NO. S168364
VANCOUVER REGISTRY

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN

COUNCIL OF CANADIANS WITH DISABILITIES

PLAINTIFF

AND

ATTORNEY GENERAL OF BRITISH COLUMBIA

DEFENDANT

AND

HEALTH JUSTICE

INTERVENER

DEFENDANT'S OPENING STATEMENT

BRANCH MACMASTER LLP
1410 - 777 Hornby Street
Vancouver, BC V6Z 1S4
Fax: 604-684-3429

Tel:
604-654-2951 (A. Sharon)
604-631-2567 (C. Jones)
416-915-4152 (H. Ahmed)
604-622-6605 (H. Richardson)

Email:
asharon@branmac.com
cjones@branmac.com
hmahmed@branmac.com
hrichardson@branmac.com

CRAIG JONES, K.C.
AVICHAY SHARON
HALLA AHMED
HALEY RICHARDSON

Counsel for the Defendant,
Attorney General of British Columbia

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OVERVIEW

1. Over the course of the next four weeks, the Court is going to hear from psychiatric patients, family members of patients, healthcare providers, medical experts and others who have had direct interactions with individuals suffering from severe mental health disorders. The Court will hear different views and perspectives on psychiatric care generally and involuntary psychiatric treatment in particular. The issues are complex and at times controversial. They engage extremely nuanced questions of clinical judgment, healthcare policy, intersection of mental health and criminal law, public safety, as well as moral and philosophical views about state paternalism and how to balance competing and, at times, directly conflicting interests and rights of patients and others.

2. However, notwithstanding these differing views, there's a reason why every jurisdiction in the free world, every free and democratic society, has in place a regulatory regime that provides for involuntary care to psychiatric patients suffering from serious mental illness who pose a risk to themselves or others.

3. We understand and acknowledge that such provisions affect patient autonomy. However, notwithstanding the short term impact on autonomy, having involuntary care available in some situations is not only permissible but it is the just and right thing to do. The moral thing to do. In some cases maybe the only thing to do to protect both the patient and others.

4. In terms of the right to life, liberty and security of the person under section 7 of the *Charter*, involuntary care saves lives and enhances liberty and security of the person. Viewed through the lens of section 15, involuntary care can be a means of promoting the dignity of the person and advancing substantive equality.

5. Over the course of this trial the Court will hear the terms liberty and autonomy many times. Two conceptions of liberty will emerge. One reflected in the plaintiff's approach which we say is reductionist and overly simplistic – liberty as freedom from state interference *per se*. The second, a more nuanced conception, will be

advanced by the defendant– liberty as freedom from impairment which constrains true free choice - be that due to external or internal constraints.

6. In a public lecture from 2005, Chief Justice McLachlin described the conception of liberty advanced by the plaintiff in the particular context of psychiatric care and involuntary treatment as "impoverished":

> …not treating severely mentally ill persons on account of their refusal to consent represents a particularly impoverished understanding of their rights and civil liberties.[1]

7. Chief Justice McLachlin commented further that:

> Failure to treat may well result in permanent impairment of [a patient's] right to be free from physical detention and their right to have a mind free from debilitating delusions, terrifying hallucinations and irrational thoughts. Although respecting a mentally ill person's decision to refuse treatment formally accords them equal treatment with non-mentally ill patients, abandoning such people to the torments of their illness, mental and physical deterioration, substance abuse and perhaps suicide surely does not respect their inherent dignity as human beings…

8. In the same lecture, Chief Justice MacLachlin posed the real question that we submit the Court must grapple with in this case: "… what obligation do we, the supposedly mentally healthy, owe to our brothers and sisters with mental illness?"

9. There is nothing compassionate in abandoning our fellow citizens to their own devices in their most difficult hour, captive to their delusions and mania. There is nothing moral or just about denying treatment to a person whose cognition and free will are constrained or controlled by hallucinations or suicidal ideation when

[1] "Medicine and the Law: the Challenges of Mental Illness", February 17 and 18, 2005 - https://www.scc-csc.ca/about-apropos/judges-juges/list-liste/beverley-mclachlin/sd-2005-02-17/ (last accessed May 28, 2025)

those conditions are treatable. We are dealing with some of the most devastating medical illnesses which distort and impair the mind in ways that can cause immense suffering to patients, their families and others.

10. The devastating consequences of untreated severe mental illnesses is perhaps best described by some of the patient witnesses the Court will hear from.

11. One of the witnesses the Court will hear from, Bryn Ditmars, who has a long history of eating disorder and schizophrenia, describes his mental illness in his memoir as follows:

> Schizophrenia is a brain disease. When a person breaks his leg, pain signals make their way to his brain, and he quickly realizes that he has broken his leg. So, he goes to the hospital and gets an x-ray, and the doctor bandages his leg in a cast, and recovery is 100% probable. But when the brain is what's broken, the propensity to address the problem is often impaired, because the problem itself is not properly identified… Many people with broken brains never realize they have a mental illness. In fact, that inability to realize they're ill is actually a symptom in and of itself…"[2]

12. Mr. Ditmars describes his state of psychosis, when he would hear voices convincing him he was the messiah and experience severe delusions, as "not being myself" and a "frightening" experience. He writes that in those moments and dark times of psychosis "if hell did exist, I found it". He describes the voices as follows: "I was hearing voices. I remember how scary it was to believe that the nurses and patients were vampires". As the Court will hear from Mr. Ditmars, these voices ultimately led him to even physically attack his own family. Involuntary psychiatric treatment ultimately led Mr. Ditmars to recovery and he is now a fully functioning member of society, and a loving and dedicated husband and father.

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[2] Bryn Genelle Ditmars, "The Man Who Mistook Himself For The Messiah: A Memoir" (Telwell Talent, 2016), p. 2.

13. Another patient the Court will hear about is G.U. G.U. was diagnosed with schizophrenia and suffered from extreme delusions and hallucinations about rats in her veins and brain. Her voices made her believe that the only way to get rid of these rats was to cut herself so she could bleed out the rats. G.U. also heard voices commanding her to kill herself. And, indeed she succumbed to these voices on a number of occasions and attempted to commit suicide. G.U. describes these psychotic situations and voices that "dictate what feels real" and in her own memoir wrote that, ultimately, "my freedom became more restricted by the Voices".

14. G.U. then wrote, nearly a decade ago, as if predicting this exact lawsuit: "There is a growing movement to "free" people of the supposed tyranny of pill-taking for psychosis. *Those medications change your brain!* They say, implying that this is a terrible thing… I say: *Yes, please*… If, unmedicated, my brain changes further and further into the substrate of psychosis. I desperately would like whatever can instead cause the changes that underlie mental wellness".[3]

15. Abandoning people suffering from such devastating illnesses that impair their minds is neither moral nor just. It is cruel. This is exactly where the state and we as a society must act to provide the safety net that will release these seriously mentally ill individuals from the captivity of their own disordered mind. And, as the evidence in this trial will make clear, this kind of paternalistic measure is truly exceptional and reserved to the most serious mental disorders that impair the person's ability to interact with their environment, appreciate their condition and need for treatment and as a result pose a risk of causing substantial harm to themselves or others.

16. However, we expect that the Court will hear some evidence from plaintiff's witnesses and experts suggesting that our system of intervention is based on some kind of sociopolitical construct. That the mentally ill do not suffer from real

[3] Bryn Genelle Ditmars, "The Man Who Mistook Himself For The Messiah: A Memoir" (Telwell Talent, 2016), p. vi

diseases, but rather from social impediments. Some activists and academics, including, we expect, some that will give evidence for the plaintiff, might have you believe that we can address serious mental disorders such as schizophrenia and severe depression by addressing social and historic phenomenon such as patriarchy, racism and colonialism. They will characterize psychiatry as a form of social control informed by stereotypes and stigma. In this view, “medicalization” of mental illness is not an avenue to treatment, but a form of abuse.

17. But this false narrative ignores the undisputed science as well as the reality of severe mental illnesses. In order to make its case the plaintiff must systematically overstate the harms of involuntary treatment, and determinedly ignore the overwhelming evidence of its benefits.

18. But, the evidence at trial will tell a very different story from that presented by the plaintiff. Psychotic conditions, personality disorders, severe depression, these are not social disadvantages – they are terrible, awful diseases of the mind. Schizophrenia for example, one of the most chronic and disabling of the major mental illnesses, involves a chemical imbalance in the brain. This imbalance can, in most cases, be alleviated with proper medication.

19. These debilitating disorders strike at the heart of what makes us human – our very consciousness, our ability to reason and function and interact socially in the world. They strip patients of their liberty, security and dignity. But their insidious effects go much further than this: the Court will hear of the devastating impact of untreated mental illness on family, friends, colleagues, heath care providers, other patients, and members of the public, almost none of whom are immune from the externalized harm that flows from allowing severe mental illness to go untreated.

20. The Court will hear from Mr. Herschel Hardin, a former member of the BC Civil Liberties Association who is also the father of an adult son who has dealt with schizophrenia and experienced multiple involuntary admissions. In 1993, Mr. Hardin published an article titled “Uncivil Liberties” in which he wrote:

> Here is the Kafkaesque irony: Far from respecting civil liberties, legal obstacle to treatment limit or destroy the liberty of the person…
>
> Such victims [the severely mentally ill] are prisoners of their illness. Their personalities are subsumed by their distorted thoughts. They cannot think for themselves and cannot exercise any meaningful liberty. The remedy is treatment.
>
> …
>
> The anti-treatment advocates say: "if that's how people want to live (babbling on a street corner, in rags), or if they wish to take their own lives, they should be allowed to exercise their free will. To interfere – with involuntary committal – is to deny them their civil liberties…
>
> …

Mr. Hardin goes on:

> How can so much degradation and death – so much inhumanity – be justified in the name of civil liberties? It cannot. The opposition to involuntary committal and treatment betrays a profound misunderstanding of civil liberties. Medication can free victims from their illness – free them from the Bastille of their psychoses – and restore their dignity, their free will and the meaningful exercise of their liberties.[4]

21. In 1973, in the midst of a growing anti-psychiatry trend, the renowned psychiatrist Dr. Darold Treffert published an article titled "Dying With Their Rights On" to describe the situation of increasing legal restrictions on mental health professionals to hospitalize and treat mentally ill patients and devastating consequences to both patients and others.[5] This is precisely the reality Mr. Hardin is describing.

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[4] Herschel Hardin, "Uncivil Liberties", Vancouver Sun, July 22, 1993
[5] D.A. Treffert, M.D., "Dying with Their Rights On", American Journal of Psychiatry, Volume 130, Number 9.

22. None of this will surprise this Court, because the untreated mentally ill appear before this Court in this building every day as well as courthouses across the province. We see untreated individuals suffering from serious mental illness everyday in the parks, on the streets and homeless encampments. The Court will hear evidence about the connections between serious mental illness and substance abuse, homelessness, social isolation, interactions with police, and in some cases violence. And it is not just violence committed by the severely mentally ill against others, but also violence committed against them.

23. Simply put, left to their own devices and untreated, individuals suffering from serious mental disorders are among the most vulnerable to the most devastating and life threatening risks and harms. Is that real liberty? Is that we mean by security of the person? And is that what we envision when we think about human dignity? The obvious and common sense answer is unequivocally no.

24. On the other hand, the evidence will show that overall treatment works. Indeed, plaintiff's own experts acknowledge this undisputable fact. It reduces symptoms and unshackles the victims of serious mental illnesses from the captivity of their own delusions and mania. It can give people their lives back and lead them on a path to recovery or, at minimum, better management of their illness. It reduces the likelihood that they will interact with the criminal justice system. Treatment reduces the risk that their condition will deteriorate thereby also reducing the likelihood of readmission as involuntary patients.

25. Treatment reduces the awful burdens experienced by family members and friends, it reduces the risks faced by fellow patients, medical staff, first responders, and the general public. And it allows scarce resources to be reallocated from warehousing the irretrievably ill toward better forms of treatment, for more people.

26. But the expert evidence will also show, including plaintiff's experts evidence, that treatment is time-sensitive, particularly for first episodes and particularly for psychotic conditions such as schizophrenia. Delays between the time of the onset of psychosis and the beginning of treatment can mean the difference

between recovery and a spiraling, irrecoverable descent. It can mean the difference between life and death. And so British Columbia's treatment-first model favours intervention that is decisive and immediate over one that must wait while the full panoply of due process protections is played out.

27. This is not a case where a more privileged socio-economic group of people are imposing oppressive measures upon another group. The rules we have made for treatment – including involuntary treatment – are made in the full knowledge that any one of us – regardless of race, age, sex or gender, wealth, education, professional status – could become seriously mentally ill. Indeed, the Court will hear from and about patients of all ages and from all walks of life and socio-economic backgrounds who have experienced mental impairment due to serious mental illness.

28. These rules are made without knowing whether it is our child, our sibling, our parent, a colleague or our neighbour who might require psychiatric care. We have decided, as a society, that if that should happen to us, or a loved one, that our main priority – the prime directive, the number one consideration – must be *treatment*. Treatment above all and even at the expense of short term autonomy. That is the decision we have taken as a society, and it's not one that we need resile from, or be ashamed of. To the contrary, as the patient witnesses and family members will testify- treatment is what has liberated them and their loved ones and made it possible for them to not only preserve their own lives but also regain true autonomy.

29. We're going to defend the involuntary treatment provisions of the Mental Health Act not just on the basis that involuntary care is legally permissible. We're going to defend it on the basis that it's the *right* thing to do, that it is the *moral* and *ethical* thing to do. That the people of British Columbia do not just have a right to help people suffering from the most serious mental illnesses. Rather, as Chief Justice McLachlin indicated in her lecture 20 years ago, we have an *obligation* to do so. We as a compassionate society will not stand on the sideline in the name of a formalistic and reductionist notion of liberty when we see our fellow citizen

standing in the middle of the road in face of oncoming traffic, we will pull them out of harm's way, both for their own sake as well as to protect others.

30. The Court will hear from the plaintiff assertions that British Columbia is an outlier in Canada because is has a provision of "deemed consent". This is another misconception about the *MHA*. The deemed consent provision of the Act, section 31(1), does not grant any authority for detention or treatment. Nor is it unique: "deemed consent" is a common law defence against liability in battery. It is a defence in the form of a legal construct that is available in every other Province in Canada, at common law. British Columbia has simply enshrined this defence in s. 31 of the Act.[6]

31. The Court will also hear from the plaintiff that BC's MHA precludes family involvement in care because it does not provide for substitute decision makers (**"SDM"**), as does the *Health Care (Consent) and Care Facility (Admission) Act* for other non-psychiatric conditions. You will also hear that other provinces allow for the designation of SDMs – often family members – to stand in the place of the patient and make treatment decisions when they are incapable.

32. However, BC's legislation does not preclude involvement of substitute decision makers or family members, to the contrary, it requires treating physicians and health care providers to take positive steps to engage with family members and SDMs. However, BC's Act does provide that, in cases of the severest forms of mental illness, ultimate decisions about treatment should be made by the treating medical professionals: persons who have three qualifications that "lay SDMs" might lack: (1) expertise with the treatment of mental illness; (2) emotional distance from the patient; and (3) an ethical and fiduciary responsibility to act in the patient's best interest.

33. The evidence will show that the mental health care system in British Columbia is not the cruel or medieval system that its critics sometimes conjure. The evidence will show that it is populated by dedicated, ethical professionals, deeply caring

[6] *N.E.T. v. British Columbia (Attorney General)*, 2018 BCCA 380, paras. 27-34

people working under difficult conditions. Like all medical professionals they don't always succeed. Treatments can fail; patients can relapse. The solution though is not to place the psychiatric system in a straightjacket, but to rather approach treatment with an open mind and an understanding that mental health is a phenomenally complex problem on both individual and societal levels.

34. This Court, in four weeks of evidence and two weeks of argument, cannot be expected to develop a better understanding of severe mental illness, its treatment, and the social ramifications of the changes the plaintiff might wish to advance. If there was ever a matter with respect to which the courts ought to show deference to the legislature, the policy experts, medical professionals, and the democratic process – this is it.

The Mental Health Act

35. With that very high-level introduction I turn to the central legislation at issue, the Mental Health Act ("**MHA**").

36. The legislation at issue and the impugned provisions, in this regard, are in essence prospective in that they aim to prevent harm or alternatively mitigate harm. Both harm to individuals suffering from serious mental disorders as well as harm to others. By definition this kind of preventative legislation involves a certain level of uncertainty requiring latitude for policy makers and subject matter experts who must make assessments and predictions about risks and benefits of treatment. At the individual level, this calls on medical experts to make assessments of risks to patients and others when determining whether an individual meets the criteria for involuntary admission and treatment. In this regard, the potential risks associated with no treatment must also be considered.

37. Inherently, this necessitates a legislative approach that rather than prescribe particular outcomes or decisions with respect to particular individuals, must provide for a flexible framework within which these individual decisions and risk assessments are made by the medical experts, while maintaining an appropriate

balance and oversight in terms of protecting individual rights.[7] Importantly, any such framework must take into account not only the patient's individual rights but also the rights of family members, other patients, healthcare providers and other members of society.

38. In other words, and this is a crucial point, the MHA and specifically s. 31 which governs involuntary care, does not mandate nor prescribe coercive treatment or any particular course of treatment for any particular mental health disorder or a class of patients. In this regard, contrary to the narrative this Court will hear from the plaintiff, the MHA is not premised on generalized assumptions about the capacity of persons with mental health disorders to make decisions about their own treatment.

39. Rather, the MHA mandates individual clinical assessment on a case by case basis to determine whether the particular individual meets very stringent criteria for involuntary admission and treatment. In this regard, contrary to plaintiff's claim and narrative, the MHA does not remove individual assessments from the equation, but rather requires such assessments. No particular mental health disorder warrants, *per se*, involuntary admission or care, and no particular course of treatment is mandated for involuntary patients. As with all health care decisions, it is up to the medical experts in consultation with the patients and their family or other supporters, where possible, to determine the best course of treatment in the particular circumstances of each individual patient.

40. It is for the legislature to determine how best to achieve this delicate balance between competing rights and interests and design a flexible framework that would achieve this end. It is not the role of the Court to second guess the legislative purpose of the MHA generally or s. 31 in particular. Nor is it the role of the Court to step into the shoes of the legislature and government and question the wisdom or efficacy of the policy chosen by government.

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[7] *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, paras. 105-106

41. In this regard, this action is not a Royal Commission or Public Inquiry about BC's mental healthcare system or involuntary care, as some of the plaintiff's experts seem to think. The only questions before this Court are whether the impugned legislation deprives the rights to life, liberty or security of the person in a manner that does not accord with the principles of fundamental justice (s. 7) and whether the impugned provisions violate the right to equal treatment or protection under (s. 15). And, if the answer is yes, then whether that violation can be saved under s. 1 of the Charter as a reasonable limit prescribed by law that is demonstrably justified in a free and democratic society.

42. In this regard, and before discussing the analytical analysis sections 7 and 15 of the *Charter* entail for the case at bar, it is perhaps equally important to first clarify what this case is <u>not</u> about.

43. This case is not about compliance by physicians and other mental health care providers with their legal and ethical obligations. Simply put, even 100% compliance by all mental health care providers cannot save an otherwise unconstitutional law. And, conversely, no compliance does not render an otherwise constitutional law unconstitutional. In this regard, we will submit that much of the evidence put forward by the plaintiff is irrelevant to the question of whether the impugned provisions are *Charter* compliant as it relates to whether physicians and other health care service providers are complying with the legislation and regulations, not whether the legislation offends the *Charter*.

44. Second, and related to this first point, this action is not a personal injury claim or a medical malpractice claim. It is not about adequacy of specific medical or treatment decisions and how they impacted any individual patient. In this regard, a significant portion of the evidence the Court will hear from plaintiff's witnesses is really about complaints relating to particular interactions they had with individual health care providers or specific treatment decisions made by physicians in their case. For example, some of the plaintiff's patient witnesses dispute their diagnoses. Others take issue with the particular medication they were prescribed. However, none of that is relevant to determining the

constitutional validity of the impugned provisions. The Court is not being asked to make any findings of fact regarding fault of physicians or other health care providers in individual cases. Nor can the Court make any such findings on the basis of the factual and evidentiary record before it.

45. Third, this case is not about historical wrongs in the context of psychiatry and psychiatric practice. Debates about how psychiatry was practiced decades ago will be of no assistance to the Court in determining the constitutional validity of the impugned provisions. Again, this is not a public inquiry or academic debate about the history of psychiatry and mental health facilities. Psychiatric medicine and psychiatrists are not on trial. We say that this will be important to keep in mind when hearing from plaintiff's witnesses and experts, as some of them appear to approach this proceeding as a forum to take psychiatry and psychiatrists to task.

46. Perhaps most importantly, this case is not about involuntary admission. Specifically, the plaintiff does not challenge section 22 of the MHA, which sets out the criteria for admitting persons with mental health disorders on an involuntarily basis. This is unsurprising as the constitutionality of s. 22 and the involuntary admission regime has been affirmed by our Courts on multiple occasions. The fact that the plaintiff does not challenge the legislative framework for involuntary admissions is of critical importance for the following reasons:

    a. First, ultimately, this action will not change the criteria or procedure for admitting patients involuntarily. That means, the same individuals who are involuntary patients today will continue to be involuntary patients even if this action is successful. The real question then is what happens with these individuals once admitted as involuntary patients.

       In other words, if we allow treatment refusal as the plaintiff seeks, whether the refusal is made by the patient or their substitute decision maker, then we would have a system in which individuals are detained but not treated. This would render involuntary admission under the MHA a means to

warehouse people, not to treat them. As I will discuss shortly, that would be contrary to the legislative purpose of the Act as a whole and s. 31 in particular. This is something we say the plaintiff, and the plaintiff's experts simply fail to grapple with.

Specifically, they do not grapple with the fundamental fact that the same persons will continue to be detained as involuntary patients and not treating them does not mean they will regain their liberty or autonomy. To the contrary, as the evidence will show, it will only prolong their detention.

So, when the plaintiff compares involuntary patients to other patients and say that the "Impugned Provisions deny involuntary patients the health care consent and decision-making rights that every other adult in British Columbia enjoys", that comparison fails to account for the fact that non-psychiatric patients and voluntary psychiatric patients can also refuse admission. But where the patient cannot refuse admission and the key to their release from detention is treatment, how can we deny their liberty and at the same time take away the key to regaining their liberty and autonomy? Ultimately, that is precisely the legislative and clinical purpose of involuntary admission- treatment. Plaintiff's case fails to grapple with this fundamental substantive difference between involuntary psychiatric patients and all other adult patients.

b. Second, and related to the previous point, the plaintiff's claim seeks to disentangle or divorce s. 22 from s. 31 of the MHA. In other words, the plaintiff disentangles involuntary admission from involuntary treatment and treats each of these as distinct and unrelated silos. However, that would essentially defeat rather than give effect to the legislative purpose of the Act. As this Court and the Court of Appeal have already determined, "the

Mental Health Act involuntarily detains people only for the purpose of treatment".[8]

47. In this regard, BC, as well as other jurisdictions the Court will hear about, have made a deliberate choice to place treatment as a focal point of involuntary admission. In other words, in BC individuals are not detained under the MHA just for the purpose of isolating them from society but rather they are detained so they may receive the treatment they need to regain their insight and autonomy and return to the community. In this regard, involuntary treatment is autonomy enhancing, contrary to the plaintiff's claim. Paradoxically, what the plaintiff is seeking would actually take us back to the days of warehousing and institutionalization of persons with mental health disorders, which plaintiff's experts identify as the root evil in terms of psychiatric care.

48. As the evidence will show, admitting persons without treatment will only lead to prolonged detentions, which would entail greater deprivation of their liberty and autonomy. The evidence will also show that detaining patients without treatment also leads to increased use of restraints and seclusion in order to deal with deterioration and risks of both self-harm and harm to others.

State Paternalism and the *Charter*

49. At a very high level, what this case is about is state paternalism. As Chief Justice McLachlin discussed in the lecture we've already mentioned, the question is 'when is it legitimate for the state be paternalistic vis-à-vis individuals and interfere with their choices?'

50. The plaintiff's approach and the philosophical and legal logic underlying the plaintiff's case echo the classic libertarian opposition or resistance to state paternalism of any kind. And this is something we can all relate to. We should always be wary whenever the state assumes authority over our bodies and

[8] *McCorkell v. Director of Riverview Hospital*, 1993 CanLII 1200 (BCSC). See also, *Mullins v. Levy*, 2009 BCCA 6, paras. 106-108 *A.T. v. British Columbia (Mental Health Review Board)*, 2023 BCCA 283, paras. 68-74.

personal choices we make in the name of looking out for our own best interests. We should equally be ready to question state interventions based on the state claiming to know better than the affected individual what is best for them.

51. However, this does not mean that state paternalism is inherently inconsistent with *Charter* values. Our legal system has always recognized that in some cases state paternalism is not only legitimate and necessary but also enhances *Charter* rights and values. Indeed, paternalism permeates many of our laws. We require vehicle passengers to wear seat belts, motorcyclists to wear helmets, prohibit individuals from willingly subjecting themselves to servitude or slavery. We prohibit certain risky behaviour or the consumption of potentially harmful substances.

52. Indeed, the Supreme Court of Canada discussed the legitimacy and appropriateness of state paternalism in the context of the legal prohibition aganst individuals consenting to subjecting themselves to intentionally inflicted bodily harm in:

> …As noted above, s. 14 of the *Code* vitiates the legal effectiveness of a person's consent to have death inflicted on him under any circumstances. The same policy appears to underlie ss. 150.1, 159 and 286 in respect of younger people, in the contexts of sexual offences, anal intercourse, and abduction, respectively. All this is to say that the notion of policy-based limits on the effectiveness of consent to some level of inflicted harms is not foreign. Parliament as well as the courts have been mindful of the need for such limits. **Autonomy is not the only value which our law seeks to protect. Some may see limiting the freedom of an adult to consent to applications of force in a fist fight as unduly paternalistic; a violation of individual self-rule. Yet while that view may commend itself to some, those persons cannot reasonably claim that the law does not know such limitations. All criminal law is "paternalistic" to some degree**

> **-- top-down guidance is inherent in any prohibitive rule**…[9] (emphasis added)

53. The recognition that, at times, paternalism may not only be warranted but mandated is also reflected in the common law doctrine of *parens patriae* which refers to the state's authority, and indeed we say obligation, to act as guardian for those who cannot protect themselves. The state assumes this role in a wide range of situations involving vulnerable individuals, including to protect them from self-harm.[10]

54. The BC Court of Appeal has rejected similar arguments made by the plaintiff here against the state paternalism in the context of BC's involuntary admission:

> Finally, the appellant and intervenors repeatedly describe the position of the Board and of the Attorney General as "paternalistic". While there is some overlap between what is protective and what may be viewed as paternalistic, the protective aspect of ongoing care necessarily dominates when there is evidence a patient is severely impaired by their disorder to the point of being at risk of self-harm or harm to others. The position of the appellant and the intervenors largely ignores these real risks.[11]

55. And we say, the plaintiff's arguments in this case likewise ignore the real risks and the harsh reality of serious mental illness, all in the name of an impoverished conception of liberty that is divorced from the reality of severe mental illness.

56. Ultimately, as the evidence will show, the vast majority of persons with mental disorders are never admitted or treated as involuntary patients in BC. Rather, it is in the very limited and exceptional circumstances that meet the stringent criteria for involuntary admission and treatment that state paternalism relating to serious mental disorders is permitted under the MHA. In our submission, in these

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[9] *R. v. Jobidon*, [1991] 2 SCR 714, p. 764
[10] *Johnston v. Johnston*, https://canlii.ca/t/5dz3, para. 19
[11] *A.T. v. British Columbia (Mental Health Review Board)*, 2023 BCCA 283, para. 80

situations state intervention to ensure treatment is provided is not only warranted, but arguably, required under the *Charter*.

Sections 7 and 15 of the *Charter*

57. In determining whether BC's involuntary psychiatric treatment regime violates section 7 or section 15 of the *Charter* and if so whether it can be saved under s. 1 it is crucial to properly define the legislative purpose. We submit that the plaintiff's articulation of the legislative purpose is inconsistent with principles of statutory interpretation. Rather than grapple with the dual purpose of the MHA, protection and treatment, the plaintiff's frame the legislative purpose narrowly in a way that would essentially avoid a proper analysis of whether the impugned provisions are rationally connected and proportionate to the legislative purpose.

58. This is critical because, as the Supreme Court of Canada has affirmed, it is essential to properly state the legislative purpose as that will determine the analysis of both the principles of fundamental justice under s. 7 as well as the s. 1 analysis.[12] Respectfully, we say this is fatal to the plaintiff's claim in this case.

59. In *McCorkell*, this Court found that "The purpose of the Act is manifestly plain: the treatment of the mentally disordered who need protection and care in a provincial psychiatric hospital".

60. In in *A.T. v. British Columbia (Mental Health Review Board)*, the Court of Appeal reaffirmed the legislative purpose as articulated by the court in *McKorkell*, adding that as part of this purpose, the Act is intended to "ensure appropriate care is available to persons who are unable, due to a disorder of the mind, to function at a minimally effectively level in the community" and, further, the objective of involuntary treatment under the *MHA* is specifically to avoid "revolving door care" and "minimizing the possibility that a patient will again be detained".[13]

61. Simply put, where the objective of involuntary admission is to ensure treatment, allowing for treatment refusal, either by the patients or substitute decision

[12] *R. v. Safarzadeh-Markhali*, 2016 SCC 14, paras. 24-29
[13] 2023 BCCA 283, paras. 69-73

makers, would clearly undermine and defeat that objective. It would render involuntary admission penal rather than protective. It would turn involuntary admission into a means of warehousing mentally ill patients.

62. However, it is important to note that the treatment purpose of the Act does not mean that the MHA precludes consent by patients or their input. Nor does it preclude or relieve physicians from properly informing and consulting with both patients and family members or other substitute decision makers about treatment decisions. In fact, as the evidence will show, not only is it not precluded by the Act but it is specifically required under the regulatory framework, Ministry guidelines, as well as the ethical duties of physicians which continue to apply to all patients, including involuntary patients treated under the MHA.

63. In this regard, the plaintiff's claim is premised on a number of mischaracterizations and misconceptions of the MHA and involuntary treatment thereunder. The plaintiff claim is premised on the notion that involuntary treatment under the MHA is based on general presumptions about patients' incapacity to consent or refuse treatment and that therefore the Act fails to provide for individual capacity assessments.[14]

64. The Court will hear evidence both regarding the legislative scheme as well as its implementation and application that will make it clear that the MHA makes no such generalized presumptions, but rather, to the contrary, mandates individual assessments of the particular needs for treatment and capacity of patients.

65. In fact, Form 5, which is the mandatory form that must be used for any psychiatric treatment for involuntary patients specifically contemplates that the patient can, and ideally will, consent to their own treatment. However, treatment may be authorized by the director without the patient's consent only where the director finds that the patient "is incapable of appreciating the nature of treatment and/or his or her need for it, and is therefore incapable of giving consent."[15]

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[14] See for example Notice of Civil Claim at p. 4, paras. 11-12
[15] Agreed Statement of Facts, Vol. I, paras. 62-66 and Tab 11

66. Moreover, the criteria for involuntary admission and treatment specifically requires a finding by the physician and/or director that:

    a. the individual suffers from a mental disorder that "seriously impairs the person's ability to react appropriately to his or her environment or to associate with others";

    b. the individual requires treatment in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others; and

    c. the individual is not suitable as a voluntary patient.

67. These criteria inherently entail a capacity assessment and an assessment of the individual's insight into their condition and need for treatment. And, only safe and effective psychiatric treatment is authorized under the MHA.

68. It is with this legislative context in mind that we must to approach the section 7 and section 15 analyses. To the extent the Court finds there is a violation of either of these sections then this context will also inform the section 1 analysis. However, we say the plaintiff's section 7 and section 15 claims must fail on the basis that there is no violation of these *Charter* rights.

69. First, it is important to recall that it is the plaintiff who bears the burden of establishing the violations under section 7 and 15 on a balance of probabilities.[16] In this regard, the starting point is a presumption of legislative validity. The plaintiff must show, with admissible and cogent evidence that the alleged violations are made out. The mere fact that some aspects of the legislation and the government's policies are controversial is immaterial. The question is not whether the impugned provisions are popular or whether there is consensus about their wisdom.

70. In this regard, it is also important to note that the plaintiff does not challenge s. 8 of the MHA which is the provision that provides that "a director may sign consent

[16] *Canada (Attorney General) v. Bedford*, 2013 SCC 72, para. 127

to treatment forms for a patient detained under section 22, 28, 29, 30 or 42". Thus, the plaintiff does not challenge the director's legal authority to consent to treatment for an involuntary patient under the Act.

71. Rather, the plaintiff only challenges section 31 of the MHA and "deemed consent". But as already mentioned, deemed consent is simply a legal construct that provides physicians and directors with a full defence to potential claims in assault and battery.[17]

Section 7

72. Turning to section 7 and the the right to life, liberty and security of the person, for the plaintiff to succeed it must establish on a balance of probabilities a sufficient causal connection between the impugned provisions and the physical or serious psychological harm to at least one person. In other words, in the particular context of this action, the plaintiff must prove, with admissible evidence, that there is at least one involuntary patient who would be better off without treatment in terms of their right to life, liberty and security of the person. And the fact that we are dealing with a public interest plaintiff and not an individual plaintiff in this case does not take away from this burden. Arguably, it only makes it that much more important to insist on the rather high evidentiary burden for establishing a violation of s. 7.

73. Plaintiff cannot prove the deprivation based on speculations or conjecture or even theoretical harms certain objectors to involuntary psychiatric care have raised. They must show that these harms have in fact materialized in BC under the existing legislative regime. In this regard, it is also not enough to simply point to individuals who say they had a negative experience in the context of their involuntary care. Rather, the plaintiff must prove, on a balance of probabilities, that there is at least one patient who either died, was exposed to increased risk of death, or was seriously physically or psychologically injured as a result of

[17] *N.E.T. v. BC (Attorney General), 2018 BCCA 380*

involuntary psychiatric treatment and that said injuries would not have occurred had they been allowed to refuse said treatment. We say the evidence will fall short of proving this.

74. Notably, in this regard, plaintiff has not tendered any expert evidence which would be necessary to establish a sufficient causal connection between the impugned provisions and worse outcomes to any particular patient. The extent of plaintiff's evidence is that some patients disagree with their involuntary detention and involuntary treatment. Namely, they take issue with their diagnosis or specific treatment decisions or have complaints about how they were treated while detained as involuntary patients under the MHA and that they would have wanted to make their own treatment decisions.

75. We say that the alleged deprivation or violation of s. 7 is not borne out by this evidence. To the contrary, the evidence the Court will hear over the next four weeks will demonstrate that, overall, the life, bodily integrity and autonomy of involuntary patients are all enhanced by treatment.

76. To be clear, we do not dispute that involuntary treatment certainly engages patients' s. 7 rights, namely liberty and security of the person but not the right to life. Indeed, as I will discuss shortly, involuntary treatment is intended and indeed preserves and saves lives.

77. But in any event, the mere fact that involuntary treatment engages liberty and security of the person interests, does not alone constitute a violation of s. 7 rights. More importantly, this a case where the competing s. 7 rights of others must also be considered- family members, health care providers, other patients and members of the general public. Ultimately, the undisputable evidence is that that the answer to serious mental health disorders is treatment and early intervention is in fact critical in this regard. Such treatment can take all kinds of forms, such as psychopharmacological medication, counseling and therapy and many others. The MHA does not and cannot prescribe nor dictate what treatment will be provided in an individual case – rather it provides the legal framework

under which such decisions can be made by the medical experts – specifically mandating individual assessments, including assessment of insight and capacity.

78. Moreover, the evidence is clear that involuntary admission and involuntary treatment saves lives. Plaintiff's experts indeed acknowledge that involuntary psychiatric treatment saves lives in at least some cases. The Court will hear evidence from patients, family members, health care providers and experts which emphasize this point – *involuntary treatment saves lives and enhances the patient's liberty and autonomy*.

79. But involuntary treatment doesn't only save lives of involuntary patients. Involuntary treatment also saves lives and protects the security of the person and liberty interests of others. In this regard, the Court of Appeal has affirmed that while the s. 7 analysis is approached from the perspective of the individual claimant "taking account of competing Charter rights within the s. 7 analysis may be appropriate where the state action directly brings competing Charter rights into conflict".[18] Part of the problem with the plaintiff's case is that it fails to account for the Charter rights and interests of others who are directly affected by serious mental illness.

80. But even if we were to take an exclusively patient centric approach, the evidence will also show that warehousing involuntary patients without treatment would only lead to even more egregious and prolonged deprivations of their liberty and security of the person, whether through longer and recurring detentions, more frequent use of restraints and seclusion or worse treatment outcomes. In this regard, it is important to appreciate that the purpose of involuntary admission is precisely to facilitate treatment in order to stabilize patients so they regain insight into their condition and can return to the community and hopefully engage with treatment on a voluntary basis.

81. Thus, this case presents a particularly unique circumstance in terms of the s. 7 analysis in that the alternative to the alleged deprivation is not liberty but rather

[18] *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, 2022 BCCA 245, para. 340

detention without treatment, when treatment is the key to regaining one's liberty and autonomy.

82. Ultimately, even if the plaintiff can show that there is an involuntary patient whose s. 7 rights would be better advanced without treatment, which we say is not the case, the plaintiff then still has to show that the impugned provisions do not accord with the principles of fundamental justice: they bear no connection to the legislative purpose in whole (arbitrary) or in part (overbroad), or that the interference with the relevant patient's s. 7 rights is "totally out of sync" with the legislative purpose (grossly disproportionate). We say that this is an insurmountable hurdle for the plaintiff given that the objective of involuntary admission, which the plaintiff does not challenge, is treatment.

83. Moreover, the evidence of patients, family members, health care providers and experts will demonstrate the rational connection between the impugned provisions and the legislative purpose. Involuntary treatment is indeed necessary in order to ensure involuntary patients receive appropriate treatment, specifically in order to regain insight and functionality so they may engage with health care services voluntarily and not be subjected to prolonged or recurring detentions. Otherwise involuntary admission would become a penal measure or a means of warehousing persons suffering from mental illnesses. Such a result would be a much more egregious affront to the dignity of involuntary patients.

Section 15

84. Turning to the s. 15 claim, respectfully, we say the plaintiff's claim does not even meet the first part of the test and is also premised on a dated a misconception of equality. Specifically, the plaintiff's claim appears to be based on a concept of formal equality not substantive equality.

85. The two part test for establishing that the impugned provisions violate section 15 requires the plaintiff to demonstrate that the impugned provisions: a. create a distinction based on enumerated or analogous grounds on its face or in its impacts; and b. imposes a burden or denies a benefit in a manner that has the

effect of reinforcing, perpetuating, or exacerbating disadvantage. A claimant cannot circumvent the first step of the analysis of showing the distinction is drawn on the basis of an enumerated or analogous grounds by simply demonstrating historic disadvantage.[19]

86. The plaintiff's s. 15 claim is premised on the notion that the impugned provisions draw a distinction on the basis of mental disability. However, this is another misconception of the MHA. The impugned provisions do not distinguish between persons with mental disabilities and persons without mental disabilities. Neither s. 31 nor the excluded provisions of the *Representation Agreement Act* and *Health Care (Consent) and Care Facility (Admission) Act* draw a distinction on the basis of mental disability. The excluded provisions, providing for SDMs or advance directives, still apply to voluntary psychiatric patients. Simply put, patients with mental health disorders are on both sides of the delineating line. We have patients with mental disabilities who are entitled to appoint SDMs to consent or refuse treatment on their behalf, or can otherwise refuse psychiatric and other treatment, and we have involuntary patients with mental disabilities who cannot. What distinguishes between these two groups of patients is not their mental disability.

87. The distinction is drawn based on whether or not the individual with the mental disorder meets the stringent criteria for involuntary admission and involuntary treatment, i.e. the criteria under section 22 of the MHA. Thus, the plaintiff's claim does not pass the first threshold step of the section 15 analysis.

88. Moreover, even if it did, the evidence will demonstrate that far from reinforcing stereotypes or disadvantage, treatment based on individual assessment as mandated by the MHA is a remedy to stigma and disadvantage. Stigma and disadvantage arise from and are reinforced by manifestations of serious mental disorders in public and the history of lack of treatment for serious mental disorders. The remedy to such historic disadvantage on both the individual and

[19] R. v. Sharma, 2022 SCC 39, paras. 27-36, 40-47, 50

societal levels is treatment. On the other hand, simply detaining patients without treatment, i.e. warehousing them, would have the opposite effect and would in fact reinforce both external and internalized stigma of patients and their potential sense of diminished self-worth. Simply put, as noted by Chief Justice McLachlin states in her lecture from 2005, treatment of the severely mentally ill promotes substantive equality and the notion that people with severe mental disorders are entitled to access adequate medical treatment in order to regain functionality and insight so they can be functional members of society.

89. In this regard, it is worth noting the observations of the Supreme Court of Canada in *Winko v. BC (Forensic Psychiatric Institute)*, a case that involved a section 15 claim regarding involuntary psychiatric care in the forensic context. The Court rejected a very similar argument made by the plaintiff here, finding that by not treating the mentally ill the same as other accused or other patients the law in fact enhanced substantive equality:

> From this perspective, the key feature of Part XX.1 -- treating every NCR accused having appropriate regard to his or her particular situation -- **far from being a denial of equality, constitutes the essence of equal treatment from a substantive point of view. It does not disadvantage or treat unequally the NCR accused, but rather recognizes the NCR accused's disability, incapacity and particular personal situation and, based upon that recognition, creates a system of individualized assessment and treatment that deliberately undermines the invidious stereotype of the mentally ill as dangerous. It treats NCR accused more appropriately and more equally**.[20]

90. Finally, we will also show that in any event, involuntary admission and treatment, as one interconnected unit, are in fact an ameliorative legislative program under section 15(2), as their object is the amelioration of disadvantaged individuals,

[20] [1999] 2 SCR 625, para. 80

persons with mental disability, who have historically suffered from institutionalization, stigma and social isolation associated with lack of treatment. The MHA, and specifically involuntary treatment has as its object to ameliorate this condition by removing barriers to treatment and not just warehouse patients, thereby enhancing and increasing their chances of regaining insight, functionality and full membership in society.

91. In this regard, it is worth recalling again, also in the context of s. 15, that this is not a case where the alternative to the impugned provisions would be to enhance dignity of persons with mental health disorders. Rather, the opposite is true. If we accept that treatment is the appropriate response to serious disorders and historic disadvantage and stigma, then lack of treatment would clearly undermine substantive equality. In this regard, paradoxically, the plaintiff's logic would take us back to the days of formal equality. The plaintiff essentially says that involuntary patients suffering from serious mental disorders should be treated the same as non-psychiatric patients or voluntary psychiatric patients. But that is formal equality, treating everyone the same. Substantive equality mandates something different. It requires the state to acknowledge difference and in fact not treat everyone the same but rather make decisions based on the unique circumstances and needs of affected individuals.

92. In this regard, the plaintiff's claim ignores the qualitative difference between psychiatric patients and non-psychiatric patients as well as voluntary vs. involuntary psychiatric patients. Someone refusing treatment for non-psychiatric condition – their medical condition does not inherently affect their decision making and cognition. Psychiatric patients, by definition, suffer from an impairment of the mind. That is in fact part of the definition of 'mental disorder' in the MHA. Further, as mentioned already, for voluntary psychiatric patients, they may refuse admission and are therefore not in the same predicament as involuntary patients who cannot refuse admission.

93. Plaintiff's approach to equality in this regard would ask that we ignore the particular characteristics and needs of involuntary patients, i.e. those who meet

the stringent criteria for involuntary admission, and simply treat them the same as we would other patients who either do not suffer from a mental disorder or voluntary patients who are not found to have a mental impairment that meets the criteria of involuntary admission. That is not substantive equality.

94. Finally, to the extent there is a violation of section 7 and/or section 15, we intend to show that the impugned provisions should be saved under section 1 of the *Charter*. Specifically, there is a rational connection between the impugned provisions and the legislative purpose, the limitations on *Charter* rights are minimally impairing and proportionate. Indeed, the evidence will show that the potential policy alternatives to the impugned provisions would either defeat the legislative purpose or lead to even worse deprivations of *Charter* rights of patients and others.

95. In this regard, the balancing of competing *Charter* rights and the weighing of societal benefits of the impugned provisions render the impugned provisions "reasonable limits… demonstrably justified in a free and democratic society" under section 1.

96. Indeed, all western democracies have some form of involuntary admission and involuntary treatment. The evidence will show that, contrary to the plaintiff's narrative, many other democratic jurisdictions also do not allow for substitute decision makers or representation agreements and advance directives that would enable treatment refusal by or on behalf of involuntary patients. BC is not an outlier in this regard as alleged by the plaintiff.

97. While the plaintiff relies heavily on the fact that in some jurisdictions, capacity is expressly mentioned in the governing legislation, we will show that this is an argument of semantics and not substance. The question is not which particular terminology is used, but rather the substance of the criteria for involuntary admission and treatment. And, when considered in this light, BC in fact requires an assessment of the patient's insight and mental capacity.

98. Further, we will show that contrary to the plaintiff's narrative, BC in fact stands out compared to other jurisdictions in terms of the guardrails and oversight mechanisms that are in place to ensure patients' rights are protected and properly balanced. This is achieved through robust and effective review and appeal procedures for challenging involuntary admissions, the right to request and obtain second opinions about both admission and treatment plans at no cost to the patient, as well as entitlement to access rights advisors, again at no cost to the patient or their family.

99. Moreover, unlike many other jurisdictions referred to in plaintiff's evidence, BC has both strict temporal limitations on involuntary admissions in order to ensure regular and ongoing individual assessments are undertaken. Unlike many of the other jurisdictions referred to by the plaintiff's experts, BC also has in place a robust system of regulatory oversight through mandatory forms and documentation to ensure patients are continuously informed and consulted about their treatment plan, as well as family members where appropriate. All of these regulatory safeguards must be taken into account when considering whether the impugned provisions are minimally impairing.

100. In this regard, it is worth reiterating that the complexity of the mental health care system and legislative regime calls for showing even greater deference to government in the context of public health care policies and legislation.

101. The Court of Appeal has described BC's healthcare system, of which mental health care is just one aspect, as "extraordinarily complex". This case illustrates that point. Because health care legislation and policy are "among the largest, most complex and most expensive social programs administered by the provincial government" an especially high degree of deference must be afforded to the government, including and perhaps in particular, with respect to "legislation

that concerns the reconciliation of claims of competing individuals or groups or the distribution of scarce government resources".[21]

102. It is in the context of this highly complex socio-economic problem and regulatory framework and the high degree of deference owed to government that the present case must be understood and approached.

Overview of Defendant's Evidence

103. In total, the Court will hear evidence tendered by the defendant about four different patients and their experiences with involuntary and voluntary psychiatric care. These witnesses will describe the devastating effects their severe mental disorders had on them and their families. They will also describe how, from their perspective, involuntary psychiatric treatment saved their lives and led them on the path to recovery and to being fully functioning members of society.

104. The Court will also hear from nine different witnesses the defendant will call about their experiences as family members trying their best to support loved ones with serious mental disorders. These family members will describe the enormous burden and hardship they have experienced, in some case being themselves the target of violence by their loved ones due to their delusions and mania. The family member witnesses will also explain why they would not want treatment in these situations to be contingent upon the consent of substitute decision makers that are not the medical experts.

105. The Court will also hear from health care providers such as psychiatric doctors and nurses, as well as witnesses like Superintendent Howard Tran from the Vancouver Police Department, about the real life harms associated with untreated serious mental disorders, both on and off the psychiatric wards. Specifically, they will talk about the impacts of managing untreated individuals

[21] *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, 2022 BCCA 245, paras. 28, 406-407

other patients, health care staff, first responders and the general public. These are some of the real life risks that we say the plaintiff fails to grapple with.

106. Finally, the Court will hear from some of the leading experts in this field. Experts like Dr. Richard O'Reilly, a clinical psychiatrist and leading academic with decades of experience in treating patients and administering psychiatric programs in Ontario and Saskatchewan. Dr. O'Reilly will discuss the benefits of involuntary care and the significant challenges and harms that arise in jurisdictions like Ontario where treatment to involuntary patients is delayed, sometimes for months, because treatment is contingent upon either consent by the patient or substitute decision makers and completion of a review process.

107. The Court will hear from Dr. Randall White, one of the leading psychiatric experts in BC for treatment of serious mental disorders, namely psychotic disorders such as schizophrenia and bipolar disorders. Dr. White will provide evidence both on the standards and practical realities of treating involuntary patients, capacity assessments and assessing risk.

108. The Court will hear from Dr. Barbara Kane a leading BC psychiatrist who has decades of experience treating patients suffering from the most severe psychiatric disorders both on an in-patient basis and in the community. Among other things, Dr. Kane will give evidence on the consequences of having untreated involuntary patients detained in the ward both on the individual detained patient and their treatment outcomes as well as for other psychiatric patients, voluntary and involuntary, and health care staff.

109. Dr. Jhilam Biswas from Boston, who has extensive clinical and academic experience in both forensic and civil mental health systems will discuss her research regarding risk assessment, capacity assessments and the interplay between psychiatric treatment and stigma associated with mental health. Dr. Biswas will give evidence about the harmful and wide ranging harmful effects of delayed treatment.

110. The Court will also hear from Dr. Lacresha Hall, a psychiatrist in BC who has extensive clinical experience treating adolescents and adults for complex concurrent disorders, especially eating disorders, trauma related disorders and personality disorders. Dr. Hall will give evidence about the clinical significant of timely care, especially in the context of disorders that can deteriorate very rapidly and become life threatening. Dr. Hall will also give evidence regarding the ways in which certain disorders, such as personality disorders and eating disorders can deny patients insight into their own condition and immediate need for treatment.

111. The Court will hear from Dr. Daniel Vigo, a leading expert in the area of treating concurrent mental health and substance use disorders. Dr. Vigo has extensive and unparalleled experience and expertise in clinical practice, academic quantitative and qualitative research, and public health policy. Dr. Vigo is also the Chief Scientific Advisor for Psychiatry, Toxic Drugs, and Concurrent Disorders for the Province of BC. He will give evidence regarding the significant challenges associated with treating severe mental disorders and the high rates of overlapping mental health and substance use disorders. He will give evidence on how these complicating factors inform public health policy and the potentially wide ranging and serious detrimental consequences of removing timely involuntary psychiatric care to involuntary psychiatric patients.

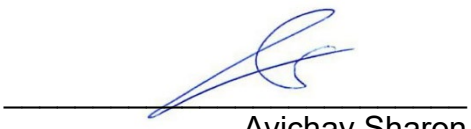
112. Dr. John Gray, one of Canada's leading experts in the area of mental health policy and the history and evolution of mental health legislation, will provide the Court with the historical context upon which BC's MHA was developed and amended over the years. Dr. Gray is one of the co-authors of the leading textbook on mental health law and policy in Canada - *Canadian Mental Health Law and Policy*. Dr. Gray will provide evidence on the policy reasons for authorizing directors and physicians to make ultimate decisions regarding involuntary treatment and how BC's policy in this regard compares to other jurisdictions, both in and outside Canada.

113. Finally, the Court will also hear from Dr. Jason Sutherland, a leading Canadian expert in the areas of healthcare policy and economics who has conducted extensive research on health services and outcomes as well as assessing treatment outcomes on a societal level. Dr. Sutherland will give evidence about the results of his analysis of BC's administrative data concerning involuntary psychiatric treatment, which shows that involuntary patients engage with mental health services at much higher rates post involuntary care episodes, both as involuntary and voluntary patients.

114. Overall, we believe that the evidence will establish the very real rational connection between the impugned provisions and the legislative purpose of protecting and treating involuntary patients. We will also submit that the evidence will show that the benefits of involuntary care outweigh the costs and that timely involuntary treatment for involuntary psychiatric patients who meet the very stringent criteria under the MHA is both necessary and the right thing to do. The moral thing to do. Timely involuntary care saves lives, enhances long term liberty and autonomy of patients, and ultimately their security of the person. It also protects the lives, bodily and psychological integrity as well as liberty interests of others, including family members, other patients, health care staff and general public.

115. For all these reasons the defendant will ask that the plaintiff's claim be dismissed with costs.

All of which is respectfully submitted on May 29, 2025.



Avichay Sharon
Counsel for the Defendant,
Attorney General of British Columbia