no one else will take care of them if they report it⁵².

Lastly, adults and children with learning or cognitive disabilities may not be able to recognize when they are being abused⁵³. If they are aware of the abuse, individuals with disabilities often face scepticism regarding their claims, leaving many feeling discouraged to take action⁵⁴.

O’Callaghan, Murphy, and Clare conducted a study on the impact of various types of abuse on adults with severe learning disabilities and their families⁵⁵. They found that the abuse led to “profound and long-lasting effects” on the individuals and their families, with symptoms and changes in behaviour amounting to Post-Traumatic Stress Disorder. For some individuals, the abuse resulted in challenging behaviours, such as self-harming or loss of skill sets (such as oral communication). As for the impact on the victim’s family, many parents described a strong sense of guilt as well as a distrust of authority⁵⁶.

In light of their findings of increased vulnerability of individuals with disabilities, researchers have made numerous recommendations on how to reduce the occurrence and impact of maltreatment. As a result of their findings from a three-year study at the University of Kent, Hershkowitz, Lamb, and Horowitz conclude that it is of “crucial importance” that individuals with learning disabilities receive sex education and training on how to be assertive, so that youth can transition into adults with the necessary tools to dispel potential abuse, or report it when it does occur⁵⁷.

Ann Sebald also maintains the importance of sex education at an early age so that children know how to recognize and communicate sexual abuse⁵⁸. Because of their unique situation, children with severe disabilities are less likely to understand the nature of sexual abuse than non-disabled children⁵⁹. Sebald notes the emphasis in institutional settings on compliance, which in turn teaches children to put up with abuse. She insists that children must be taught to think independently, have adult role models with whom they can freely communicate and approach about abuse issues, and be taught by their parents the difference between acceptable and unacceptable behaviours⁶⁰.

Lastly, experts recommend that training and recognition programs be implemented in institutions as well with family members and that there be available adequate resources for counselling to individuals and their families after maltreatment has occurred. According to Brown and Turk, both staff and family members need to be trained to recognize and report signs of abuse⁶¹. Nosek et al. agree that it is critical that institutions develop recognition and intervention methods in order to detect and treat abuse when it occurs⁶². Lastly, O’Callaghan, Murphy, and Clare stress the importance of ongoing support and counselling for the victims and their families⁶³.

⁵² Nosek, *supra* note 37 at 179

⁵³ *Ibid.*

⁵⁴ Oosterhoorn, *supra* note 37 at 244; Nosek, *supra* note 37 at 178; Paul, *supra* note 37 at 264.

⁵⁵ O’Callaghan, *supra* note 29 at 175.

⁵⁶ *Ibid.* at 178.

⁵⁷ Hershkowitz, *supra* note 33 at 627; see also Paul, *supra* note 37 at 276.

⁵⁸ Sebald, *supra* note 30 at 379.

⁵⁹ Hershkowitz, *supra* note 33 at 633.

⁶⁰ Sebald, *supra* note 30 at 379.

⁶¹ Brown, *supra* note 32 at 34.

⁶² Nosek, *supra* note 37 at 187.

⁶³ O’Callaghan, *supra* note 29 at 179.

Although individuals of all ages with disabilities may be more vulnerable to abuse for various reasons, the implementation of these recommendations by care facilities and families will help to mitigate maltreatment.

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Mental Health:

Mental Health Injuries in the Canadian Forces

By Stephanie Swift
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The Changing Face of Combat Injuries

According to the Canadian Mental Health Association, one out of every ten Canadians suffers from Post-Traumatic Stress Disorder (PTSD).⁶⁴ Although commonly associated with “shell-shock” of the two World Wars and the increase of diagnoses after the Vietnam War, PTSD can be triggered by a traumatic experience in any context and is not limited to that of military combat.⁶⁵ However, in addition to the increase of Canadian casualties in Afghanistan since the mission began in 2002, more members are being diagnosed with PTSD, as well as other operational stress injuries (OSI).

In light of the Canadian military’s commitment to remain in Afghanistan until 2011, as well as the increasing number of mental health injuries among members, the necessity of the availability of treatment and resources to members and their families is obvious. However, for some veterans of Afghanistan, help is hard to find. Even when it is found, social stigma, unequal access, and inadequate resources create another battle to be fought at home.

Symptoms and Treatment

PTSD is one form of anxiety disorder and “...is caused by a psychologically traumatic event involving actual or threatened death or serious injury to oneself or others.”⁶⁶ Military combat is just one of many situations in which a stressor can trigger PTSD.⁶⁷ According to the Canadian Mental Health Association, there are three main symptoms of PTSD. Firstly, the individual relives the traumatic event, either through memories, nightmares, or flashbacks, experiencing great distress and anxiety. Secondly, emotions are numbed. The individual avoids situations that can trigger memories of the traumatic event, leading to a loss of interest in activities as well as withdrawal from social interactions with friends and family. Lastly, the individual may also exhibit changes in normal sleeping patterns, such as insomnia, and an increase in anxiety. Often the individual is unable to complete tasks or suffers through periods of aggression.⁶⁸

PTSD can arise anywhere from three months to several years after the initial traumatic event.⁶⁹ It can be treated through a combination of medication (to help with the depression and anxiety) and various modes of therapy.⁷⁰

PTSD in the Canadian Military

⁶⁴ Canadian Mental Health Association, “Post Traumatic Stress Disorder,” http://www.cmha.ca/bins/content_page.asp?cid=3-94-97&lang=1.

⁶⁵ *Ibid.*

⁶⁶ *Ibid.*

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

⁷⁰ *Ibid.*

Since the Canadian Forces (CF) began its mission in Afghanistan, 26,800 men and women have been deployed, with many members serving multiple tours. As of July 16, 2009, 125 Canadian military personnel have died serving in Afghanistan.⁷¹ However, the Canadian military is not only experiencing the highest casualty rate since the Korean War, but also an increase in mental health injuries. According to the *Toronto Star*, "...more than one in five Canadian soldiers and police officers deployed to Afghanistan leave the force with psychiatric problems."⁷² Veterans Affairs Canada claims that since 2002 the number of individuals suffering from PTSD has tripled.⁷³ Due to both the fact that the Department of National Defence (DND) does not keep track of the mental health injuries of CF members and the fact that PTSD can take years to develop, the full extent of the mental health injuries suffered by Canadian Forces members who have served and continue to serve in Afghanistan is not yet fully known.⁷⁴

However, the need for adequate treatment to be made available to members and their families has been highlighted by DND Ombudsman Reports in 2002 and 2008.⁷⁵ While the most recent report acknowledges that DND has made some progress in its identification and treatment of PTSD,⁷⁶ much more remains to be done.⁷⁷ The 2002 Ombudsman report concluded that PTSD was a serious issue for many members and that the military was not adequately treating members with PTSD and other mental health injuries.⁷⁸ It provided thirty-one recommendations for the CF and DND to implement to improve the treatment and aid available to members and their families. Out of those thirty recommendations, only 13 were satisfactorily implemented according to the Ombudsman follow-up report in 2008.⁷⁹

To prepare the 2008 report, entitled "The Long Road to Recovery: Battling Operational Stress Injuries", the Ombudsman investigators interviewed 360 military members diagnosed with PTSD, their families, staff, and caregivers.⁸⁰ Based on their investigations, the report concluded that unequal access to treatment, social stigma from within the Canadian Forces, lack of resources, and burned-out health care providers await many members who return home from serving their country in Afghanistan.⁸¹

In light of these observations, the report recommended that the CF and DND take the following actions:

- appoint a senior officer as the national coordinator for a program committed to dealing with PTSD and OSI;⁸²

⁷¹ CBC News In-Depth Afghanistan, "In the Line of Duty: Canada's Casualties," CBC News Online, <http://www.cbc.ca/news/background/afghanistan/casualties/list.html>.

⁷² David Bruser, "A Soldier's Rage," *The Toronto Star*, June 13, 2009, A1, A10-A11.

⁷³ The Canadian Press, "Reported PTSD Cases Triple Among Soldiers Since '02", CTV News, http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20080229/ptsd_soldiers_080229/20080229.

⁷⁴ Mary McFadyen, "A Long Road to Recovery: Battling Operational Stress Injuries," DND Ombudsman Special Report to the Minister of National Defence, December 2008, <http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/osi-tso-3/doc/osi-tso-3-eng.pdf>.

⁷⁵ *Ibid.*

⁷⁶ *Ibid.*

⁷⁷ *Ibid.*

⁷⁸ *Ibid.*

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ *Ibid.*

⁸² *Ibid.*

- create a national database to keep track of mental health injuries of CF members and to gather statistical information;⁸³
- change the accommodation policy;⁸⁴
- change the occupational transfer policy to make it more flexible for members to transfer occupations and avoid the CF losing valuable members;⁸⁵
- ensure adequate care and resources are available to members and their families;⁸⁶
- increase the number of health care givers and resources available;⁸⁷ and
- create a national program to assist the mental health care community so as to avoid burn-out among health care providers⁸⁸.

Resources for Members and Their Families

Although more remains to be done for returning members, the DND and CF have taken some steps to ensure the well-being of their members' mental health. There are screening processes in place by the CF prior to deployment, as well as decompression phases for troops returning from Afghanistan.⁸⁹

In addition to their deployment training, members are also given various resources to prepare them for their mission abroad. One such resource is the Canadian Forces Operational Deployment Handbook, which provides many tips and guides on how to deal with stress, anger, and fatigue, both on deployment as well as at homecoming time.⁹⁰ The handbook also provides a list of mental health resources, with a list of descriptions of organizations and their contact information, signalling the efforts made by the CF and DND to educate their members on the importance of mental health.

The CF also has several programs in place to support members when they return from deployment. According to the Canadian Forces Mental Health Services website, Mental Health Services offers several programs to help members and their families cope with mental injuries.⁹¹

Firstly, the Psychosocial Program is available at all Canadian Forces medical clinics and offers crisis interventions, addictions consultations, mental health information, and pre-and-post deployment screening.⁹² Members do not require a doctor referral to access these services, which are provided by social workers and addictions counsellors.

Another program offered is the Mental Health Program, although this is only available at larger bases and a member does require a doctor's referral to access these services.⁹³ The Mental Health Program provides a general assessment and treatment for a number of mental health issues; it also provides aid on operational stress injuries to members and their families.

⁸³ *Ibid.*

⁸⁴ *Ibid.*

⁸⁵ *Ibid.*

⁸⁶ *Ibid.*

⁸⁷ *Ibid.*

⁸⁸ *Ibid.*

⁸⁹ *Ibid.*

⁹⁰ Canadian Forces Deployment Handbook.

⁹¹ Canadian Forces Health Services, "Mental Health Services," National Defence and the Canadian Forces, <http://www.forces.gc.ca/health-sante/ps/mh-sm/default-eng.asp>.

⁹² *Ibid.*

⁹³ *Ibid.*

Lastly, the Operational & Trauma Stress Support Centres exist to provide assessment and treatment specifically on mental health issues arising from deployment.⁹⁴ Currently, there are only five clinics available across the country.

The Operational Stress Injury Social Support program is also in place to treat and help members cope with OSI.⁹⁵ The program has peer support sites across Canada while the website provides tips on how to deal with OSI. Such tips include: avoiding “triggers” of the traumatic event, staying active, having a pet or hobby, avoiding crowds, keeping a journal, volunteering, and maintaining a routine. Also available on their website is a self-assessment from the Anxiety Disorders Association of America for those who think they may be suffering from PTSD.⁹⁶

The Future of PTSD and OSI in the Canadian Military

With the mission extended to 2011 and the prospect of more members returning from Afghanistan with mental health injuries, it is imperative that there is a system of support and treatment available to them. After serving their country abroad and being placed in the most terrifying and deadly of situations, these members cannot be abandoned to battle mental health injuries alone. As the Ombudsman December 2008 report concluded, now more than ever it is imperative to educate, prevent, and treat PTSD.⁹⁷ Progress has been made since 2002, but still many members are unable to access treatment for mental health injuries due to such factors as the location of a posting, cultural attitudes within the CF, and the availability of mental health resources.⁹⁸ Although some initiatives and programs are in place, the DND and CF needs to do more to ensure that no more military personnel “fall through the cracks”.

Organizations and Contact Information

For further information on PTSD and the resources available to CF members and their families, please visit the following websites:

- Canadian Forces Mental Health Services: <http://www.forces.gc.ca/health-sante/ps/mh-sm/default-eng.asp>
- Operational Stress Injury Social Support: www.ossis.ca
- Canadian Mental Health Association: www.cmha.ca

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⁹⁴ *Ibid.*

⁹⁵ Operational Stress Injury Social Support, “About OSISS,” http://www.ossis.ca/engraph/about_e.asp?sidecat=3.

⁹⁶ Operational Stress Injury Social Support, “How to Help Yourself,” http://www.ossis.ca/engraph/about_e.asp?sidecat=3.

⁹⁷ Mary McFadyen, “A Long Road to Recovery: Battling Operational Stress Injuries,” DND Ombudsman Special Report to the Minister of National Defence, December 2008, <http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/osi-tso-3/doc/osi-tso-3-eng.pdf>.

⁹⁸ *Ibid.*

Disability and Immigration: *Double Jeopardy*

By Aleksandra Pisarek
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Disability and Immigration is a topic necessitating extensive research, and consequently more attention of legal academics and practitioners. It is also a subject that requires more public awareness, especially in a society such as Canada's, which is one of the most multicultural nations in the world where differences, their understanding and accommodation are the permanent thread of our social fabric. The additional fact that our well-entrenched right to free speech provides space for a meaningful public debate makes the topic of disability and immigration well-suited for the Canadian society.

The issues related to this topic are vast and can be divided into two categories: treatment of disability prior to entry to Canada and living with a disability after a successful entry. It becomes often apparent that regardless of the category into which a person fits, he or she will face a double jeopardy: first hurdle is being "foreign"; second hurdle is having a disability.

Prospective Immigrants with Disabilities (Prior to Entry)

Historically, prospective immigrants with disabilities had meager chances of entering Canada (or the United States, for that matter). The early immigration scene reflects the societal attitudes of the time, and today we work within the framework of the heritage that we, as Canadians, have inherited. Taking a brief look at history allows us to take a step back and realize that we have inherited a rather prejudiced system.

In the late 1800s and early 1900s, being blind, deaf, "crippled" or even having active tuberculosis was considered sufficient grounds for denial of entry into Canada or the United States⁹⁹. This prohibition would become automatic unless an entrant was able to prove the existence of a family member who would be capable and willing to provide permanently for the allegedly disabled person in question¹⁰⁰. This exception changed in 1927 with amendments to the *Immigration Act*, which entirely prohibited such entrants regardless of family situation¹⁰¹. An initial "no" became routine in many cases (especially where a physical disability was visually apparent, such as blindness, deafness or dismemberment) and non-negotiable.

This attitude towards physical disablement has been predicated upon the idea that the immigration policy is supposed to create the most productive pool of immigrants possible for the betterment of the Canadian society. Even today this approach towards immigration dominates and hardly seems to be an outrageous proposition. However, this presumption is not the biggest problem on hand. Rather, it is the public perception that disability necessarily leads to a lesser productivity and value of a person in an economically driven society. This assumption, which is so pervasive in large segments of our

⁹⁹ Katrin S. Mautino, "Law Watch: Immigration and Physical Disability" (2002) 4:2 *Journal of Immigrant and Minority Health* 59 [Mautino] and Ena Chadha, "'Mentally Defectives' Not Welcome: Mental Disability in Canadian Immigration Law" (2008) 28:1 *Disability Studies Quarterly* 67 <<http://www.ds-q-sds.org/article/view/67/67>> [Chadha].

¹⁰⁰ Mautino, *supra* note 99. Chadha, *supra* note 99.

¹⁰¹ Ravi Malhotra, "Disability Rights and Immigration" *New Socialist* 55 (February-March 2006) 4 <<http://newsocialist.org/newsite/index.php?id=717>> [Malhotra].

society, is faulty in that it does not take into account the many hurdles our society places in the way of those willing to take up jobs. Those who are willing to work often find themselves unable or discouraged due to attitudinal and physical barriers that exist, which are invisible to the non-disabled part of society (e.g. lack of necessary accommodation, such as appropriate equipment in work place, or lack of staff training to sensitize towards disablement).

The issue of mental disability was treated with even more suspicion. The early immigration statutes, such as the 1869 *Act Respecting Immigration and Immigrants* (Canada's first immigration statute) required inspection of incoming vessels for presence of "any lunatic or idiotic person"¹⁰². The perception of mental disability was so wide as to encompass people who were homosexual, or had a narcotic or alcohol abuse^{103 104}. In fact, the vocabulary of the early 1900s statutes is highly indicative of the intolerant attitude towards the mentally disabled. "Lunatic", "idiotic", "feeble-minded", "infirm", and "mentally defective" are illustrative of this point¹⁰⁵. This thinking was highly influenced by the Eugenics¹⁰⁶ movement ever-present in the 1900s. As noted by some scholars, this movement of the inter-war years often had the "self-serving" consequence of augmenting the place of medical professionals in immigration policy¹⁰⁷. An excellent example of that is the work of Doctor C.K. Clarke¹⁰⁸, one of the most prominent doctors of the time, who campaigned against "the dumping of the defective and diseased classes on Canadian soil". His observations went as far as to claim that "immigrant children were disproportionately feeble-minded and/ or insaner when compared with the host population"¹⁰⁹. It is a rather accurate statement that the Eugenics movement was "a dysfunctional attempt to improve society through a misuse of science by weeding out, through segregation or sterilization, those elements that were regarded as inferior"¹¹⁰. Yet, it garnered considerable support in the early 1900s.

Fortunately, today the attitude toward disablement, both physical and mental, has changed tremendously and the Eugenics thinking died in the aftermath of the Second World War and the Nazi Holocaust. Disability alone, whether physical or mental, cannot constitute grounds for denial of entry into Canada. A disablement will lead to inadmissibility when it is "likely to be a danger to public health or safety", or when it "might reasonably be expected to cause excessive demand on health or social services"¹¹¹. Prima facie, this wording seems to be reasonable, however, in practice, it allows for a large degree of discretion and is dependent upon the knowledge and attitude of a given immigration officer. By necessary implication such adjudication is also dependent upon the training the Immigration and Refugee Board (IRB) provides to its officers. The amount of case law under the

¹⁰² Chadha, *supra* note 99.

¹⁰³ Mautino, *supra* note 99.

¹⁰⁴ Today, while substance addiction may be grounds for denying a person access to Canada, it is not considered a disability "per se", and does not amount to an automatic prohibition.

¹⁰⁵ Chadha, *supra* note 99.

¹⁰⁶ Eugenics refers to the so-called "science" of improving a population by controlled breeding to increase the occurrence of desirable heritable characteristics. Eugenics in its most basic form believes in discouraging the reproduction of persons having a "genetic defect" or an "undesirable trait".

¹⁰⁷ Ninette Kelley and M.J. Trebilcock, *The Making of the Mosaic* (Toronto: University of Toronto Press Inc., 1998) at 214 [Kelley and Trebilcock]. See also Chadha, *supra* note 99.

¹⁰⁸ The Toronto Clarke Institute of Psychiatry was named after Doctor C.K. Clarke. Today the Institute has been amalgamated into The Centre for Addiction and Mental Health (CAMH). Doctor Clarke's name continues to be the pride of the University of Toronto's Department of Psychiatry, which was founded in 1907 and first headed by Clarke. Please see on-line: <http://www.utpsychiatry.ca/centenary/vignette/Aug07-Vig2-CK_Clarke.pdf>.

¹⁰⁹ Kelley and Trebilcock, *supra* note 107 at 213.

¹¹⁰ Malhotra, *supra* note 101 at 5.

¹¹¹ *Immigration and Refugee Protection Act*, S.C. 2001, c. 27, s. 38 [IRPA].

“excessive demands” clause demonstrates how contentious this issue is in practice and how much difficulty it poses in interpretation (as opposed to “danger to public health or safety”)¹¹². What is excessive? Can a person pose an excessive demand on a service that he is not certain to use? Should the degree of excess be compared with an average, non-disabled Canadian, or an average, disabled Canadian?

First, it is important to note that virtually all foreign nationals seeking to immigrate to Canada require a medical examination. A few notable exceptions exist, but they mostly refer to those, who do not seek to establish themselves permanently in Canada¹¹³. If a foreign national has a family member that is non-accompanying, the *Immigration and Refugee Protection Act (IRPA)* still requires a medical examination of the non-accompanying individuals¹¹⁴. This requirement allows for a potential refusal in cases where families wish to split in order to later be able to bring the rest of the family under the “family re-unification” category. The family re-unification category is one of the exceptions to the “excessive demands” grounds for inadmissibility¹¹⁵: theoretically, family re-unification policy turns a blind eye when a foreign national is likely to pose an excessive demand on the medical/social services so long as the family is re-united. However, the seeming leniency vis-à-vis “excessive demand” is only an illusion because the sponsoring family member needs to be a permanent resident or a Canadian citizen already, which can be prevented if a close, non-accompanying, family member has a disability that in the eyes of the Canadian immigration officer is likely to pose an “excessive demand” on the system. This is the type of circular reasoning that is hard to break.

The requirement to undergo a medical examination hardly seems unreasonable when analyzed on its own. However, how the medical examination results are used together with other evidence to lead to inadmissibility reveals a systemic problem. Up until 2005, the case law was clear that if the medical examination revealed a health condition, which upon evidence created a reasonable expectation of excessive costs on medical and/ or social services, this was sufficient grounds to dismiss an applicant. A decision/ intention of an applicant not to use certain services or ability to pay for those services independently did not detract from sufficient basis to bar entry to Canada¹¹⁶.

The 2005 Supreme Court Decision in *Hilewitz v. Canada*¹¹⁷ has made a positive change to medical inadmissibility. The majority of the Court held that the specific circumstances of the individual were relevant factors when assessing excessive demands on social/ medical services. Hence, if a

¹¹² Please see Lorne Waldman, “Canadian Immigration & Refugee Law Practice 2008” (LexisNexis: 2007) under s. 38 caselaw analysis. There is no caselaw analysis to accompany the interpretation of “danger to public health or safety”. As Waldman indicates, “the danger to public health or safety” concerns medical conditions that are contagious. The degree of contagiousness that is required to refuse a claimant entry has not been addressed yet. In a recent decision in *Singh v. Canada* (2000), the Federal Court upheld that an HIV-positive person was medically inadmissible. However, this decision was justified on “excessive demands” grounds, rather than the “public health or safety” endangerment grounds. By contrast, the “excessive demands” ground of inadmissibility has been widely litigated, suggesting room for interpretation and disagreement.

¹¹³ *Immigration and Refugee Protection Regulations*, S.O.R. /2002-227, s. 30(1) - (2) [*IRPA Regulations*]. The exceptions include, for example, people visiting Canada to perform official duties and visiting armed forces. A notable exception is also a protected person who cannot be deemed inadmissible based upon determination that he or she might pose an “excessive demand” on medical or social services.

¹¹⁴ *IRPA Regulations*, *ibid.*, s. 30 (1)(a).

¹¹⁵ *IRPA*, *supra* note 12, s.38 (2)(a).

¹¹⁶ *Deol v. Canada (Minister of Citizenship & Immigration)*, [2003] 1 F.C. 301, [2002] F.C.J. No. 949, 2002 FCA 271, leave to appeal to S.C.C. refused (2003).

¹¹⁷ *Hilewitz v. Canada (Minister of Citizenship & Immigration)*, [2003] 2 F.C. 3, [2002] F.C.J. No. 1121, 2002 FCT 844, revd [2004] 1 F.C.R. 696, [2003] F.C.J. No. 1677, 2003 FCA 420, revd [2005] S.C.J. No. 58. 2005 SCC 57.

prospective immigrant family was able to demonstrate that they had sufficient resources to pay for the care of their disabled child, it ought to be taken into consideration.

While this is a positive development to some degree, it privileges foreign nationals who possess considerable financial resources, or belong to a family that fits into the business/investment category. Of course, an appeal from the decision of the Immigration Board is possible, but again it favours those foreign nationals who can afford to go through an appeal process. The bottom line is that a family who has a member with a disability can be successful in immigrating when it has considerable financial resources, or if he or she is in need of protection (i.e. refugee category) since this category is exempt from medical examination requirement. However, Canada admits much less refugees than immigrants, suggesting that the “excessive demand” exemption serves a relatively small number of incoming foreign nationals.

As discussed above, Canada has initially inherited an immigration system deeply prejudiced against disablement. Of course, our attitudes have evolved and become more tolerant, partly due to the catastrophic misuse of science by humanity during the first half of the 20th Century (also present in the earlier colonial era) and general progress science has made since then. However, today immigration still remains a contentious topic on its own. It is predicated upon an idea that who is admitted should always depend upon preference of the host population. While there is merit to this assumption, we must not overlook who the decision-makers of the host population often are: white, Caucasian, mostly male and largely non-disabled persons. We must prevent the tyranny of majority. We ought to realize that even if our prerogative is economic growth, it does not mean that disability stands in its way. What stands in the way are the barriers put in the way of those who are disabled and willing to work and participate meaningfully in our society.

Immigrants & Refugees Living in Canada with Disabilities (After Entry)

The issues in this category are different in that they are difficult to address due to relative lack of research in this field. There is ample academic discourse and activism in the area of immigrant and refugee integration/ assimilation. There is also, though less, academic research in the area of disability studies and the problems of accommodating disablement in Canadian society. The intersection of these two fields, however, has not been adequately addressed. By intersection of these two areas, I mean our knowledge of the condition of immigrants and refugees who have successfully (in relative terms) established themselves in Canada, but who still face significant obstacles in meaningful integration due to their disability *and* their new status in Canada. Here is where the issue of “double jeopardy” gains even more power than suggested in the first section of the article.

In a particularly precarious situation are refugees from oppressive regimes who have experienced various forms of torture. We do not tend to think of this category of people as persons with a disability (at least not in the common use of the term “disability”), but rather “unassimilated immigrants”, “traumatized persons”, or sometimes even “unwilling to assimilate”. To this category also belong people who come from war zones and have witnessed a range of war-related atrocities (possibly suffering from post traumatic stress disorder, or PTSD)¹¹⁸. I suggest that we often fail to see difficulties of assimilation of “plain” immigrants; let alone hurdles faced by immigrants/refugees with a disability, such as newly arrived persons with post-traumatic stress disorder or depression.

¹¹⁸ For the definition of PTSD, please refer to the preceding article of this newsletter edition.

Unfortunately, our systemic blindness is reinforced by Canada's reluctance to show leadership and commitment on an international scale. Canada has shown considerable efforts in participating in the drafting process of the *Convention on the Rights of Persons with Disabilities*. However, our country still has not ratified this international instrument. As long as it is not ratified, it does not legally bind Canada. Our assistance in negotiating the document and our signature on the final draft is only a token of support, but not a commitment that can be relied upon as an example to the rest of the world. Of particular interest is the Convention's definition of disablement. The Convention acknowledges that "disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others"¹¹⁹. Such definition is highly progressive and positive. Canada's lack of ratification of this document demonstrates unpreparedness to understand disability as a societal problem, in lieu perpetuating the notion of disability as an individual's "unfortunate" condition. Nowhere is this more obvious than in Canada's treatment of disability in our immigration system. Certainly, the ratification of this treaty would require Canada to rethink its immigration policy, which we do not seem to be ready to do.

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¹¹⁹ *Convention on the Rights of Persons with Disabilities*, 30 March 2007, UN Doc. A/61/611, preamble (e). http://treaties.un.org/doc/source/RecentTexts/IV_15_english.pdf

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