Date of Release: June 17, 1993 No. A911598

Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:	)	
JOSEPH MCCORKELL	)	**REASONS FOR JUDGMENT**
PLAINTIFF	)	
AND:	)	**OF THE HONOURABLE**
DIRECTOR OF RIVERVIEW HOSPITAL) REVIEW PANEL UNDER MENTAL HEALTH ACT, HELD MARCH 14, 1991, AND CHAIRED BY DANIEL BROWN and ATTORNEY GENERAL OF BRITISH COLUMBIA	)	**MR. JUSTICE DONALD**
DEFENDANTS	)	

Counsel for the Plaintiff:	David Mossop & Frances Kelly
Counsel for the Defendants:	Harvey Groberman & Lisa Mrozinski
Dates and Place of Trial:	January 11-15 & May 25-26, 1993 Vancouver, B.C.

INTRODUCTION

The plaintiff challenges the constitutional validity of the provisions of the ***Mental Health Act***, R.S.B.C. 1979, c. 256 ("the ***Act***"), dealing with the involuntary committal and detention of mentally ill persons. His experiences as a patient are put forward as a test case by the Community Legal Assistance Society (CLAS) in an effort to narrow the criteria for involuntary committal. CLAS takes on public interest advocacy cases and, amongst other worthwhile tasks, acts as an agency for the giving of advice and representation to mental patients in relation to their involuntary status at the provincial mental health facility at Riverview Hospital or at the major general hospitals in the Lower Mainland area.

The plaintiff argues that the ***Act*** denied him his liberty contrary to s. 7 of the ***Canadian Charter of Rights and Freedoms*** and subjected him to arbitrary detention contrary to s. 9 of the ***Charter***, in that the criteria for committal are vague and overbroad, and the procedures for committal and review of committal lack sufficient safeguards to protect the liberty of the individual.

The Attorney General of British Columbia contends that the criteria and the ***Act*** are neither vague nor overbroad and the process for committal and review laid down by the ***Act*** is both fair and appropriate.

PRELIMINARY MATTERS

At the outset of the trial, the plaintiff moved to amend his Statement of Claim to include a claim for damages against the members of a Review Panel who ruled against the plaintiff and thereby extended his stay at Riverview Hospital as an involuntary patient. By consent, I granted an order that the Attorney General of British Columbia be added as a party to the action. The Attorney General then made a preliminary motion to strike out everything in the plaintiff's action except the ***Charter*** issues.

It became apparent in the course of argument that the real matter in dispute was the constitutionality of the ***Mental Health Act***. Mr. Mossop conceded that he did not need to pursue an application under s. 27 of the ***Act*** which is the mechanism to obtain a court order discharging an involuntary patient, nor did he require an order remitting the review back to a panel for rehearing. He said the habeas corpus aspect of the claim was inserted to ensure a full opportunity to present evidence and on receiving the court's assurance that the ***Charter*** inquiry would allow a broad examination of the facts he was content to drop the habeas corpus claim. That left a claim for a declaration that the Review Panel's decision was invalid and should be quashed, as well as the suit for damages against the Review Panel and the ***Charter*** question.

This proceeding began as a petition for judicial review of the Review Board decision with habeas corpus as an ancillary remedy. By a consent order made on January 22, 1992, the petition became an action so that there could be a trial of the issues. The respondents to the petition did not know then that the plaintiff intended to add a claim for damages to the proceeding.

For reasons given briefly at the conclusion of argument on the preliminary questions, I struck out the items relating to damages and declaratory relief in connection with the Review Panel decision. On the question of damages, Mr. Groberman persuaded me that as a matter of law and policy, the Review Panel members could not be liable in damages simply because they made a good faith decision according to the statute. Who would undertake such public duties if they bore the risk of being sued for damages when the statute upon which they acted was later declared unconstitutional? The contention is unanswerable. In ***Schacter v. Canada*** (1992), 93 D.L.R. (4th) 1, Lamer C.J.C. said at p. 29:

An individual remedy under s. 24(1) of the Charter will rarely be available in conjunction with action under s. 52 of the ***Constitution Act, 1982***. Ordinarily, where a provision is declared unconstitutional and immediately struck down pursuant to s. 52, that will be the end of the matter. No retroactive s. 24 remedy will be available. It follows that where the declaration of invalidity is temporarily suspended, a s. 24 remedy will not often be available either. To allow for s. 24 remedies during the period of suspension would be tantamount to giving the declaration of invalidity retroactive effect. Finally, if a court takes the course of reading down or in, a s. 24 remedy would probably only duplicate the relief flowing from the action that court has already taken.

No corrupt motive or mala fides is alleged against the Review Panel; the only issue is the validity of the constituent statute. The plaintiff recognizes the need for a transition period if the provisions of the ***Act*** are struck down and proposes that I suspend my order declaring the ***Act***unconstitutional for six months. A retroactive remedy in damages is inconsistent with this position.

On the question of the declaration quashing the Review Panel decision itself, I ruled that the matter was moot. The chronology of the plaintiff's latest committal (he had been committed on seven previous occasions for acute symptoms of bipolar mood disorder) is as follows:

1. On November 22, 1990, the plaintiff was involuntarily detained and admitted to Riverview Hospital on the certification of two doctors who said he displayed dangerously aggressive behaviour in the manic phase of his bipolar mood disorder.

2. On December 22, 1990, his detention was extended to January 22, 1991 by a single doctor on the ground that his condition had not yet stabilized.

3. On January 21, 1991, a Review Panel conducted a hearing at the plaintiff's request to review his detention and decided that he should be detained for the following reason: "We are of the opinion that the patient suffers from a mental disorder and is a danger to himself due to his non-compliance with medication."

4. On January 22, 1991, a further extension to April 22, 1991 was made by a doctor for the same reason as given in the first extension.

5. On March 14, 1991, the Review Panel named as defendants in these proceedings conducted a further review. The majority said:

We feel the patient needs the care and control of a supervised setting and though he said he would stay informally, the majority felt that temptation should not be before him to leave and get into problems as his history shows he has in the past. We recommend another panel in six weeks to see what progress has been made. Please have the same panel members.

The minority, namely, Dr. McFarlane, the hospital's nominee on the panel, dissented and said:

This patient clearly suffers from chronic alcoholism but the reported bi-polar effective disorder is now resolved and or under control. Although there is a probability that if discharged he may revert to the use of alcohol this Province has no legislation for compulsory treatment of alcoholism. Although it would be desirable for him to remain in hospital until his vascular surgery is completed I do not agree that we have sufficient grounds to detain him against his will.

6. By April 24, 1991, the plaintiff's condition had improved to the point that he was ready to be discharged to Cordova House, the community care facility where he lived before his committal, when they had a place for him. He cancelled a Review Panel he had requested for April 30, 1991 and the hospital accepted his application for readmission thereby changing his status from an involuntary to a voluntary patient awaiting community placement.

7. On May 21, 1991, the plaintiff was discharged from Riverview Hospital. He has remained in the community since that time.

In these circumstances, the validity of the decision of the Review Panel made on March 14, 1991 is an academic issue. The principle of judicial economy requires that in the rationing of the court's resources, no time should be spent on a dead issue. Accordingly, I ruled that since a judicial review of the decision would serve no useful purpose, the decision no longer having any effect, the declaratory relief should be struck from the Statement of Claim.

There remains the question whether the entire matter is moot. Both sides were content to proceed on the ***Charter*** issue; indeed Mr. Groberman said the province wants this question decided because it is a continuing source of controversy.

During a lengthy adjournment of the trial, I asked counsel to give me written submissions on mootness. In a memorandum to counsel on April 26, 1993, I said, in part, as follows:

The policy implications of this case are such that I feel I need to hear argument from counsel on the question of mootness.

At the outset, it appeared that the Attorney General would take the position that because the plaintiff is no longer confined under the impugned legislation, the matter should be declared moot and the action dismissed. Mr. Groberman did not press that argument and said that his instructions were to proceed in order to obtain a ***Charter*** determination on the present form of involuntary committal criteria.

Bluntly stated, I want to be assured that the Court is not simply being asked to provide a legal opinion on a question that has apparently vexed a broadly representative committee struck by government to enquire into and make recommendations on this difficult issue.

Counsel responded with complete and well reasoned arguments. I acceded to their joint position that I should continue to hear and decide the case.

The leading authority on mootness is ***Borowski v. Canada (Attorney General)***, [1989] 1 S.C.R. 342. The proper approach to a mootness problem was described by Sopinka J., who gave the judgment for the court, at p. 353:

The approach in recent cases involves a two-step analysis. First it is necessary to determine whether the required tangible and concrete dispute has disappeared and the issues have become academic. Second, if the response to the first question is affirmative, it is necessary to decide if the court should exercise its discretion to hear the case. The cases do not always make it clear whether the term "moot" applies to cases that do not present a concrete controversy or whether the term applies only to such of those cases as the court declines to hear. In the interest of clarity, I consider that a case is moot if it fails to meet the "live controversy" test. A court may nonetheless elect to address a moot issue if the circumstances warrant.

He went on to identify three basic rationalia underlying the doctrine of mootness in order to develop criteria for the exercise of discretion in hearing a moot case:

1. The first rationale for policy and practice referred to above is that a court's competence to resolve legal disputes is rooted in the adversary system. The requirement of an adversarial context is a fundamental tenet of our legal system and helps guarantee that issues are well and fully argued by parties who have a stake in the outcome. It is apparent that this requirement may be satisfied if, despite the cessation of a live controversy, the necessary adversarial relationships will nevertheless prevail. (pp.358-9)

.....

2. The second broad rationale on which the mootness doctrine is based is the concern for judicial economy. (See: Sharpe, "Mootness, Abstract Questions and Alternative Grounds: Deciding Whether to Decide", ***Charter Litigation***.) It is an unfortunate reality that there is a need to ration scarce judicial resources among competing claimants.

.....

The concern for conserving judicial resources is partially answered in cases that have become moot if the court's decision will have some practical effect on the rights of the parties notwithstanding that it will not have the effect of determining the controversy which gave rise to the action.

.....

Similarly an expenditure of judicial resources is considered warranted in cases which although moot are of a recurring nature but brief duration. In order to ensure that an important question which might independently evade review be heard by the court, the mootness doctrine is not applied strictly.

.....

There also exists a rather ill-defined basis for justifying the deployment of judicial resources in cases which raise an issue of public importance of which a resolution is in the public interest. The economics of judicial involvement are weighed against the social cost of continued uncertainty in the law. (p. 360-361)

.....

3. The third underlying rationale of the mootness doctrine is the need for the Court to demonstrate a measure of awareness of its proper law-making function. The Court must be sensitive to its role as the adjudicative branch in our political framework. Pronouncing judgments in the absence of a dispute affecting the rights of the parties may be viewed as intruding into the role of the legislative branch. (p. 362)

Sopinka J. concluded his remarks on this part of his analysis by saying at p. 363:

In exercising its discretion in an appeal which is moot, the Court should consider the extent to which each of the three basic rationalia for enforcement of the mootness doctrine is present. This is not to suggest that it is a mechanical process. The principles identified above may not all support the same conclusion. The presence of one or two of the factors may be overborne by the absence of the third, and vice versa.

Applying these criteria to the instant case, I find as follows:

1. While the case is now technically moot in relation to the plaintiff, he has a history of neglecting his medication and having to be committed to a mental hospital when his disorder becomes acutely symptomatic. Consequently, he continues to be at risk of coming under the impugned provisions of the ***Act***.

2. The case is sponsored by CLAS which is concerned about other persons who are affected by the ***Act***. CLAS advances this as a test case, not only for the future handling of the plaintiff should he need hospitalization again, but also for the numerous other mentally disordered persons who rely on CLAS to help them with their involuntary status. There was a full adversarial test of the issues in this case.

3. Unless the court grapples with a test case, even though it may be moot, the constitutionality of the ***Act*** may never be examined. The plaintiff's circumstances provide a typical example of the short term nature of involuntarily detention. Given the time it takes to bring a case to trial in this court, it is unlikely that any such controversy could remain alive for adjudication. This case falls within the exception noted by Sopinka J. under the judicial economy rationale.

4. Any concern for a real or perceived intrusion by the court into the legislative function can be laid to rest since the Attorney General has plainly requested a judicial determination of the ***Charter*** issue. This is a controversy that will not go away and needs to be settled.

RELEVANT ENACTMENTS

Canadian Charter of Rights and Freedoms

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

9. Everyone has the right not to be arbitrarily detained or imprisoned.

1. The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Mental Health Act

Interpretation

1. In this ***Act***

... "mentally disordered person" means a mentally retarded or mentally ill person;

"mentally ill person" means a person who is suffering from a disorder of the mind

(a) that seriously impairs his ability to react appropriately to his environment or to associate with others; and

(b) that requires medical treatment or makes care, supervision and control of the person necessary for his protection or for the protection of others; ...

Involuntary Admission

20. (1) On receipt of 2 medical certificates completed by 2 physicians in accordance with subsection (3), the director of a Provincial mental health facility may admit a person to the facility and detain him in it.

(2) [Repealed 1987-42-66, effective October 1, 1987 (B.C. Reg. 345/87).]

(3) Each medical certificate shall be completed and signed by a physician who is not disqualified under subsection (4) and who has examined the person whose admission is requested not more than 14 days prior to the date of admission and shall set forth

(a) a statement by the physician that he has examined the person whose admission is requested on the date or dates set forth and is of the opinion that the person is a mentally disordered person;

(b) in summary form the reasons on which his opinion is founded; and

(c) in addition to the statement required under paragraph (a), a separate statement by the physician that he is of the opinion that the person whose admission is requested

(i) requires medical treatment in a Provincial mental health facility;

and

(ii) requires care, supervision and control in a Provincial mental health facility for his own protection or for the protection of others.

(4) A physician is disqualified from giving a valid medical certificate under this section if he is

(a) the person whose admission is requested;

(b) and (c) [Repealed 1987-42-68, effective October 1, 1987 (B.C. Reg. 345/87).]

(d) engaged in the practice of medicine in partnership with the physician who completes the other certificate; or

(e) a person employed as an assistant by a physician who completes either of the medical certificates in respect of the person whose admission is requested.

(f) [Repealed 1985-12-6.]

(5) [Repealed 1985-12-6.]

(6) A medical certificate given under this section becomes invalid on the 15th clear day after the date on which the physician examined the person who is the subject of the certificate.

(7) The 2 certificates completed as required under this section are sufficient authority for a person to apprehend and convey the person named in the statement made under subsection (3)(a) to a Provincial mental health facility.

1964-29-23; 1968-27-8;

1973-127-13,22; 1985-12-

6; 1987-42-66 to 68,

effective October 1, 1987

(B.C. Reg. 345/87); 1989-

48-22.

Duration of Detention

21. (1) A patient admitted under section 20 may be detained in a Provincial mental health facility for one month after the date of his admission, and he shall be discharged at the end of that month unless the authority for his detention is renewed in accordance with this section.

(2) Authority for the detention of a patient may, unless the patient has previously been discharged, be renewed under this section

(a) from the expiration of the period referred to in subsection (1) of this section for a further period of one month,

(b) from the expiration of any period of renewal under paragraph (a) for a further period of 3 months, and

(c) from the expiration of any period of renewal under paragraph (b) for a further period, or further successive periods, of 6 months.

(3) During

(a) every one month period referred to in subsection (1),

(b) every further one month period referred to in subsection (2)(a), and

(c) the last month of every 3 month or 6 month period referred to in subsection (2)(b) or (c),

the director of the Provincial mental health facility or a physician authorized by him shall examine the patient who has been detained in the facility and either discharge him or record a written report of the examination and include in it the reasons of the director or physician for concluding that the detention of the patient should be renewed.

(3.1) The written report referred to in subsection (3) is a renewal of the authority for the detention of the patient referred to in subsection (3).

(4) At his request or at the request of a person on his behalf, a person admitted to a Provincial mental health facility under section 20 is entitled to a hearing by a review panel

(a) within a prescribed time after the commencement of a one month period, or further one month period, referred to in subsection (1) or (2)(a),

(b) within a prescribed time after the commencement of a 3 month period referred to in subsection (2)(b), or

(c) during any 6 month period referred to in subsection (2)(c), within a prescribed time after 90 days after the conclusion of any previous hearing,

in order to determine whether or not he should continue to be detained.

(4.1) A chairman appointed under subsection (5.1) may abridge the time period in subsection (4)(c) where he considers it to be in the best interests of the patient or where new information relative to the patient's detention has become available.

(5) For the purposes of a hearing under subsection (4),

(a) the patient shall not be discharged until the results of the hearing are made known to him and then only if the results of the hearing indicate that he should be discharged; and

(b) a review panel shall consist of

(i) a chairman;

(ii) a physician who is appointed by the Provincial mental health facility to which the patient is admitted; and

(iii)a person, other than the patient or a member of his family, who is appointed by the patient. Where the patient does not appoint a person, the director of the Provincial mental health facility to which the patient is admitted may appoint a person who, in his opinion, has knowledge of the circumstances of the patient.

(5.1) The minister shall appoint one or more chairmen under subsection (5)(b)(i) for the purpose of conducting hearings as and when they may be required under subsection (4) and for the purpose of making decisions as and when they may be required under subsection (4.1)

(6) The minister may reimburse a person appointed under subsection (5) or (5.1) for reasonable travelling or out of pocket expenses necessarily incurred by him in discharging his duties under this section, and, in addition, may pay him the remuneration for his services the minister may determine.

1964-29-24; 1973-127-

14,22; 1983-10-21,

effective October 26,

1983 (B.C. Reg. 393/83);

1985-12-7; 1987-42-69 to

73, effective October 1,

1987 (B.C. Reg. 345/87);

1989-48-23.

Application to court for discharge

27. (1) A person for whose admission to a Provincial mental health facility a request is made under section 19(1)(b) or 20 or a patient or a near relative of the person or patient or anyone who believes that there is not sufficient reason for the admission or detention of the person or patient under this Act, may apply before admission of the person or after the date of admission of the patient to a Provincial mental health facility to the court for

(a) an order prohibiting the admission of the person to a Provincial mental health facility pursuant to that request;

(b) an order prohibiting the admission of the person to a Provincial mental health facility pursuant to that request or any other request for admission of the person to a Provincial mental health facility made prior to the date of the order; or

(c) an order that the patient be discharged from the Provincial mental health facility.

(2) Nothing in this section affects the right of a person to apply for a writ of habeas corpus or other prerogative writ.

(3) On hearing an application under subsection (1), the court may review the evidence, including all papers relating to the admission requested or the admission and detention of the patient and may hear further evidence it deems relevant.

(4) Where the court is satisfied that there is or was sufficient reason and authority for the admission of a person or patient to a Provincial mental health facility and for his detention in it, it shall order that the person or patient be detained in a Provincial mental health facility for care and treatment.

(5) Where the court is not satisfied that there is or was sufficient reason or authority for the admission of the person to a Provincial mental health facility or for the detention of the patient in it, it may make an order

(a) prohibiting anyone from admitting the person to a Provincial mental health facility pursuant to the request for admission that gave rise to the application under this section;

(b) prohibiting anyone from admitting the person to a Provincial mental health facility pursuant to a request for admission made prior to the date of the order;

(c) that the patient be discharged from the Provincial mental health facility; or

(d) that the director of a designated Provincial mental health facility obtain within 10 days a report from a physician who is recognized by the College of Physicians and Surgeons of British Columbia as being a specialist in psychiatry and who would not be disqualified from giving a valid medical certificate under section 20, stating whether or not in his opinion the person or patient is in fact mentally disordered and consequently requiring care and treatment in a Provincial mental health facility, and that the person, if he is not detained at the time of the making of the order in a Provincial mental health facility, attend before the physician for examination at a time and place appointed by the director.

(6) On receipt of the report made under an order under subsection (5), the court shall,

(a) if it is satisfied that the person or patient is mentally disordered and requiring care and treatment in a Provincial mental health facility, order that the person or patient be admitted to and detained in the Provincial mental health facility; or

(b) if it is not satisfied that the person or patient is mentally disordered and requiring care and treatment in a Provincial mental health facility, make an order under subsection (5)(a), (b) or (c).

(7) Where an order is made under this section for the discharge of a person or patient from a Provincial mental health facility, the director of the Provincial mental health facility shall immediately discharge the person or patient.

(8) In this section, "Provincial mental health facility" includes a psychiatric unit and a director of a Provincial mental health facility includes the officer in charge of a psychiatric unit. Where a person has, under section 22, been admitted to a psychiatric unit and removed to a Provincial mental health facility, an application made under this section prior to his removal shall be continued with the substitution of the appropriate parties and shall be deemed to include an application in relation to admission and detention in the Provincial mental health facility.

1964-29-30; 1968-27-11;

1973-127-22; 1974-87-28;

1976-33-96; 1987-42-75,

effective October 1, 1987

(B.C. Reg. 345/87); 1990-

51-27.

ISSUES

1. Are the criteria for involuntary committal vague?

2. Is the scheme for involuntary detention in accord with fundamental justice?

FACTS

The plaintiff read into evidence portions of the examination for discovery of Dr. Joseph Noone, Clinical Director and Psychiatrist-in-Chief of Riverview Hospital. He said that in 1955 Riverview had 5,500 patients and that the current census is 850, although there are presently 1,000 beds available. The Ministry of Health plans to reduce the population of Riverview to 300 beds and to open a 100 bed psychiatric facility to serve the Thompson/Okanagan/Kootenay areas and another with the same size for Vancouver Island. To realize this plan, many patients will have to be placed into the community.

Dr. Noone discussed an evaluation of Riverview conducted in 1989 by a national body which surveys hospitals and rates them according to generally accepted standards. The evaluation report criticized the hospital for having over 90% of its patients in the involuntary status. When Dr. Noone accepted his position as Clinical Director, he resolved to reduce that percentage and in two years he brought it down to 60%. He accomplished this by changing the status of some patients from involuntary to informal and by discharging others. The accreditation rating of the hospital went up as a result. At p. 42 of the transcript of his examination this passage appears:

Q What is your final goal for numbers of involuntary patients?

A I don't actually have a particular goal in the number of involuntary patients. I do have a position that it should be --

MR. GROBERMAN: You are asking for the hospital's position I take it?

MS. FRANCES: I am asking for the hospital's position.

MR. GROBERMAN: Okay, Thank you.

A Okay. That it should be continued to be reduced from what it presently is and restricted to a fairly -- how shall I put the word? Conservative interpretation of the Mental Health Act.

The plaintiff relies on this evidence to prove the vagueness of the criteria: such a dramatic shift in the ratio of involuntary patients as was created by Dr. Noone could only be achieved with poorly defined criteria in the ***Act***.

The plaintiff called Dr. Jaime Paredes, a psychiatrist who reviewed the plaintiff's medical records and opined that the plaintiff was not mentally ill at the time of his Review Panel hearing in March, 1991. He said that lithium carbonate effectively controls the symptoms of bi-polar mood disorder and that the plaintiff was in remission as a result of taking that medication.

In his own testimony, the plaintiff, a 73 year old painter, expressed his dislike for Riverview Hospital and his resentment at remaining there as an involuntary patient as long as he did on the last occasion. He gave a history of going off his medication and abusing alcohol in the manic phase of his illness, as a result of which he had to be placed in mental hospitals. He recognized the need to be in a controlled situation in the community and to ensure that he takes his medication; and he knows that if he gets into trouble when off his medication he must go to a hospital. He simply does not want that hospital to be Riverview.

Both sides in this case filed a large body of literature, most of which addressed the question of committal criteria and examined the medical and social effects of a change from a "need for treatment" approach to a much more restrictive "physical dangerousness" approach. Included in the defendant's evidence was a 436 page book entitled ***Madness in the Streets, How Psychiatry and the Law Abandoned the Mentally Ill***, by R.J. Isaac and V.C. Armat, (New York: The Free Press, 1990). As the title suggests the book condemns the American authorities' decision to adopt dangerousness criteria, close psychiatric hospital beds, and put mentally ill people on the streets to fend for themselves. Amongst other articles and reports, the plaintiff filed a study from Pennsylvania: S. Cleveland, E.P. Mulvey, P.S. Appelbaum, and C.W. Lidz, "Do Dangerousness-oriented Commitment Law Restrict Hospitalization of Patients Who Need Treatment: A Test?" (March 1989) 40:3 Hospital and Community Psychiatry, p. 266, to present a contrary view. Experts offer conflicting opinions on the causes of the tragic phenomenon of the homeless mentally ill.

I shall not engage in a detailed review of the literature. The court's task is not to conduct a commission of inquiry nor to choose amongst policy alternatives. The question at hand is whether the impugned provisions of the ***Act*** can survive ***Charter*** scrutiny. Brief references to the material later in these reasons will suffice to give a context within which the constitutional issue must be resolved.

The viva voce evidence called by the defendants was devoted to the proposition that narrowly defined dangerousness criteria for committal fail to provide proper mental health care. Hugh Wilkinson recounted the poignant story of his son's long descent into schizophrenia, unchecked by psychiatric intervention because of an unwillingness by doctors and other authorities to use the ***Act*** to commit his son to hospital unless and until he committed an act of violence. It was only through the criminal justice system, a probation order following an assault conviction, that he received the treatment that he needed for years. Mr. Wilkinson watched helplessly as his son became more and more dysfunctional and alienated. The young man lived in squalid filth; he often behaved in a bizarre manner; he could not work; he neglected his personal needs as to hygiene and nutrition; and yet, because he was not dangerous to others, no one was prepared to answer Mr. Wilkinson's pleas that his son be taken into hospital. Psychiatrists agree that early treatment of schizophrenia vastly improves the patient's prognosis.

John Wilson and George Laurie, both schizophrenics whose disease is in remission, gave their personal histories and stressed the fact that they resisted treatment initially. They said that it was a part of their illness not to know that they were psychotic and needed treatment. They said they went far too long and caused their families too much grief before they were involuntarily committed. With treatment and a continuing course of medication, they have gone on to

productive, useful lives in the community. Both said it took some time for them to gain insight into their illness so that they could identify when they needed a doctor's help.

Robert Winram suffers from bi-polar disorder. He is the executive director of the Mood Disorder Association, an organization founded by mental patients suffering from that disorder. In his personal history, he spoke of the several onsets of the acute manic phase in which the feelings of elation and power he experienced clouded his appreciation that he was becoming ill. Although he had to be forced to go to hospital, he was grateful that he was taken involuntarily before his behaviour got him into serious trouble. He said that the changes that signal a relapse are often subtle and difficult for him to appreciate and consequently he cannot rely only on his insight gained over the years but must heed the warnings his friends will give him. In his view and in the view of those in his organization, a strict dangerousness criterion would leave many bipolar sufferers untreated. They will seldom be physically dangerous to anyone but they can quickly ruin their jobs, family relationships, friendships and reputations by their often outrageous conduct.

A comparable organization for schizophrenics known as Friends of Schizophrenics also rejects the change to a dangerousness criterion for many of the same reasons.

Dr. Donald Remick of the Department of Psychiatry at St. Paul's treats mood disorders as a large part of his practice. He said that most patients with that illness are not physically dangerous to themselves or others. Few check themselves in for treatment until they have learned from bitter experience what their disease can do to them. Once in hospital they can be quickly stabilized and enjoy a high rate of successful recovery. Most only need acute care and will be discharged within one to four weeks. Untreated, they can destroy their lives by giving away their money and possessions, plunging recklessly into losing financial ventures, becoming sexually promiscuous, quitting their jobs and insulting their bosses and so on. He referred to the case of a general practitioner who, when he became manic, stopped treating his patients and had them pray with him instead. Had he not been treated quickly he could have ruined his practice and professional reputation. Dr. Remick stressed the importance of early intervention to prevent such disasters.

Mental illness in the provincial jails was discussed by Dr. Diane Rothon, Director of Health Services for the Corrections Branch, Ministry of Attorney General. The burden of her testimony was that the criteria in the ***Act***, when applied to inmates, effectively operate on the dangerousness principle. When mentally ill inmates act out corrections staff restrain and isolate them so that they and the other inmates are protected. The principal aim of the jails is security - protection is built into the system - and, therefore, only the most extreme cases of the mentally disordered, those who are very dangerous to themselves or others, are committed to a psychiatric facility from jail. In Dr. Rothon's opinion, this is an unacceptable state of affairs because too many mentally ill persons remain in jail where they receive little or no treatment and often endure the abuse of other inmates who rate them low on the prison hierarchy.

In cross-examination, Dr. Rothon was referred to a written response made on September 9, 1992 by the Corrections Branch to a discussion paper on mental health legislation presented by a

committee struck by the Ministry of Health where it was argued that mentally ill inmates were "victims of vague and in appropriate committal criteria." She agreed with that characterization.

The defendants called Dr. John Gray to provide an expert opinion on committal criteria. He is a registered psychologist holding a Ph.D. in psychology from the University of London. His background includes positions such as the executive director of Saskatchewan's provincial mental hospital, assistant executive director of Riverview, and executive director of Mental Health Services, Ministry of Health for British Columbia. He continues to occupy a senior position in the Ministry and in that capacity he coordinated a process known as the Mental Health Act Review which began in 1990. Out of this grew a consultation committee representing over 20 groups and covering the full range of interests. Dr. Gray has been asked by the Ministry to contribute to policy discussions regarding committal criteria since 1980. The Mental Health Act Review required Dr. Gray to study the literature and legislation in other jurisdictions; and he attended many public meetings and received numerous submissions. I accepted his qualifications to speak with authority on the topic of committal criteria.

In his testimony, he followed a written outline (Ex. 15). The more important points were supported by a brief of articles, commentaries and studies as well as the book, ***Madness in the Streets***, to which I earlier referred. He divided committal criteria into three broad groups: need for treatment, modified need for treatment, and bodily harm or physical dangerousness. He classified the British Columbia ***Act*** (as it read before amendment to its present form in 1987) as a pure "need for treatment" statute: involuntary admission could be justified on the basis that mental disorder affected a person's "welfare." Because the present ***Act*** stipulates treatment, care, supervision, and control for the protection of self or others as the requisite grounds for committal he places our current criteria in the middle category, as he does with the Manitoba and Saskatchewan legislation. He cited the Ontario legislation as an illustration of the third category. In that jurisdiction, whether or not a mentally disordered person is treatable in a provincial psychiatric facility, the person can only be committed if physically dangerous. Alberta and Nova Scotia also use the term "danger" in their statutes, but they do not define it as closely as Ontario.

This evidence serves the limited purpose of providing a context for the ***Charter*** analysis. I have attempted only a point form summary of Dr. Gray's testimony and I acknowledge that it will not do justice to his well researched and thoughtful presentation:

1. The American experience with dangerousness legislation combined with deinstitutionalization (eliminating psychiatric hospital beds) has been disastrous. Large numbers of mentally ill people do not have the care and asylum that they need. Many are homeless because their illness isolates them, and many end up in jail because they cannot function autonomously in the community and their behaviour gets them into trouble.

2. "Physical dangerousness" as a criterion does not apply to many persons suffering from the major psychiatric illnesses, schizophrenia and the two mood disorders. Most sufferers do not seek treatment and refuse the offer of treatment because their illnesses deprive them of the reason and understanding necessary to recognize their needs.

3. In these circumstances, timely intervention is impossible. Early treatment can prevent the ruinous behaviour of the manic, bring the depressed out of despair and improve the schizophrenic's prognosis.

4. The families of untreated patients bear a crushing burden of worry, disruption, fear and uncertainty. Family members can become sick themselves because of the trouble caused by the mentally disordered.

5. Doctors are poor at predicting dangerousness or risk of bodily harm but they are good at diagnosing mental illness. Many patients withdraw from family and friends and keep to themselves. Since they seldom announce their intention to cause harm, their dangerousness remains hidden. Therefore, dangerousness criteria will tend to operate only after a violent incident has occurred, like the Wilkinson case, where the fact of dangerousness was demonstrated.

6. In the United States, dangerousness abbreviates the period of treatment so that patients leave the hospital when their acute symptoms, i.e., those that made them dangerous, pass but before they have received a proper course of treatment to stabilize their condition. They are deprived of a reasonable chance of managing in the community, and they live in a cycle of committal and early discharge or they go to jail or die on the streets.

7. Many states in America have amended their legislation to provide for modified need for treatment criteria and have reversed the trend of reducing capacity in the state psychiatric hospitals.

On February 12, 1992, the committee conducting the Mental Health Act Review under Dr. Gray's coordination published a discussion paper setting forth its recommendations. These recommendations represented a majority view and not a consensus. They have two main features: (1) committal criteria should be physical harm to self and others (i.e., dangerousness) and deterioration leading to serious physical impairment; and, (2) government should enact a companion piece of legislation to establish a guardianship scheme to cover the mentally disordered who do not fit the dangerousness and deterioration criteria. Under the proposed guardianship legislation, mentally ill persons will be able to make agreements with trusted persons giving them, as guardians, authority to consent on the patient's behalf to voluntary admission to hospital when symptoms described in the agreement appear. The patient can determine in the agreement the nature and extent of the treatment while in hospital. For non-dangerous patients who have not made an agreement but whose condition requires treatment in a psychiatric hospital an application must be made to the Supreme Court for an order committing the patient.

Dr. Gray said that the recommendations for the change of criteria provoked strong opposition from the psychiatric section of the British Columbia Medical Association, the Friends of Schizophrenics and the Mood Disorder Organization. On receiving the discussion paper, doctors at the Vancouver General Hospital Emergency Psychiatric Service conducted a study and published the results on August 4, 1992. They found that, of the 80 patients studied, roughly 40% would fail the proposed dangerousness criteria and very few, approximately 5%, would have

been admitted on the grounds of deterioration. The report commented that deterioration is an unworkable criterion because in the emergency setting where most acutely ill mental patients are first taken there is simply not enough information to make a judgment on the terms proposed. It concluded with the observation: "Finally, one predictable consequence of the change will be an increase in the amount of 'revolving-door' patients".

Dr. Gray said that the Ministry of Health has not acted on the recommendations to change the committal criteria but it has started to draw guardianship legislation. While strongly in favour of guardianship, he criticized the notion that it can act as a suitable substitute for a modified need-for-treatment model. He also said that guardianship should not allow the patient to dictate the treatment while in hospital, because a right to refuse treatment will result in hospitals having to deal with crazy and dangerous behaviour without being able to do anything about it. Also the patient may not be able to foresee what treatment is appropriate in future circumstances and the preplanning in the agreement may therefore operate to the patient's detriment. Guardianship leaves out of account patients who have no one to act as their guardian and who are interested in bringing an application in court for committal. Those who lack insight and do not realize that they are sick or do not recognize the warnings of the onset of an acute phase will also fall outside the guardianship scheme.

Dr. Gray agreed in cross-examination that the philosophy adopted in provinces such as Alberta and Ontario is that*Mental Health Acts* deal with the physically dangerous and the guardianship*Act* deals with the others; but he observed that Ontario has not yet proclaimed its guardianship statute and the scheme is not working in Alberta because only 15 patients have been admitted under it. He said that the court order feature of guardianship introduces an element of delay, and serious mental illness should be treated at the early signs. Citing Quebec as an example, where it takes 13 months to get a guardianship order from the Superior Court, he warned that the court process will not be able to respond to the needs of the situation. His view is that too many mentally ill persons will fall between an act based on dangerousness and a guardianship statute.

ARGUMENTS OF COUNSEL

Mr. Mossop for the plaintiff made the following submissions in his concluding argument:

1. The committal criteria in the ***Act*** are vague. The language is so loose that it allowed Dr. Noone to reduce involuntary patients from 90% to 60%. It prompted Dr. Rothon to complain that the language is vague and inappropriate because it keeps too many mentally ill persons in jail when they should be treated in hospital.

2. The ***Act*** provides no criteria for the review of committal. Continued detention is, therefore, arbitrary and contrary to the principles of fundamental justice.

3. Charter jurisprudence holds that the detention of the mentally disordered can only be justified on grounds of dangerousness.

4. Mentally disordered persons are innocent victims of disease, unlike convicted criminals, and, therefore, are entitled to the least impairment of liberty as possible - dangerousness achieves that goal. An alternative to the present criteria is available, namely a guardianship scheme. Guardianship avoids the stigma of involuntary committal with its implication of dangerousness; and promotes conditions where the patient can exercise some control over his or her life and maintain dignity.

Mr. Groberman made the following points in argument:

1. The ***Act*** clearly affects the liberty of a mentally disordered person.

2. The case should be decided on s. 7 of the ***Charter***; it is broader than s. 9 and has a residual scope that encompasses the s. 9 issue.

3. The criteria and the scheme for the application of the ***Act*** satisfy the substantive and procedural requirements of fundamental justice.

4. The definition of those requirements depends on the context in which the ***Charter*** issue arises. Criminal law rules are inapplicable to the field of mental health because of the differing contexts.

5. On the substantive elements:

(a) given the rationale for the ***Act*** - protection and treatment - it is appropriate that the initial decision makers are doctors, and not judges;

(b) the standards of detention are clear and well-defined;

(c) the ***Act*** need not define criteria for Review Panels; "review" necessarily implies the use of the same criteria as for committal.

6. On the procedural elements:

(a) the patient has a full array of protections on committal, including both administrative and judicial procedures for review. Review Panels must convene quickly at the patient's request. On court review, under s. 27, the hospital bears the reverse onus of justifying committal;

(b) the ***Act*** lays down strict time limits for continuation of a patient's involuntary status.

7. If the ***Act*** violates s. 7, it is saved by s. 1. Detention under the current criteria is justifiable as fulfilling society's duty to care for the mentally ill.

8. Dangerousness criteria will not meet government's objective to care for the mentally ill.

9. Guardianship legislation is not a suitable substitute for the ***Act*** in its present form. It misses too many people and it judicializes a matter best left in the administrative area.

10. Concerns for "stigma" are misconceived. Unlike the criminal justice system which consciously applies a stigma to a convicted criminal, the mental health system commits persons to help and protect them because they are disabled. The stigma arises in the latter instance from fear and ignorance and, therefore, it should not dictate the terms of mental health legislation.

ANALYSIS

Charter Sections

The first question to address is which sections of the ***Charter*** are involved in this case; in particular, whether both ss. 7 and 9 should be considered or only s. 7. I agree with Mr. Groberman's contention that in the circumstances of this case, it is appropriate to test the constitutionality of the ***Act*** by reference to s. 7 and that it is unnecessary to undertake a separate inquiry under s. 9. Mr. Mossop does not agree with that approach. The claim of arbitrary detention of the plaintiff can be dealt with under s. 7 which encompasses all forms of deprivation of liberty.

The defendants concede that involuntary detention under the ***Act*** is a deprivation of liberty within the meaning of s. 7. There remains the issue whether the detention occurs "in accordance with the principles of fundamental justice."

Context

Both counsel stressed the importance of understanding the context in which the ***Charter*** issues arise. In ***Edmonton Home Journal v. Alberta (Attorney General)***, [1989] 2 S.C.R. 1326, Wilson J. said at p. 1352:

Of the two possible approaches to the **Charter's** application one might be described as the abstract approach and the other the contextual approach. While the mechanics of application, i.e. the proper analytical steps to be taken are the same under each, which one is adopted may tend to affect the result of the balancing process called for under s. 1.

Under each approach it is necessary to ascertain the underlying value which the right alleged to be violated was designed to protect. This is achieved through a purposive interpretation of **Charter** rights. It is also necessary under each approach to ascertain the legislative objective sought to be advanced by the impugned legislation. This is done by ascertaining the intention of the legislator in enacting the particular piece of legislation. When both the underlying value and the legislative objective have been identified, and it becomes clear that the legislative objective cannot be achieved without some infringement of the right, it must then be determined whether the impugned legislation constitutes a reasonable limit on the right which can be demonstrably justified in a free and democratic society.

Then at pp. 1355-1356:

One virtue of the contextual approach, it seems to me, is that it recognizes that a particular right or freedom may have a different value depending on the context. It may be, for example, that freedom of expression has greater value in a political context than it does in the context of disclosure of the details of a matrimonial dispute. The contextual approach attempts to bring into sharp relief the aspect of the right or freedom which is truly at stake in the case as well as the relevant aspects of any values in competition with it. It seems to be more sensitive to the reality of the dilemma posed by the particular facts and therefore more conducive to finding a fair and just compromise between the two competing values under s. 1. [emphasis added]

The words emphasized in the above passage take on particular significance in this case because the plaintiff attempts to analogize detention of criminals with committal of the mentally disordered. With all due respect to the able argument of counsel for the plaintiff, the contextual approach militates against drawing such an analogy. I refer to a more recent pronouncement of the Supreme Court of Canada, ***R. v. Pearson*** (1992), 77 C.C.C. (3d) 124, where Lamer C.J.C. said at p. 136:

As the majority of this court (per La Forest J.) noted in ***R. v. Lyons*** (1987), 37 C.C.C. (3d) 1 at p. 45, 44 D.L.R. (4th) 193, [1987] 2 S.C.R. 309:

It is also clear that the requirements of fundamental justice are not immutable; rather, they vary according to the context in which they are invoked. Thus, certain procedural protections might be constitutionally mandated in one context but not in another.

Statutes dealing with criminal law are penal in nature; incarceration is a punishment of culpable individuals and serves the objectives of public safety and denunciation of crime. The ***Mental Health Act*** involuntarily detains people only for the purpose of treatment; the punitive element is wholly absent. The impact of the difference in context will be brought into sharper focus when the specific grounds of attack on the legislation are examined.

Vagueness

The doctrine of vagueness has been defined in succinct terms by Gonthier J. in ***R. v. Nova Scotia Pharmaceutical Society***, [1992]

2 S.C.R. 606, at p. 643:

The doctrine of vagueness can therefore be summed up in this proposition: a law will be found unconstitutionally vague if it so lacks in precision as not to give sufficient guidance for legal debate. This statement of the doctrine best conforms to the dictates of the rule of law in the modern State, and it reflects the prevailing argumentative, adversarial framework for the administration of justice.

He went on to discuss at pp. 627, 628 and 632 the concept of overbreadth and held that it has no independent existence in ***Charter*** law, although it may serve as an analytical tool to establish the breach of a ***Charter*** right.

Under s. 20 of the ***Act*** the two certifying physicians must state that:

1. the person whose involuntary admission is sought is a mentally disordered person (defined in s. 1);

2. the person requires medical treatment in a provincial mental health facility; and,

3. he "requires care, supervision and control in a Provincial mental health facility for his own protection or for the protection of others."

The plaintiff argues that the protection criterion is imprecise; and that it permits too broad a range of interpretation. Dr. Noone can use it to reduce the proportion of involuntary patients in Riverview by a significant percentage; and it can operate to exclude too many offenders who, according to Dr. Rothon, should be transferred from jail to hospital for treatment of mental illness.

I reject this argument because it ignores the purposive approach in constitutional analysis and imposes an unrealistically strict requirement for precision. As Gonthier J. said in ***Nova Scotia Pharmaceutical Society****, supra*, at pp. 641-2:

> ... laws that are framed in general terms may be better suited to the achievement of their objectives, inasmuch as in fields governed by public policy circumstances may vary widely in time and from one case to the other. A very detailed enactment would not provide the required flexibility, and it might furthermore obscure its purposes behind a veil of detailed provisions. The modern State intervenes today in fields where some generality in the enactments is inevitable. The substance of these enactments remains nonetheless intelligible. One must be wary of using the doctrine of vagueness to prevent or impede State action in furtherance of valid social objectives, by requiring the law to achieve a degree of precision to which the subject-matter does not lend itself. A delicate balance must be maintained between societal interests and individual rights. A measure of generality also sometimes allows for greater respect for fundamental rights, since circumstances that would not justify the invalidation of a more precise enactment may be accommodated through the application of a more general one.
>
> What becomes more problematic is not so much general terms conferring broad discretion, but terms failing to give direction as to how to exercise this discretion, so that this exercise may be controlled. Once more, an unpermissibly vague law will not provide a sufficient basis for legal debate; it will not give a sufficient indication as to how decisions must be reached, such as factors to be considered or determinative elements.

The purpose of the ***Act*** is manifestly plain: the treatment of the mentally disordered who need protection and care in a provincial psychiatric hospital. Commenting on a similar statute for Prince Edward Island, McQuaid J., speaking for the Supreme Court of that province, in the case of Reference ***Re Procedures and the Mental Health Act*** (1984), 5 D.L.R. (4th) 577 at pp. 589-590 said:

The thrust of the ***Mental Health Act***, including its predecessors, has been the safety, support and succour of those who suffer from, or appear to suffer from, a debilitating mental disability or disorder and who, as a consequence, require hospitalization, whether voluntary or otherwise, for their own safety or the safety of others. In this context the word "safety" goes beyond mere protection from the infliction of physical injury....

Historically, the law in the English tradition has had a special care and regard for all subjects who suffered from mental disturbance. Although one might question some of the earlier methods countenanced by the law of an earlier day, none the less, the intent was benign....

The point to be made here is that from the earliest days of English legal history those originally termed "lunatics", now more euphemistically "persons suffering from a mental disorder", were treated as a separate class, requiring and deserving of special care and consideration by the Crown itself but, by reason of their infirmity, subject to certain restrictions as to their freedom of conduct.

The evidence upon which the plaintiff relies to demonstrate vagueness in the application of the criteria are simply examples of differences in interpretation; they do not prove that the words are incapable of guiding legal debate. Given the purpose of the ***Act***, the language must permit the exercise of some discretion. Overly detailed language may only serve to confuse those who have to apply it and it may leave out unforeseen circumstances that should be included in the scheme. This court has been able to work with the criteria in s. 27 applications: ***Hoskins v. Hislop*** (1981), 26 B.C.L.R. 165 (S.C.) and ***Greggor v. Director of Riverview Hospital*** (March 31, 1992), Van. Reg. No. A920330 (B.C.S.C.); and has not found it so vague as to make legal debate impossible.

The plaintiff argues that case law holds that "dangerousness" is the only constitutionally valid criterion. In ***Thwaites v. Health Sciences Centre Psychiatric Facility***, [1988] 3 W.W.R. 217 (Man. C.A.), the Manitoba Court of Appeal struck down the provisions of the ***Mental Health Act*** dealing with compulsory admission as arbitrary, contrary to s. 9 of the ***Charter***. Section 9(1) of that ***Act*** which provided:

9(1) Where a duly qualified medical practitioner issues a medical certificate to the effect that he has examined the person named therein, and that*the person should be confined as a patient of a psychiatric facility*, the person may be admitted to a psychiatric facility as a compulsory patient. [emphasis added]

Philp J.A. who gave the judgment of the court said at p. 228:

In ***Lyons***, La Forest J. said of the appellant's contention that Pt. XXI of the Criminal Code offends s. 9 of the Charter (p. 35) [p. 347]:

However, even giving the word "arbitrary" its broadest signification, it is readily apparent that not only is the incarceration statutorily authorized, but that the legislation narrowly defines a class of offenders with respect to whom it may properly be invoked, and prescribes quite specifically the conditions under which an offender may be designated as dangerous.

Applying those considerations to the compulsory admission provisions of the Act, detention is statutorily authorized, but the legislation does not narrowly define those persons with respect to whom it may be properly invoked, and does not prescribe specifically the conditions under which a person may be detained. The compulsory admission provisions of the Act fail the test and are clearly arbitrary.

In dealing with the s. 1 justification argument he said at pp. 230-1:

Although I am satisfied that the objective of the compulsory admission provisions of the Act is one of sufficient importance to warrant overriding the right "not to be arbitrarily detained", I am equally satisfied that the provisions clearly fail all components of the proportionality test. Firstly, I have concluded that the provisions have not been carefully chosen to achieve their objective; that they are arbitrary and unfair for the reasons set out above. Secondly, I do not think it can be said that, in the absence of a "dangerousness" or like standard, the provisions impair as little as possible on the right of a person "not to be arbitrarily detained." Finally, when compared with other legislation, including the amendments to the Act which have been passed but not proclaimed, the provisions strike the wrong balance between the liberty of the individual and the interests of the community. In the absence of objective standards, the possibility of compulsory examination and detention hangs over the heads of all persons suffering from a mental disorder, regardless of the nature of the disorder, and the availability and suitability of alternative and less restrictive forms of treatment.

I do not read his remarks as stipulating physical dangerousness as the only permissible standard. Neither apparently did the Manitoba legislature which amended the Manitoba Act after ***Thwaites*** was decided to provide the following criteria:

16(1) ...

(a) the person is suffering from a mental disorder as a result of which

(i) he or she is likely to cause serious harm to himself, herself or others or to suffer substantial mental or physical deterioration if not detained in a psychiatric facility;

(ii) the person is in need of continuing treatment that can reasonably be provided only in a psychiatric facility; and

(b) the person is unwilling to agree to a voluntary admission.

The new language survived another ***Charter***challenge. In ***Bobbie v. Health Sciences Centre***, [1989] 2 W.W.R. 153 (Man. Q.B.), the court held at p. 157:

The definition of "mental disorder", combined with the introduction of the objective tests under s. 16(1) of the Act, answer the concerns raised by the Court of Appeal in ***Thwaites*** as to the arbitrariness of the detention procedure under the old Act.

I agree with Mr. Groberman's argument that the Manitoba criteria bears a close similarity to the British Columbia standard. In the Manitoba legislation, "serious harm" is not qualified; it can include harms that relate to the social, family, vocational or financial life of the patient as well as to the patient's physical condition. The operative word in the British Columbia ***Act*** is "protection" which necessarily involves the notion of harm. The Shorter Oxford English Dictionary defines "protection" as "... defence from harm, danger, or evil." The Manitoba cases dealt initially with a statute that had no criteria at all, then with an amended statute with criteria remarkably like British Columbia's ***Act*** which passed a ***Charter*** examination.

The Supreme Court of Canada struck down the insanity provisions in the ***Criminal Code*** in ***R. v. Swain***, [1991] 1 S.C.R. 933, because they gave no criteria or standards to the trial judge who was required to automatically order strict custody for persons found not guilty by reason of insanity. Lamer C.J.C. held that the provisions were arbitrary because, amongst other reasons, "[n]ot of all of these individuals will be dangerous" (p. 1013).

Parliament amended the ***Code*** to give authority to a tribunal known as the Review Board to determine whether a person found not criminally responsible for an offence by reason of mental disorder should be detained. In making its disposition, the board is governed by considerations listed in s. 672.54 of the ***Code***, namely:

... to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, ...

In ***Orlowski v. British Columbia (A.G.)*** (1992), 10 C.R.R. (2d) 301 (B.C.C.A.), the court was moved to criticize the Review Board's approach in the following way at p. 307:

... it appears that the board adopted an avuncular or patronizing attitude toward the appellants, and seemed more concerned with their own subjective views about what would best insure successful integration into society than with the legal questions which they were also called upon to decide under the provisions of the ***Code***.

This passage was cited by the plaintiff to support the contention that in considering the liberty rights of a mentally ill person, subjective standards that relate to the best interests of the person are too vague and the criterion of dangerousness should govern the question of detention. I am unable to find any relationship between the remarks in ***Orlowski*** and the problem in the instant case. In ***Orlowski***, the Court of Appeal was simply reminding the Review Board of the requirements of the statute; it was not prescribing the constitutional limits for involuntary detention.

It is necessary at this point to repeat what I said earlier concerning the use of criminal cases to decide a mental health matter: the objects and purposes of criminal law and mental health legislation are so different that cases in one area will be of little guidance in the other. A protective statute and a penal statute operate in dramatically dissimilar contexts. Strict and narrow criteria for the detention of persons in a criminal law context reflect our society's notions of fundamental justice for an accused person and protection of the public is a foremost

consideration. But in the field of mental health, the same criteria would defeat the purpose of the legislation which is to help seriously mentally ill people in need of protection.

In my view, the plaintiff has failed to show that the courts have determined "dangerousness" as the only permissible criterion under the ***Charter***. I also find that the criteria under the ***Act*** are not invalid on the doctrine of vagueness.

Fair Balance

I propose to complete this analysis by determining whether the enactments in question meet the "fair balance" test for the purpose of s. 7 as recently articulated by McLachlin J. in ***Cunningham v. Canada*** (April 22, 1993) File No. 22451 (S.C.C.). At p. 9, she said:

Having concluded that the appellant has been deprived of a liberty interest protected by s. 7 of the ***Charter***, we must determine whether this is contrary to the principles of fundamental justice under s. 7 of the ***Charter***. In my view, while the amendment of the ***Parole Act*** to eliminate automatic release on mandatory supervision restricted the appellant's liberty interest, it did not violate the principles of fundamental justice. The principles of fundamental justice are concerned not only with the interest of the person who claims his liberty has been limited, but with the protection of society. Fundamental justice requires that a fair balance be struck between these interests, both substantively and procedurally (see ***Re B.C. Motor Vehicle Act***, [1985] 2 S.C.R. 486, at pp. 502-3,*per* Lamer J.,; ***Singh v. Minister of Employment and Immigration***, [1985] 1 S.C.R. 177, at p. 212,*per* Wilson J.; ***Pearlman v. Manitoba Law Society Judicial Committee***, [1991] 2 S.C.R. 869, at p. 882,*per* Iacobucci J.). In my view the balance struck in this case conforms to this requirement.

As to the standards for committal, I find that they strike a reasonable balance between the rights of the individual to be free from restraint by the state and society's obligation to help and protect the mentally ill. In fact, as the testimony from the former mental patients shows, the interests of the individual and the state are not always opposed in this area. The patients' only regret was that they were not involuntarily committed earlier. Unlike incarceration in the criminal justice system, involuntary committal is primarily directed to the benefit of the individual so that they will regain their health.

I reject the plaintiff's argument that because the mentally ill are innocent victims of disease they should have their liberty interfered with as little as possible. Culpability has nothing to do with the question. The extremes of the civil libertarian view have been painfully documented in the United States where one learned commentator observed that the authorities leave the mentally ill "to die with their rights on": ***Madness in the Streets****supra*, at p. 127.

In determining the fairness of the balance, I take into account my perception that Canadians want to live in a society that helps and protects the mentally ill and that they accept the burden of care which has always been part of our tradition.

A major theme in the plaintiff's case is the guardianship alternative for the non-dangerous patient who needs to be placed in hospital. The virtues of the guardianship concept are self-

evident, but guardianship does not serve all the cases that the scheme must cope with. As Dr. Gray said, too many people will fall between dangerousness and guardianship and so the latter cannot operate as an acceptable substitute for the current ***Act***. The other major deficiency is the judicialization of committal for the non-dangerous who do not have a representation agreement. Again, the American experience provides a valuable lesson: in a shift from the administrative mode to the courts, the process of committal bogged down in extensive delays and created much cost for the parties. As a result, many applicants simply gave up or did not bother trying to have the mentally ill person committed.

On the question of stigma, I express full agreement with the arguments advanced by Mr. Groberman. It is doubtful that hospitalization by guardianship would carry less stigma than by involuntary committal; what matters to those who stigmatize the mentally ill is that the person was a patient in a psychiatric hospital.

I am satisfied that there are adequate procedural safeguards in place in the current ***Act***. The certification by two physicians, each independent of the other, is preferable to a hearing prior to committal because those who are certifiable are in urgent need of treatment. Applications to court are expensive and time consuming. The patient is informed, soon after admission, of the right to a review, and the service offered by CLAS (mentioned at the beginning of these reasons) provides ready advice and representation to the patient. The ***Act*** lays down time limits for the duration of involuntary status and a physician must recertify the patient or the patient will be released. The absence of any criteria for the Review Panel is inconsequential. It is unnecessary to repeat in the ***Act*** the committal criteria for the review process because a review necessarily implies the application of the same standards used in the decision of first instance.

Although seldom used, the ***Act*** provides access to the Supreme Court, under s. 27, giving the patient the advantage of a reverse onus on the hospital to justify detention, or by way of a habeas corpus application.

Having examined both substantive and procedural elements of the disputed portion of the ***Act***, I find that a fair balance has been struck and that there is no violation of s. 7. It is, therefore, unnecessary for me to discuss the issues under s. 1.

CONCLUSION

The action is dismissed.

As this was a test case on an important public issue, I will not award costs.

"DONALD J."

June 17, l993

Vancouver, B.C.