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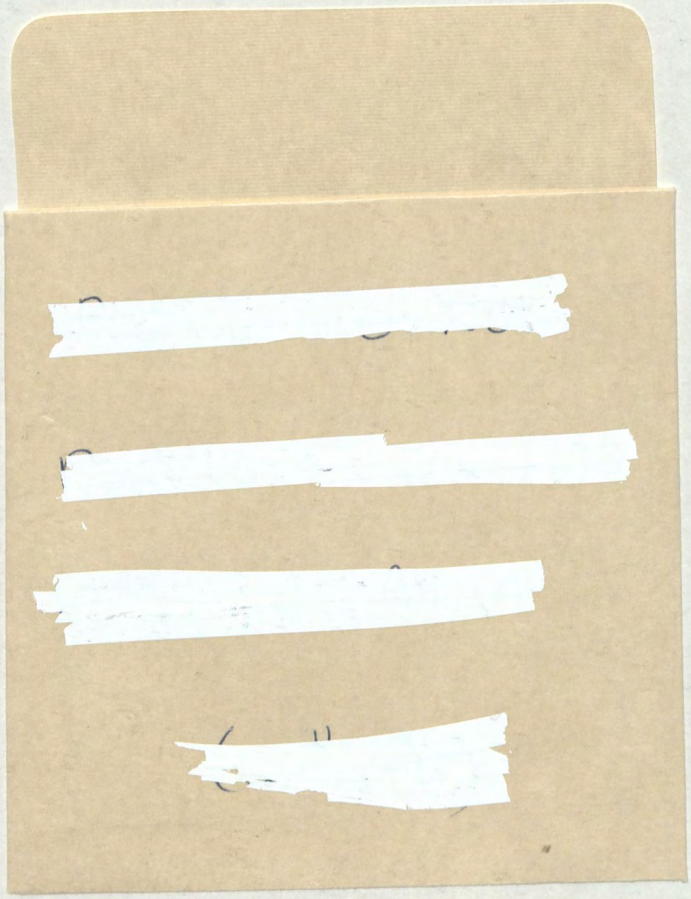

LEGAL AID FOR MENTAL PATIENTS

An Evaluation Report

April 17, 1981

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The views expressed in this report are those of the authors and do not necessarily reflect the views or policies of the Department of Justice.

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PREFACE

This report is an evaluation of a concept in the delivery of legal aid. It is concerned with the provision of legal services for civilly committed mental patients. Because many of the crucial issues are conceptual or definitional, the report is divided into two major sections. The first section attempts to establish the theoretical and empirical background - the material which has led a number of lawyers and social scientists to hypothesize the need for mental patients' legal advocates. The second section focuses on the experience of one legal aid experiment, the Mental Patients' Advocates Project in Vancouver, B.C. The experiment was studied using the traditional tools of the social scientist: observation, interview, the analysis of files and documents and the interpretation of these data to answer specific questions. Also in the tradition of scientific studies the evaluation draws heavily on the findings of other investigations. Science is a cumulative exercise and no one study seeks to answer all questions. Instead each uses the knowledge of past studies and adds to it. Thus armed with already existing knowledge and our own study of the implementation of an experiment to deliver legal aid to mental patients we have attempted to evaluate the "Mental Patients' Advocates model".

INTRODUCTION

One of the traditional guarantees implicit in the western system of law is freedom from detention without due process. In Canada, despite widespread discretion, we pride ourselves in a legal system based on the rule of law, rather than the rule of men. The conditions and procedures which define the legitimate and lawful deprivation of liberty and physical autonomy are formal, that is written, and as precise as possible. The adversarial system is meant to serve as a guarantee that these conditions are met and the procedures adhered to.

The adversarial system, of course, presupposes expert counsel speaking on behalf of, representing, those in jeopardy of the deprivation of liberty. The government, to ensure for all the right to a "fair and proper" hearing, has sought to provide free legal counsel to those who do not have the resources to pay for it themselves. Legal aid in Canada is already well established in criminal and family law. With the increased development of legal aid in traditional areas of law, the legal aid movement has the capacity more fully to explore its larger mandate - to improve equality of access to the law and equality before the law for all the disadvantaged sectors of Canadian society. This concern is manifested in the special initiatives taken for legal aid to immigrants, Native Canadians, children, the physically handicapped and the mentally disadvantaged.

Attempts to provide legal aid to this latter group - the mentally disadvantaged - have raised particular and pressing questions. These issues are the topic of this paper. More specifically, we ask whether and how legal aid should be provided to persons who, through civil procedures, are involuntarily committed to mental institutions.

At first glance, few client groups would seem to be more in need of zealous advocates than the civilly committed mental patient. Deprived, involuntarily, of their liberty and many other fundamental rights, they are often least able to speak on their own behalf. Indeed the very label they wish to protest undermines their credibility and the force of their protestations. Yet, the provision of legal aid to this client group has given rise to a number of philosophical and practical questions which reflect on the complex relationship between legal and medical models, legal and medical personnel. Detention is explained, justified some would say, on therapeutic rather than punitive grounds. Those against whom the committed might wish to protest do not see themselves as adversaries but as helpers. The introduction of legal counsel to represent the committed may often be seen as a threat to the therapeutic relationship and, therefore, to the best interests of the mental patient. One might expect far less controversy over the employment of counsel to assist mental patients on issues not directly related to their hospitalization. Even here, however, some question the patients' ability to instruct counsel.

Clearly, then, the provision of legal aid to mental patients raises special problems and concerns, many of which revolve around the complex perceptions and definitions held regarding the patients themselves. This paper addresses these issues, first, through a review of the now abundant literature on law and psychiatry, and second, through a detailed examination of an experimental project on the provision of legal aid to mental patients - the Vancouver Community Legal Assistance Society, Mental Patients' Advocates Project.

Basic Issues

Civil commitment must be seen as an extreme form of state intervention, representing as it does the deprivation of our most fundamental rights and particularly, the right of autonomy over physical self. Given the loss of liberty, privacy and self-determination and the dramatic consequences of hospitalization, it is not surprising that many have begun to ask basic questions about involuntary commitment: when is it justified and how best can one achieve a balance between freedom and protection of the individual and society? (See, for example, the Law Reform Commission of Canada, 1975.) And, it is in this context that we can understand the renewed vigour of the movement in North America to ensure stringent procedural safeguards in the commitment process, that is, to ensure the mental patient's "natural justice" right to a hearing in the absence of bias (see Shone, 1976; Langlois; 1976; Gupta, 1970-71).

The traditional legal justifications for civil commitment are the *parens patriae* and "police powers"[1] of the state. In many ways, these two justifications represent different and even competing cosmologies. *Parens patriae* forms the basis for the therapeutic model of detention.

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[1] "*Parens patriae*" goals involve: a) providing care and treatment for those in need; and b) protecting the allegedly irresponsible from themselves.

"Police" goals involve: a) protecting society from their irresponsible acts; and b) relieving society (or the family) from the burden of accommodating them. See Scott, et al. (1977).

Increasingly, the state's responsibility to protect individuals from themselves has been translated into the State's obligation to ensure treatment (Kittrie, 1971). At the same time, involuntary psychiatric intervention is justified on the basis of police power - the detention of an individual to protect others from potential harm. But despite first appearances, these are not truly complementary powers; they juxtapose therapy and incarceration, treatment and punishment, in such a way that what is intended and how this is justified is open to ambiguity and confusion. Indeed, therapeutic legal rules, an emphasis on treatment, obscure the policing aspects of commitment. But if only the therapeutic model were operating we would expect that those designated as "untreatable" or those who appear not to benefit from commitment would be released.

While we traditionnally employ safeguards when applying the state's policing power, the therapeutic rules are applied outside the public view, away from public scrutiny. The therapeutic model may make us careless of the importance of procedural safeguards whenever one's liberty is at stake. As it stands, both the treatment and policing functions rest on psychiatric diagnosis. And this means that psychiatrists are often in effect asked (a) to make the key legal decisions, i.e. decisions in an area outside of their professional concern and competence, and (b) to balance the demands of the state and the demands of those they seek to help. Clearly the intents and justifications for civil commitment require examination and clarification and, as we shall argue, this might be best achieved in the legal arena.

Psychiatric Diagnosis

Diagnostic decisions are at the core of legal decisions concerning the fate of mental patients. The standards of committal vary widely across Canada, though there is a move towards a medical-legal model which demands not only that the patient be diagnosed as mentally ill and in need of treatment, but also that he be shown to be a danger to himself or others.[2] Psychiatrists, then, have been asked to diagnose the patient and to assess his dangerousness.

a) Diagnosis of Mental Illness

The last two decades have produced a voluminous literature on the reliability and validity of psychiatric diagnosis. Early criticisms (Sutherland, 1950a, 1950b; Hakeem, 1958) have been replicated by more sophisticated research designs (Robitscher, 1977; 1978; Ennis and Litwack 1974; Rosenhan, 1973; 1975; Ziskin, 1975), all with the same conclusion: that psychiatric diagnoses have low reliability and validity.[3] Recently, Pfohl (1978) argued that this was true across all forms of mental illness.

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[2] Compare the Ontario Mental Health Amendment Act (1978) c. 50 section 5.

[3] While there have been recent improvements to the reliability of psychiatric diagnoses, the more critical problem of their validity remains intractable as ever.

The difficulties in psychiatric assessment and diagnosis are not surprising. Mental illness is a complex phenomenon which cuts across medical, normative, cultural and ethical considerations (Szasz, 1961; 1963; 1965; Torrey, 1974; Kittrie, 1971). This, then, is not a criticism of psychiatry or psychiatrists, only a further indication of the need to deal with the inevitable ambiguities in all Mental Health legislation (Langlois, 1976) and to protect the individual from the uncertainties in the consequential diagnostic process. In short, unsure diagnosis can be successively qualified and modified in an ongoing (voluntary) treatment relationship, but must be subject to close scrutiny and challenge when it is the basis for committal.

b) Predictions of Dangerousness

The problems in predicting dangerousness to onself or others are, perhaps, even greater. There are three basic problems:

1) What standard of measurement is to be used? Or, how serious does the perceived threat have to be before it can be legitimately designated "dangerous"?
   - Does one use civil or criminal standards? (See Petrunik, 1980)
   - Does one specify physical danger or does one include emotional or psychic danger, whatever these may mean?

2) What is the relationship between dangerousness and mental illness?
   - Are these largely independent phenomena?
   - Is the relationship general or specific? (See Diamond, 1974; LRCC, 1975)

3) Are there adequate clinical tests of dangerousness?
   - Can one accurately assess dangerousness to self?
   - Can one accurately assess dangerousness to others?[4]

This latter question has also stimulated a good deal of research. The findings consistently indicate a strong propensity on the part of psychiatrists to over-predict dangerousness both to self and others, what is often called the problem of <u>false positives</u> (Hakeem, 1961; Rappeport et al., 1967; Kozol et al., 1972; 1973; 1975; Wenk et al., 1975; Stone, 1975; MDLR, 1977). Kozol and his colleagues (1972), for example, found that at least 60% of psychiatric assessments were of "false positives" while only 8% were "false negatives". Hakeem (1961), among others, has argued that psychiatric assessments are no more reliable than court assessments.

Dershowitz (1970) points out the small chance that psychiatrists will be made aware of erroneous commitments. One can easily understand the psychiatrists' predispotiion

[4] This discussion draws heavily on Shone (1976). For a recent discussion of the tendency toward dangerousness criteria, see Wald and Friedman (1978).

to "false positives", to commitment when in doubt. Released patients who kill themselves, for example, are a harsh reminder of what will certainly appear to be an error in psychiatric judgement. Added to this will be the inevitably negative public reaction and publicity of the suicide or criminal activity of a recently released patient. Selective reporting, based often on stereotypes of the "mentally ill", serves to dramatize and exaggerate what may be isolated and relatively rare incidents.5

The patient erroneously committed will not pose these kinds of personal, institutional or even political threats to the psychiatrist or mental hospital. Indeed, the failure of the unnecessarily committed patient to engage in violent behaviour will not be taken as a sign of mistaken diagnosis, but more likely as a sign of successful intervention. Here one can see the vicious circle, the Catch-22, of diagnosis and commitment. A patient, once committed to a mental institution, may not be able to disprove or challenge his diagnostic label. Even if he exhibits no bizarre or violent "symptoms", this may be taken as proof of the validity of the course of treatment and commitment more generally. At best, the patient may hope to be re-categorized in time as "in remission" (Rosenhan, 1975).

It seems safe to conclude that no group has successfully been able to predict dangerousness. In fact it is not psychiatrists but law makers who have imposed this

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5 See, for example, the "Lingley Case" as reported in the London Free Press, Jan. 28, 1980.

criterion. The key point here is that dangerousness is not a medical concept, but a legal test for involuntary commitment (Tanay, 1976). The uncertainty and ambiguity in psychiatric assessments and the contradictions built into the hybrid "medical-legal model" have led a number of social psychiatrists and reformers in most modern western societies to challenge the very process of civil commitment (see Szasz 1961; 1963, 1972; Torrey, 1974; Kittrie, 1971). Certainly, many psychiatrists would welcome being relieved of the responsibility of judging dangerousness, for example, and of being associated with the police powers of the governing state. Freed from the ambiguous role demands, they could, perhaps, focus their energies more exclusively on professional/medical diagnosis and treatment.

The very term, "involuntary commitment", implies policing, appreciates that there is a dispute or conflict - between psychiatrist and patient - over diagnosis, issues of fact and/or questions of procedure. Simply, the patient does not agree that he should be hospitalized and the psychiatrist realizes the power of the state to impose hospitalization. And all of this points to the need for counsel to represent the patient during commitment.[6]

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[6] Several have argued that voluntarily committed patients have a similarly pressing need for counsel to ensure that commitment is indeed voluntary, that the patient is adequately informed of the consequences of his decision. Also, a number of hospital related issues, which we discuss in the next section, apply equally to both voluntary and involuntary patients. (See, MDLR, 1977 (Sept. - Dec.): pp. 270-272 and Ludlam, 1978) Similarly, criminal cases which find themselves in the mental hospital will also make use of such counsel.

A number of researchers have demonstrated that without such legal vigilance, inadequate and possibly illegal commitment certificates will go unchallenged and even unnoticed (see Page and Yates, 1973, 1974; Perrin, 1973; Reitsma, 1973; Firth, 1975; Shone, 1976).

It is important to note as well that representation during commitment procedures is only one of the many special legal needs of the mental patient. In the following pages, we shall examine the legal problems directly and indirectly associated with commitment and hospitalization.

Problems of Commitment

Whatever the positive results of hospitalization, there are many obvious profound and well-documented disadvantages. The patients' lives, their total round of activity, are regulated in minute detail by hospital staff. Many social scientists have likened their enforced status to that of children whose rights to privacy, physical autonomy, even the rights over their own bodies are denied as a matter of course. Predictably, this will have serious implications for the patients' sense of self worth and individuality (see Scheff, 1966, Rock et al., 1968; Goffman, 1961; Vail, 1966; Glass, 1965). Enforced examination, treatment without consent, the withholding of personal information and reports; all reinforce this loss of status. The consequences, many argue, may often be counter-therapeutic[7], especially given

[7] Furman and Conners (1970) argue that the institutionalized even have a higher mortality rate.

that confinement is also disruptive of family and community relationships. And upon release, former mental patients will experience discrimination in housing, employment, and more generally in their everyday lives; interned mental patients face the loss of property rights, loss of domestic rights, professional and fiduciary privileges, and discrimination in voting, retaining driver and professional licences and marrying (Chilke et al., n.d.).

These consequences of confinement serve to underscore the care and attention to proper procedure which this form of extreme state intervention demands. At the same time, this brief overview points to some of the legal problems which arise as a result of hospitalization. Janopaul (1962) details the following specific legal problems:

1. guardianship over estate
2. guardianship over body and personal integrity
3. possible foreclosures on installment purchase contracts
4. pending legal actions

Shone (1976) adds:

5. objections regarding privileges and treatment
6. voluntary/involuntary status[8]

Given the vulnerability of the class of clients and the gravity of the issues, the ready availability and accessibility of counsel to represent their rights seems

[8] Schwitzgebel (1975) shows, in his study, that most people could not remember signing voluntary admission forms ten days after their doing so.

imperative. And one might well argue that effective advocacy is therapeutic. Strand (1972) sums it up rather well:

> To patients confronted with eviction, bankruptcy and even domestic distress, traditional hospital chemothereapy and psychotherapy, which deal with personal symptoms, may not be as therapeutically effective as legal services.

Counsel may help alleviate feelings of anxiety and apprehension which inhibit treatment and may, to some extent, relieve hospital administrators of the burden of adjudicating disputes. Accordingly, the hospital may come to be seen as less a prison and the staff as helpers rather than gaolers (see MDLR, 1977a).

The need for legal aid for the mental patient - during committal procedures, during hospitalization and even upon release - seems inescapable. But just what kind of legal aid would be most appropriate and beneficial?

What Kind of Legal Aid?

Of first importance, the kind of legal aid offered the mental patients must reflect their special needs. Several editions of the Mental Disability Law Reporter have emphasized the importance of providing legal counsel at the earliest possible moment in order to maximize time for preparation and to ensure that information is taken and advice given before treatment has been initiated. Simply, the lawyer can then assess the client's case before the effects of treatment and prolonged detention and can, at the same time, allay some of the client's immediate and pressing concerns and fears.

Furthermore, we are dealing with a seriously disadvantaged population: their access to resources and freedom of movement are severely restricted; their appearance and manner often make them unattractive and difficult clients for private lawyers; and often they are relatively ignorant of their rights (Gupta, 1970-71). Most lawyers would find that they were unprepared for the role of advocate for the mental patient, uncertain of how to assess cases, of what role to adopt, of the constellation of circumstances the patient faces in his daily life and of how to interact and communicate with their clients. An advocate for mental patients must fulfill certain basic requirements:

1. Specialization - The counsel must have familiarity with mental health terminology, mental health legislation, and sufficient knowledge and understanding of mental patients and their circumstances to assess cases, empathize and communicate with his clients, and, ideally, represent group as well as individual interests.[9]

2. Personal Skills - The counsel must have the personal and interpersonal skills - stability and "sympathy" - to withstand the particular rigours and stresses of dealing with a client population of mental patients, while at the same time providing "zealous" advocacy.

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[9] This probably also demands continuing legal education.

3. Accessibility - The counsel must be immediately available to his clients, highly visible and even willing and able to seek out, educate and inform clients who have not sought him out. As Brunetti (1975) argues, detention and treatment may produce "an inhibitive or repressive environment".10 Only a full-time lawyer could meet these challenges.

4. Diligent and Independent Advocacy - The counsel must take the role of advocate of the mental patient. Clearly no one else adopts this role; often the patient feels that even his relatives, who may have participated in the commitment process, cannot be trusted (Waddams, 1972). In order to achieve this role, he must take seriously the clients' demands and perceptions; he cannot see himself as part of the therapeutic team. The therapertic team is needed but that role is already well occupied; the equally critical role of spokesperson for the patient himself is not. If the lawyer were to adopt the medical version of the client's best interest, rather than the client's stated interests, he would be failing to provide the

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10 He cites the effects of sedation (e.g. thorazine, stelazine and mellaril may reduce initiatve) and electro-schock therapy (which seems to disorient and at least to have some effect on immediate memory).

> independent legal representation necessary to ensure that the rights of his clients have been observed. While certainly the lawyer would be expected to exercise judgment in his assessment and selection of cases, he must do so on legal, not medical, grounds. "Compassion is no substitute for legal safeguards" (Shone, 1976).

To quote Litwack (1974, 839):

> Only full-time patient advocates can be expected to have the time, the expertise, the relative freedom from governmental pressure, and the sense of commitment to adequatly represent clients who are likely to be poor, disturbed, and otherwise alone in defending their rights.

We would argue, then, that what is needed is a full time, on site, specialist, independent patient advocate. An advocate who could:

1. ensure immediately that clients are aware of their right to counsel;
2. explain proceedings and legal alternatives;
3. interview to action;
4. provide factual investigation;
5. act on legislative provisions for public hearings;
6. speak on behalf of the timid, illiterate and inarticulate;
7. provide ordinary advocacy skills act as patients' solicitor;

8. investigate alternatives to hospitalization;
9. prepare client for commitment; and
10. represent group interests.11

It seems apparent that private lawyers, unfamiliar with the circumstances of detention, without an adequate conceptualization of their role in the proceedings, and unable to identify with the clients, would not be able to provide diligent advocacy (Cohen, 1966). Similarly ombudsmen and duty counsel, for example, could not be expected to have the expertise and special skills necessary and ombudsmen, in particular, are likely to have divided responsibilities.12 Finally, hospital administrators are likely to be compromised in their work if they are not freed from the investigative role and referee's position (Dobson and Hansen, 1976). To reiterate, we argue that only a full-time on site advocate would meet the needs of both the mental patient and the therapeutic community.13

Nevertheless, we anticipate a number of objections to our argument. In the following section we take up these objections in light of available evidence.

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11 This is distilled from Shone (1976) and Litwack (1974).

12 An attempt to represent patient's interests with an ombudsman's programme was tried in Windsor Ontario.

13 A detailed and effective account of the benefits of such a model for both patients and hospital can be found in Andalman and Chambers (1974).

Objections to "Mental Patients' Advocates"

Objections to the provision of mental patients' advocates typically fall into four broad categories:

1. Clients' ability to use counsel - Many have claimed that mental patients cannot make effective use of legal aid, cannot inform counsel and may abuse the process by virtue of the very reasons for which they have been committed. Most available evidence, however, points to the contrary. Epstein and Lowinger (1975), for example, found that almost all categories of mental patients could use legal counsel well and this was especially the case for the involuntarily committed. These researchers also found a marked increase in the patients' awareness of their legal status and legal aspects of hospitalization when legal counsel was available.

2. Consequences for the Therapeutic Relationship - Some critics have voiced concern over the potentially disruptive effects the availability of mental advocates would have on therapy (see, e.g., Shived, 1978). On the other hand, many would argue that advocacy is positively therapeutic. Kumasaka et al. (1972), for example, argue that the resultant reduction in numbers of committals has a positive feedback effect and creates a more efficient hospital. Strand (1972) goes further to argue that:

"in-hospital patient advocacy is therapeutic because it provides otherwise dehumanized, institutionalized patients with some ability to affect their own destiny."

Furthermore, we have already pointed out the likelihood that resolving the legal issues which may have to some extent precipitated commitment or which occur as a result of it will have a strong rehabilitative effect. And several researchers have argued that if medical opinion were legally substantiated, patients would be more amenable and susceptible to treatment (Roth et al., 1973; Waddams, 1972; Draper, 1976). In any case, the advocate cannot adopt the therapeutic model if he is to assist in the determination of the applicability of the model.

Finally, this criticism points to the importance of minimizing delay between commitment and commitment hearings, and says little about the role of mental advocates per se.

3. Premature or Unwarranted Release - Another concern often expressed is the possibility that mental patients' advocates will be able to secure the release of patients who will be deprived of necessary treatment and who may,

therefore, pose a danger to themselves and the community. There is, however, little evidence to support this claim. The few follow-up studies (e.g. Steadman, 1976; Monahan and Cummings, 1975) have, as we have indicated, found a greater likelihood that psychiatrists had very much over-predicted dangerousness. (See also Steadman and Cocozza, 1975; McGarry and Parker, 1974; Thornberry, 1979; Jacoby, 1976, studies which examined the results of the Baxtrom vs. Herold Supreme Court decision in the U.S.) The small number of follow-ups (and the methodological difficulties associated with such studies) means that we can say little with confidence on this issue.

However, the problem of premature or unwarranted release is not a comment on mental advocacy, but rather on the availability of alternative resources for the mental patient and on the adequacy of mental health legislation. While it may be true that some mental patients have nowhere else to go when released, the mental patient's advocate cannot accept society's failure to provide suitable facilities as an excuse to deny his client's rights to legal representation. To do so would be implicitly to accept an unacceptable situation. Indeed his efforts at advocacy may highlight and help to specify the need for community based mental health resources.

Ultimately, however, if the advocate is indeed successful in blocking commitment for those "legitimately in need", this surely reflects on the ambiguous state of mental health legislation. Ambiguity in the law[14] inevitably opens the possibility of abuse of discretionary power. Perhaps only through battling cases in the courts will these ambiguities be pinpointed and the laws sharpened and improved. In other words, the mental patient's advocate can play a very important role in law reform.

4. Unnecessary Legalism - The most general and basic complaint regarding the automatic provision of legal services to the mentally ill is that it introduces unnecessary legalism into what is primarily a therapeutic relationship. But, the very use of involuntary commitment brings into play the legal system; the advocate attempts simply to ensure fair and proper procedure. And to the notion that this vigilance is "unnecessary", one need only point to the numerous studies which indicate that without such representation the patients' rights may be ignored (Wenger and Fletcher, 1969; Kumasaka

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[14] We recognize that there is always discretion in law but where individual liberty is at state highly ambiguous laws are not acceptable.

et al., 1972; Morris and Luby, 1975).15 Gupta (1970-71) points out that, without such representation, hearings and contested committals are rare and that the hearings, if held, are inadequate and the evidence presented is scanty. Wenger and Fletcher (1969) found a positive correlation between presence of counsel and both duration of commitment proceedings and the likelihood of not hospitalizing the client. Similarly, Shone (1976 : 226) found that review panels:

> "took more care to comply with the minimal procedural decencies when counsel appeared than when he did not, a fact which is not surprising because, unlike the average patient or lay representative, the lawyer has the wherewithal to object to deviations from acceptable procedure and to apply for judicial review or to launch an appeal."

The legal aid lawyer, then, can serve to ensure that committal is not solely an "unchecked" medical decision.[16]

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15 See, in particular, Arnold Bruner's (1977) summary of two unpublished Ontario studies, and the work of Fox and Erickson (1972).

16 A mental patients' advocate can also serve as a check on the use that police may make of civil legislation to arrest or detain "disturbed" individuals who may be dealt with illegally but never have the opportunity to see the inside of a court (Fox and Erickson, 1972).

We have tried to make the case for the provision of a special form of legal aid to mental patients. Legislation such as Section 30 of B.C.'s Mental Health Act reinforces the desirability of the Mental Patients' Advocates model by creating the right for patients to go through normal legal channels and therefore a mechanism which requires the use of counsel. In the final section of the report we provide a detailed examination of one such project.

The Mental Patients' Advocates Project

The Mental Patients' Advocate Project is the first Canadian experiment in providing free legal services to present and former mental patients by maintaining a law office on the grounds of a Provincial mental health facility but independent of the institution.

Because the Project is operating under the auspices of the Vancouver Community Legal Assistance Society, it can also use the facilities of a well-established community law office to ensure continuity in the provision of services to those of its clients (a large percentage) who settle in or return to the Lower Mainland when they leave the hospital.

The Project has been in operation since September, 1977. The discussions which led up to the creation of the Project involved representatives of the Mental Patients' Association, which gave editorial support to the idea of a patients' advocate in its newspaper and assistance in the

designing of the Project before the initial application for funding was made. In its first year the Project was financed by a grant from the Donner Canadian Foundation of Toronto. Since September, 1978 it has been funded by the Law Foundation of British Columbia and the Department of Justice of the Government of Canada. The principal aim of the Department of Justice in funding the Project was to do an intensive evaluation of the Project from both a conceptual and a functional perspective.

Project staff describe their objectives in terms of two functions:

1. The raising of issues pertaining to the legal status and the legal rights of present and former mental patients with the objective of making new law or reforming the existing law;

2. The provision of free, uncompromised legal advocacy for mental patients in regard to legal problems arising out of their status as mental patients.

The working hypothesis that resulted in the establishment of the project is that the problems in living which beset mental patients very often have a legal dimension, but for reasons having little to do with the justice of their cause or with their intrinsic worth as human beings, mental patients have tended to have little access to the assistance of legal counsel and little influence upon the ways in which the legal process impinges upon their lives. The Project is trying to change this situation by its activities in the performance of both its law reform and service functions.

Our discussion of the project will be based on a variety of sources of data:

1. interviews with project staff,
2. interviews with hospital staff,
3. interviews with other interested parties,
4. an analysis of case files, and
5. field observation.

We will discuss the project under the following headings:

1. the philosophy of advocacy,
2. the staff,
3. carrier agency,
4. the physical facilities,
5. the relationships with the hospital,
6. representation of individual clients,
7. representation of group interests and educational activities, and
8. available alternatives.

1. The Philosophy of Advocacy

The project sought to serve the legal needs of mental patients. In order to do so it was felt that two approaches were necessary. First, individuals who had problems amenable to legal solution were to be given legal assistance. Second, the legal interests of mental patients as a group were to be represented through litigation, law reform and educational activities. We will examine each in turn.

As we indicated, individuals whose mental competence is at issue pose a fundamental question for legal advocacy; does one pursue the client's wishes or the client's "best interest"? The question is both fundamental and problematic. It is fundamental because it defines the role of the lawyer and affects all the decisions he takes in representing his clients. The question is problematic because it leaves an assumption unstated - the assumption that the client is not competent to judge what his "best interests" are. In many mental health cases this is the very question at issue; in cases such as this, if the lawyer fails to present his clients' point of view, he acts as judge rather than advocate. It is important to note that acting in terms of a) the client's self defined interests and b) the legal merits of the case is the essence of legal ethics. One would be scandalized, for example, by a criminal lawyer who failed to represent his client because he thought the client needed "correction".

The philosophy which guided the activities of the mental patients' advocates project was based on three simple premises. First, a lawyer's role is to represent his client - he works for his client only within the framework of the canon of ethics. Second, the law applies (except where the law itself says otherwise) to all citizens regardless of their therapeutic status. And third, the lawyer's role is legal - it is to make the legal rights and remedies accessible to the client.

The mental patients' advocates selected their cases on their legal merits. If a client had a reasonable case in law it was accepted. Consideration of whether the client was right was left to the judge. If a client should

not be released from hospital it was for the judge to so find on the evidence. If a client was not capable of custody of a child it was for the judge to so find on the evidence. If a client demanded more control over his life than the hospital permitted it was for the judge to determine on the evidence who was right. The mental patients' advocates asserted that the rules are defined by government and it is the client's right to be dealt with in acordance with the rules. This is the essence of rule of law rather than rule of men.

The problem of clients who could not instruct counsel was dealt with simply. The mental advocate did not represent clients who could not articulate coherent objectives.[17] The problems of clients who had, in legal terms, unreasonable objectives were dealt with as they are in all responsible legal practice by telling the clients their cases did not have sufficient legal merit. In summary, the advocates chose to be faithful to the legal model when they were asked to address legal issues. They left responsibility for non-legal issues to social workers and medical staff.

The second mode of representation is advocacy of group interests. The project staff believes that in order to protect the rights of individuals the interests of the group must be represented. This is accomplished in four

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[17] This was rare and, in many instances, a matter of timing. That is, an "inarticulate" client might, the very next day, be able to state his case clearly. Again this emphasizes the importance of on site counsel.

ways. The first of these is test case litigation. While the mental health area has been the subject of considerable legal activity in the criminal courts little law has been "made" in the civil courts. In order to establish the rights already present in the common law and written law, cases must be brought before the courts so that clear precedents are set.

The second approach to representing group interests is encouraging improvements in the written law. Laws are made by people, who listen to the points of view of interested parties. In mental health law the point of view of the patient is rarely heard. The medical profession's interests and those of their patients are not always identical. A group lacking power and credibility, such as mental patients, needs a spokesperson in the law development/reform process.

The third manner in which group interests are represented is community education. If the dignity and legal rights of mental patients are to be respected the community must come to understand the issues involved.

Finally, the interests of all members of the group are furthered by the ardent representation of individuals within the group. The representation of individuals furthers the interests of mental patients in general because it serves as a deterrent. Rights are only rights when they are enforced. When no one challenges administrative decisions which are outside what is allowed in law, even the best intentioned officials may become unmindful of the legal

limits of their discretion. Thus, legally challenging some procedures or decisions for individuals may put administrative officials on notice and encourage stricter adherence to acceptable procedures for all.

In summary, the philosophy of advocacy is similar to that employed in most legal aid clinics. Individuals are to be represented zealously by independent counsel whom they employ and, group interests are to be furthered through all available legal channels.

2. The Project Staff

The project is staffed by two lawyers, one working full-time, the other working sixty percent of the time.[18] The staff of the Project are all salaried, with the salary structure of the Legal Aid Society of British Columbia providing rough guidelines for the salary structure of the Project.

The part-time lawyer is the senior counsel. He has been seven years at the Bar. Prior to initiating the Mental Patients' Advocates Project he served on a similar project in the United States. He undertakes the majority of the work involving disputes with the hospital, the majority of the court work and almost all the law reform cases. He also provides senior collegial support to the full-time lawyer.

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[18] The other 40% of his time is devoted to his VCLAS law practice.

The full-time lawyer deals with the majority of the matrimonial and civil matters and some of the hospital related matters. To date two lawyers have successively filled the full-time post, one who served for the first two and one-half years of the project and another who began work a few months before the writing of this report. The reason for change in staff is related to the tensions intrinsic to this type of legal practice.

Staffing of projects such as the Mental Patients' Advocates and maintaining continuity of staff (essential for the development of full expertise) may prove to be a problem in the implementation of this model. One of the problems encountered in the present project was the sense of isolation experienced by the lawyers filling this role. The interview data described below make it clear that the hospital staff and the administration of the hospital neither understand nor appreciate the role of the "helping professional" who advocates the patient's point of view against their own point of view. Thus the mental advocate is isolated from the professional community in the environment in which he works.[19] The clients are an unusual and troubled group and they can in many instances exacerbate rather than alleviate the advocate's sense of isolation. Finally, the area of practice leaves the mental patients' advocate well outside the mainstream of his own professional group. Colleagues facing the same legal and social problems

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[19] This problem of "communication" is quite typical in programme implementation. See, for example, Rogers and Shoemaker (1971) who explore the problem in general terms.

as the mental patients' advocate are indeed few and thus many of the assets of being one of a "brotherhood of lawyers" are absent.

This isolation is a potential weakness in the mental patients' advocates model. To staff this sort of office one requires an individual who is committed, self-determined, and "mature" enough to withstand the stresses of isolation. While "burn-out" is a factor associated with many legal aid clinical situations it is a special danger in the Mental Patients' Advocates' model.

One of the ways in which the stress of isolation was mitigated for the lawyers was their activity on the Law Society Sub-Committee on Mental Health where they could discuss with colleagues interested in similar issues, the problems and opportunities that this type of practice presents. In addition, the advocate described his association with the carrier agency as a source of moral and legal support. Nonetheless because experience plays such a large role in the mental patients' advocates' skills and, because maintaining independence is critical to his role, problems of isolation must be addressed and steps taken to alleviate its impact when full-time mental patients' advocates' projects are being established.

3. Carrier Agency

The carrier agency for this project is the Vancouver Community Legal Assistance Society (VCLAS). The Vancouver Community Legal Assistance Society is an organization whose primary purpose is test case litigation and law reform.

Given the mental patients' advocates' intentions in the area of law reform and given the pioneering nature of the services provided by the Mental Patients' Advocate Project, VCLAS appears to be an appropriate agency to sponsor such a project.

Attaching the project to a larger agency seems in this case to have had advantages that would not have been present had the project been entirely independent. As we noted above, the novelty of the type of law practised, the novelty of the delivery mechanism, the nature of the clients, and the medical rather than legal atmosphere in which the practice is conducted opens the lawyers in this field to a sense of isolation. The larger agency sponsoring the project provided these lawyers with moral support, critical collegial support, and access to the world of "law reform lawyers", an important professional retreat from the world of mental patients and psychiatrists. But, because no other lawyers in the carrier agency were particularly concerned with mental health law the agency was lacking in its capacity to provide full collegial support in discussions of the particular legal problems involved.

4. Physical Facilities

The office of the Mental Patients' Advocate is located on the grounds of the Riverview Hospital which is 15 miles outside of Vancouver in Coquitlam, British Columbia. The office was situated in a small row of "storefront" services which includes the hospital post office, a tuck shop and a mental patients' association centre. The office,

rather small and cramped, contained two closed working spaces for the lawyers, but these were not adequately separated from the rest of the office to provide the sound-proofing necessary to solicitor/client privilege. The internal facilities of the office could best be described as merely adequate.

The location of the office was obviously advantageous. It was accessible to all mobile patients and visible to all those in the hospital who frequented the other service shops such as the post office and the tuck shop. Locating the office in the hospital had several advantages:

(a) it provided the lawyers with a contact with the hospital environment that they could not otherwise have;
(b) it provided the lawyers with ease of access to hospital record rooms, wards, and hospital staff;
(c) it provided the clients, whose mobility is obviously limited, with ease of access at all office hours;
(d) it provided the patients with the psychological sense that it was a law office for them and part of the services offered to them.

Space for the mental patients' advocates' project was provided free of charge by the hospital. Hospital administrators stated that they did so because of their commitment to the concept of respecting patients' rights.

The hospital also cooperated by giving project personnel liberal access to the wards of Riverview Hospital and the Forensic Psychiatric Institute and permission to see clients both on the wards and in the office.

5. Relationship with the Hospital

The Mental Patients' Advocates Project is located on the grounds of the Riverview Hospital. A large proportion of the clients were patients in that hospital. In 60% of the cases the hospital was the opposite party in the legal actions the project lawyers took on behalf of their clients. In most legal aid evaluations, relationships with opposing parties are not of central interest. If the issue does arise, for example in criminal legal aid, the concern is whether the legal aid lawyer develops "too cosy" a relationship with his opposing parties. However, the novelty of mental health practice does make relationships with the hospital a matter of considerable importance.

A member of the hospital staff, a psychologist on study leave at the University of British Columbia, interviewed social workers, nurses and doctors at the hospital. Using a questionnaire of both closed - and open-ended questions, a total of forty-seven hospital staff were interviewed on their attitudes to the concept of mental patients' advocacy and to the Project staff. These included all 18 hospital social workers employed at the time, the two psychologists who had had contact with the project, the

supervising nurse and five charge nurses20, 16 physicians who had had contact with the Project and who were available, two department heads and three members of the Mental Patient's Association. As well, one of the authors conducted discussions with hospital administrators. The interviews asked the hospital staff to react to the project in terms of their perceptions of its objectives, its procedures, its impact on hospital functioning and its impact on therapy.

The majority of hospital staff understood the objectives of the project to be provision of legal services to patients (49%) and the protection of their legal rights (60%). Only four responses (9%) might be taken as indicative that the general programme goals were not appreciated. Most expressed approval of the project's giving assistance to patients who had legal problems which did not directly involve the hospital (93%). Further, 82% supported the legal aid role in helping the patient secure legitimate release, and 67% supported its role in treatment and other hospital related disputes. Although only two realized that the reform and clarification of law was a goal of the project, most agreed that the testing and clarification of mental health law was a worthwhile goal (60%).

The response of the hospital staff was less positive when they discussed actual cases involving patients' relationships with the hospital. While no one

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20 We were unable to get the random sample of 30 nurses which we originally requested.

"likes" to be drawn into litigation, their expressed objections stemmed, at least in part, from more fundamental concerns. These related to the philosophy of advocacy, the effects on therapy, their own legal position and the issue of communication between project staff and hospital staff.

In terms of the philosophy of advocacy, hospital staff expressed concern over the intrusion of the legal adversarial model of dispute resolution. Hospital decisions are taken by discussion among hospital staff based on "what's good for the patient". The win or lose adversarial approach appears to them inappropriate. Hospital staff see themselves as acting for, not against, their clients. Their role as their clients'"adversaries" in legal proceedings is foreign and unwelcome.

Nonetheless, as we indicated previously, the very label "involuntary patient" illustrates that, from the patient's point of view, a dispute exists. In other words, to the extent that the hospital staff and the patient disagree about what is desirable, an adversarial situation is already present. When the hospital can mobilize the law to commit the patient and the patient is unrepresented, the dispute is quickly settled in favour of the hospital's point of view. When the patient hires a lawyer to represent his point of view, the dispute is, of course, less easily settled in favour of the hospital. It is not surprising that hospital staff view the lawyer as the source of an adversarial situation. But, the patient's lawyer does not introduce this situation, he merely balances it. Again, it is the tension between the medical/therapeutic and the legal professional models which is at the base of these staff perceptions.

Hospital staff believed the lawyers should, as they themselves do, decide what is good - in therapeutic terms - for the patient. Sixty-four per cent disagree that the lawyer should follow clients' instructions as in normal legal practice. Therapists make judgements as to what is best for a patient even when the patient disagrees. They seemed to expect the lawyer to make similar judgements rather than advocating the patient's point of view, making legal decisions about what is in the patients' best interest, and letting the judge decide. Indeed many of the objections of the hospital staff - to the project and to the advocates themselves - can be traced to a misperception of the role of a lawyer.

In regard to general hospital functioning, the majority of the staff agree the project was not a serious problem (57%). But about one half of them expressed serious concerns in the area of therapy. Some felt that when a client hired a lawyer to dispute his treatment or committal, the client stopped fully participating in therapy. A few even suggested that staff were somewhat inhibited from treating patients with legal cases pending, because they feared an early termination of therapy or further legal entanglements.

Whether mental patient's advocacy is therapeutically harmful or beneficial is not certain. It has not been shown to be harmful in any of the research and some psychiatrists with long experience in dealing with represented patients have found it beneficial, for example, in that patients who lose their cases come to see successful therapy as the only way out of the hospital. In either case, as we have said, these concerns are not of the essence. Legal

rights cannot be denied because they are bad for you. Legal rights set limits on therapeutic impositions. To ignore legal rights for therapeutic purposes would be to make a mockery of these rights.

What about the inhibiting effect on therapists? To the extent that legal advocacy inhibits lawful therapy it is regrettable. This can in part be avoided by consultation with hospital legal counsel to ensure lawful therapy is not inhibited. Where legal issues are uncertain, the problem can be resolved by having the test cases of the mental patients' advocate settled in court so that clear precedents can be set. If legally indefensible activities are inhibited, this is a desirable outcome, and a fulfillment of one of the objectives of the project.

The volunteered (open-ended) responses of the hospital staff indicated concerns for their own legal position. They do not have a full-time advocate. Legal counsel for the hospital is costly and a drain on limited resources. This too is regrettable. Nonetheless, involuntary commitment is a legal procedure and the law cannot be kept out of it. Hospital staff should be given a better sense of having access to counsel.

The final concern is communication. Eighty-seven per cent cited communication problems as most in need of resolution. Only 34% had received direct explanation of the project from project staff. Predictably, most feel the consultation on individual cases was inadequate. While some of them wanted this consultation to fall into the

therapeutic model of conferring on the best interests of the patient, and therefore an inappropriate activity for legal counsel, hospital staff do have information which may prove useful in legal representation and should therefore be consulted. In the past year, both sides have attempted to correct the situation.

Members of the project's legal staff have appeared in the last year at meetings of medical staff and social services staff of Riverview Hospital to explain the aims and activities of the project and to discuss issues raised by what the project is doing. Discussions which begin at these meetings often continue on other occasions. In November, 1979 the project staff were invited by the Vancouver People's Law School to appear on an interview program on cable television concerning mental patients' rights. The project suggested that the host of this program invite Dr. Walter Goresky, the Clinical Director of Riverview Hospital, to appear on the same program to debate the issue of whether involuntary patients should have any right to refuse treatment. Also, the lawyers have explained their philosophy of advocacy in an exchange of correspondence with the doctor in charge of admissions for the hospital.

It is now the practice of the project's legal staff to discuss with the attending physician or psychiatrist every case which may involve an application to court for release of a client from hospital (where the client authorizes the lawyer to do so) before an action is initiated, and to relay the substance of the discussion to the client. The purpose of seeking the doctor's opinion is threefold: first, to obtain information about the content and strength of the case the client will have to meet if he

proceeds with court action; second, to open or improve communication between doctor and patient and between medical staff and project staff; and, third, to put the doctor on notice of the patient's intentions. Fairly often these contacts result in a non-litigious resolution of the client's problem.

In summary the responses of the hospital staff reflect the basic issues which have been discussed throughout this paper. Therapists operate within the therapeutic model. They object to lawyers representing patients when this representation conflicts with the role definitions that are assumed in the therapeutic model for "helper" and "client". They respect and appreciate the concept of patient rights but are taken aback by the normal legal model through which these rights are operationalized. Nevertheless, and despite their objections, 94% of those who had an opinion felt that patients were satisfied with the legal advice provided.

6. Activities of the Project

The activities of the Project can be described under two headings: first, representation of individuals, and, second, representation of group interests and community education.

Representation of Individuals

The bulk of the work is individual case work. Here we shall consider the clients, the legal problems, the legal strategy and the results.

The Clients

The project completed 465 cases in its three years of operation. An additional 140 cases remain as open files. In addition summary advice was given each month to approximately 30 clients for whom no files were opened.

The description of the client population is presented in Table 1. Clearly, the advocates must deal with a wide range of clients, males and females of all ages and with differing mental and therapeutic status. However, the low proportion of clients in the "chronic" category as contrasted to the hospital population deserves comment. Among the project's clients, chronic patients are far out numbered by clients designated as "acute"; the opposite is true for the overall hospital population. Without questionning the validity of the legal problems faced by acute patients, one must questions the very low representation of chronic patients. The underrepresentation of older people is probably a reflection of their being more frequently categorized as chronic patients.

Project staff explain this low representation in terms of self selection and case load. Acute patients request the services of the lawyers more frequently and the already heavy caseload resulted in little motivation to expand the client group. However, when case selection is constrained by limited resources, priorities must be based on the legal merits of individual cases. It is a moot point whether legal solutions are more difficult for chronic or acute patients - for both, liberty and rights are at stake.

An analysis of the cases which did involve chronic patients reveals a high success rate in achieving discharge or extended leave from hospital. If fact, 75% of the chronic patients seeking release were either discharged or received extended leave from hospital.

TABLE 1

THE CLIENTS	Project Clients	Total hospital population
Status in the Hospital		
Voluntary	7%	
Involuntary	89%	
Discharged	3%	
Age in Years		
16-20 under 20 years	2%	1.5%
20-29	32%	12.7%
30-39	27%	12.7%
40-49	16%	12.0%
50-59	12%	19.8%
61 and over	0%	41.3%
Sex		
Male	41%	57%
Female	59%	43%
Marital Status		
Single	56%	60.7%
Married/Common Law	19%	20.9%
Separated	12%	6.7%
Divorced	13%	5.6%
Other	0%	6.1%
Therapeutic Status		
Chronic	27%	84%
Acute	73%	16%

While we do not know how representative these patients are of chronic patients generally, we do know that this label does not preclude effective representation. There is little doubt that the low representation of chronic patients is in part a result of their decreased "motivation" given the greater time they have had to adapt to or suffer the effects of being hospitalized. Perhaps this means that the project must be prepared to respond in such a way as to counteract some of the effects of hospitalization and institutionalization more generally (see Goffman, 1961).

The Mental Patients' Advocate Project responded to requests from clients and did not solicit business. Of course, this is in accordance with the ethics of a legal profession which has traditionally adopted a reactive role of responding to clients' requests and has generally shunned the proactive role which demands that they strive to make clients aware of their legal problems. This philosophy is consistent with the traditional role of the lawyer. However, while one would at first glance be hesitant to suggest that the Mental Patients' Advocate engage in "ambulance chasing", we face a serious practical dilemma. Access to the law requires not only that legal counsel be available but also that the potential client be aware that some of the problems he is experiencing are amenable to legal solution. In traditional legal practice, middle class, wealthy and corporate clients are much more likely to be aware of the range of uses to which the law can be put to further their own ends. Therefore, there is no need for the legal profession to preach the values of their services.[21]

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21 It is, however, not uncommon for lawyers to make their clients which they already have, be they private or corporate, aware of new ways in which the law can be used to further their own ends.

However, reliance on the reactive approach for the provision of legal aid has been shown to have many disadvantages. The poor and the disadvantaged are not as likely to be able to articulate their rights, nor to see the link between their "personal problems" and the legal process.[22] This phenomenon is well known within legal aid with the result that various "outreach" programmes have been developed to inform clients about "what the law is good for". This has been perceived as a major objective of public legal education, and the activities of community legal workers, for example. Far from being "ambulance chasing", outreach represents an essential component of providing equality before the law and equality of access to the law. Surely a similar case for outreach activities can be made with respect to mental patients. The chronic long-term inmate of a mental hospital cannot truly be said to have access to the law unless he is made aware of what legal remedies exist and what the chances are that his point of view in a dispute with the hospital or the outside world will be represented. The case distribution of the Mental Patients' Advocate Project would seem to indicate that it would be appropriate for this sort of outreach activity to be a project aim.

Because this is a legal aid project, clients' eligibility for state supported legal services is an obvious concern. Eighty-three percent of the clients easily met the financial eligibility criteria for legal aid in British

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22 See, for example, the studies conducted by Messier (1975), Marks (1971), Messier (1975), Sykes (1969) and Hazard (1969).

Columbia under its judicare component. While only 20% of the cases fell into the normal range of cases for which legal aid is provided under the judicare component, most of the civil and criminal cases would be accepted by legal aid clinics in British Columbia.

The hospital cases are a point in question for legal aid. Indeed one of the reasons for the project was to assess the need for legal aid in this area. Given the fundamental legal issues involved and, as we shall see below, the degree of relief legal aid can bring, one would expect involuntary hospitalization to become a normal area for legal aid service. Indeed, legal aid is universally available in Canada in criminal cases where loss of liberty is at stake. - In involuntary hospitalization both liberty and the right to physical autonomy are in jeopardy (see Harvard Law Review, 1974: 1200-1201; Sharpe, 1978; Hill, 1977; Amand, 1979). The present Legal Services Society Act explicitly states that one of the purposes of legal aid in British Columbia is the ensure legal services to any whose liberty is at risk through civil proceedings. Thus, the provision of legal aid to civilly committed mental patients must be viewed as a central legal aid service, not as a "frill".

Types of Cases

The text which follows provides a statistical profile of the caseload. Figure 1 gives "life" to these data with a sampling of "illustrative" cases.

The types of cases fall under two major headings: a) cases in which there is a dispute regarding committal, therapy or conditions of life in the hospital; and b) cases in which matters directly regarding hospitalization are not at issue.23

Sixty percent of all cases directly involved the hospital (See Table 3). Of these, 80% were requests for release. Because there are no rights to a hearing in the commital process itself, no cases involved disputes at the time of the original commital. The remaining cases in this category related to complaints regarding treatment (5%) and availability of records, loss of personal effects, mail opening, transfer, hospital status, and a variety of other individual problems.

The remaining forty percent of cases did not involve direct disputes with the hospital. Sixteen percent of all cases involved matrimonial matters, mostly divorce (67%), but also child custody (22%). The remaining family law cases included maintenace, alimony, and separation. Eighteen percent of all the cases involved other civil matters. Of these twenty-nine percent were landlord and tenant cases. The remainder included capability hearings, small claims court actions, restraining orders, debts, workmen's compensation hearings, unemployment insurance, deportation and wills. It is worth noting that the family and civil caseload is similar to that experienced by most legal aid clinics. Finally, criminal matters accounted for only six percent of the caseload. Most of these involved Order in Council hearings.

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23 It should be noted that many of the latter type involve issues that result from or resulted in hospitalization.

Table 2: Types of Cases

Area of Law	% of cases
Hospital	60
Family	16
Other Civil	18
Criminal	6

n = 465

Figure 1

Descriptions of Cases 1979-80

Cases

1. A woman who had formerly been a patient at Riverview and was residing in a boarding home in Chilliwack was being denied any access to her children by her husband without lawful authority. The advocate was able to negotiate settled arrangements for regular access to the children by contacting the husband and his solicitor on behalf of the client.

2. The advocate drafted and saw to the execution of a power of attorney on behalf of a client who remained capable although committed to a mental institution and prepared and saw to the execution of medical affidavits necessary to establish the validity of the power of attorney in the event of any future dispute.

3. The advocate used the transfer provisions of the Mental Health Act to assist a client in getting transferred from Riverview to an institution on Vancouver Island closer to his home.

4. The advocate prepared a separation agreement for a client and assisted him in obtaining an order for the sale of the matrimonial home and a division of the proceeds of the sale.

5. The advocate negotiated an agreement between a client and a collection agency for the payment of a dental bill by monthly installments.

6. The client who had been discharged from Riverview, but had not been advised of the fact that she had been discharged, was being told by a member of a community care team that she had to remain on medication for a further period of two years and would be returned to hospital if she went off medication. She claimed that the medication was having unpleasant effects upon her. The advocate obtained documentary proof of the fact that the client had been discharged from hospital and advised her that she was free to continue or discontinue medication as she saw fit.

7. The advocate assisted a client in negotiating with his doctor for a form of treatment other than ECT (shock treatment). Client agreed not to petition for his release from hospital. His doctor agreed not to give him ECT.

8. The advocate assisted a client in obtaining a therapeutic abortion by explaining to her doctor the difference between incapability of managing oneself and incapability of managing one's affairs under the Patients' Estates Act.

9. The advocate negotiated voluntary departure in lieu of deportation on behalf of a client who was on the verge of being deported from Canada. He was also able to assist this client in recovering his vehicle, which had been impounded by the immigration authorities.

10. The advocate represented a woman whose child had been taken from her in proceedings under the Protection of Children Act at the time of her admission to Riverview Hospital in a two and one-half day trial in Provincial Court. She had been discharged from hospital just before the start of the trial. At trial she was awarded custody of her child over the opposition of the Superintendent of Child Welfare and of her estranged common law spouse (who was represented by counsel) subject to supervision. On review six months later the supervision was lifted and permanent custody of the child was awarded to the client.

11. The advocate negotiated a consent order terminating a client's obligation to pay maintenance and various arrangements for deferred payment of debts on behalf of the client whose business had failed shortly prior to his admission to hospital.

12. The advocate assisted a client with an application for a pardon in a criminal matter.

13. The advocate negotiated an agreement with the solicitor for the Superintendent of Child Welfare and with the solicitor for the client's former husband to arrange for permanent custody of the client's four children, who had been taken from her under the Protection of Children Act at the time of her admission to hospital. Implementation of the agreement was monitored by the Family Court in Surrey. The interim consent order setting out the negotiated custody arrangement eventually became final.

14. A client recovered civil damages against the proprietor of a boarding home for breach of the proprietor's duty as a bailee. The proprietor had promised the client that he would see to the safe storage of the client's belongings at the time the client was committed to hospital and had then allowed other residents of the boarding home to help themselves to the client's belongings.

15. The advocates secured the return of furniture and personal effects to a client from a former landlord who had levied an illegal distress upon those belongings for arrears of rent existing at the time of the client's involuntary admission to hospital.

16. A client received a cash settlement from the City of New Westminster for the unlawful impounding and subsequent sale of his car under the Highways Scenic Improvement Act. The basis of the settlement was the City's admission that there had not been an abandonment of the car within the meaning of that term as it is used in the statute.

17. The advocate assisted a client in prosecuting a successful appeal against a special verdict of 'Not Guilty by Reason of Insanity' on the basis of various improprieties in the conduct of the case by the trial court and by the client's appointed counsel. The client had claimed that the insanity defence had been forced upon him and that he had not been represented effectively by his counsel. His case was argued in the B.C. Court of Appeal by a private lawyer appointed by the Legal Aid Society at the Project's request. The client was released from custody and did not stand trial again.

18. The advocate secured a substantial cash settlement of a claim for benefits under a long-term disability insurance policy on behalf of a client who had suffered a mental breakdown on the job and had been denied disability benefits because he had not completed proper proofs of claim.

19. The advocate obtained a substantial cash settlement on behalf of a client who, while of full age and legal capability, had been given shock treatment in a private hospital without his consent and had brought an action against the treating doctor and the hospital in B.C. Supreme Court.

Current Cases

20. An action to try to get discharged from extended leave a patient whose doctor has refused to lower his dosage of psychotropic medication during the year-and-one-half that the patient has been out of hospital despite the patient's complaints that he is unable to work or to lead a normal life on his present dosage of medication.

21. An action against a railway express company for losing a suitcase which was being shipped to a client who is confined at an institution for the criminally insane.

22. A case in which the Project is attempting to secure for a client the return of a security deposit on residential premises from which she was evicted at the time of her admission to hospital.

23. An action against the City of Vancouver and two police officers for seizing and destroying personal property taken from a client at the time of his arrest on a criminal charge several years ago. The Defendants have agreed to a cash settlement of this claim (after one-half day in court during which the claim survived various motions for dismissal).

24. A case in which a client (a woman who was formerly an involuntary patient) was attacked and injured by a fellow patient and is attempting to obtain an award under the Criminal Injuries Compensation Act.

25. A case in which the Project represented an Order-in-Council patient in proceedings before the Order-in-Council Review Board, presented to the Board the report of a psychiatrist from outside of the institution where the client is being held, and made various submissions of law in an effort to convince the Board to recommend that the client receive a conditional release from custody. The client had been found not guilty by reason of insanity on charges arising out of his efforts to obtain money from banks on false pretences. The Board recommended a conditional discharge and the Provincial government is considering the recommendation.

26. A case in which a client was held for nine days at the psychiatric wing of a general hospital without being lawfully admitted after his arrest on criminal charges and diversion from the criminal justice system into the mental health system.

27. An action against two R.C.M.P. officers and the Attorney-General of British Columbia for damages for the use of excessive force by the officers in effecting the apprehension of a client for emergency treatment under the Mental Health Act.

28. An action for conversion and for the return of a security deposit against a large corporate landlord whose employee evicted the client and had his belongings taken away and stored on the occasion of his admission to hospital.

29. An application to Supreme Court for an order declaring the client capable of managing her affairs and reversing a determination that she was incapable made by her psychiatrist at the urging of various members of client's family. The client does not want to sell her home, but her doctor wants her to sell it because he thinks that she should live in a boarding home. If she remains defined as incapable, the person who manages her affairs will be able to sell the house.

30. A case in which a client claims she was forced to take oral contraceptives while she was an involuntary patient on a chronic ward of a mental institution.

31. An application to Supreme Court seeking the release from an institution for the criminally insane of a client who was committed to that institution when minor criminal charges against him were stayed. The charges did not involve violence and the client, who is a diabetic with a history of alcohol problems, was placed there because he was thought to be unfit to stand trial following his arrest.

Action Taken

The work of the Mental Patient Advocates was in some respects not markedly different from normal legal practice. Clients, witnesses, social workers and doctors were interviewed. Law was searched. Writs were issued and petitions filed. Relevant documents were requested and clients were advised on legal matters. The procurement of expert testimony from non-hospital medical experts was a particular problem in terms of the length of time this took.

The largest single component of the Project's caseload consists of cases in which clients who, having been certified for admission to mental institutions under the Mental Health Act, sought the assistance of the Project in obtaining their release from hospital. The first step that is taken on behalf of these clients is to obtain copies of the documents by which the admission was perfected. The Project's Advocate then renders the client an opinion on the question of whether the admission was in accordance with statutory requirements. In the few cases where the admission is irregular and where the advocate is instructed to do so by the client, the advocate writes a demand letter and proceeds with habeas corpus proceedings. Where the admission is regular on its face but the client wishes to argue that there is no longer sufficient reason and authority for his/her detention in the institution, it is project practice to present the client's position to the treating doctor as described in the preceding section. Where grounds exist for such proceedings, the lawyer initiates an application to B.C. Supreme Court under Section 30 of the Mental Health Act, which provides for judicial review of involuntary civil admissions to mental

institutions. Very often these cases are settled without the necessity of issuing proceedings on the basis of a conditional release or an unconditional discharge from the institution. Where it has been necessary to proceed with litigation, cases are normally settled in the same way at some point during the process of litigation. In no court case handled by the Project has the case been disposed of by a judicial affirmation of the legality of the client's detention. However, the majority of these cases have not seen the inside of a court room because the hospital has agreed to release the patient.

The hospital's willingness to release the project's clients poses some crucial questions. Clients are not accepted by the project on therapeutic criteria and no credit should go to the project for infallible medical insight. Perhaps self-selection plays a role and clients only seek release when it is medically advisable. This may well be a factor but some other forces must also be at play. The director of the hospital maintains that all discharges of the Project's clients were medically sound. Perhaps all the released clients did not meet the criteria for commitment, but if this is the case one wonders how many of the non-clients remain improperly committed?

A factor which may be at play is the medical staff's reluctance to participate in the legal process. To the extent that this reluctance exists it is both understandable and regrettable. Legal proceedings are time-consuming and few of us would like to have our professional opinions challenged in court. Nonetheless, committal is a

legal action and cannot be divorced from law. More important, if patients who are properly committed are discharged to avoid legal entanglements, the hospital is seriously remiss in the discharge of its responsibilities. The source of our concern in this area are opinions expressed by hospital staff and administrators that the project is the cause of patients' being prematurely released. Perhaps the project has facilitated medically desirable releases or perhaps the hospital, by its reluctance to go to court, has released patients prior to what the medical staff might have otherwise deemed optimum.

As an alternative to litigating the matter in Supreme Court, the Review Panel (a tribunal constituted under Section 24(4) of the Mental Health Act) is available to review the case of any client who has been detained for more than thirty days and again once every six months after the initial review. The Advocates advise their clients of the relative advantages and disadvantages of proceeding in the review panel and in Supreme Court. A substantial number of clients elect to proceed with the former. It is project practice to assist them in applying for the panel, to explain to them how the panel operates, and to make suggestions for the conduct of their case. Where clients are unsuccessful in procuring their discharge from hospital through the review panel and wish to proceed with a petition to Supreme Court, the Advocates will act for them in the proceedings in Supreme Court.

A number of people interviewed regarding the project suggested that the Advocate should proceed more often under Section 24 (Review Panel) as it consumes less time and cost. It would have been possible for the Mental Patients' Advocate to so represent his clients in two ways: first, he could have sat as the patient's representative on the panel itself; or second, he could have represented the patient's interests before the panel. The Advocates responded that they did not wish to sit on the panel because this would put them in the role of both advocate and judge. They pointed out that this would place them in an untenable conflict of interest. Their reluctance to serve on these review panels for clients they are representing is consistent with basis tenets of legal ethics. When a client employs a lawyer, the client then has the right to expect that the lawyer will seriously represent his point of view. If the lawyer were to proceed otherwise, he would do injury to his role in the legal process.[24] Similarly, if the Advocate elected to sit on the panel - as a representative of the patient - he would not be fulfilling his role as an unbiased participant in the review.

Another role that the Mental Patients' Advocate could play on the review panel is to act as the client's representative before the panel of three "judges". This has been tried in several cases but has been found wanting. The

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[24] That these clients are legally aided does not enter into the question. Legal aid practice in all areas of law dictates that the lawyer behave in the same manner that he would if the client were himself paying the bill. The legal aid lawyer is employed by the client even if the bills are paid by the state.

review panel does not employ formal legal process: rules of evidence do not apply; witnesses cannot be compelled; evidence cannot be subpoenaed; in short, the advantages of legal representation are minimized. The review panel belongs to the administrative model and not the legal adversarial, due process model. It is clearly a useful tool for the hospital to review its diagnostic and therapeutic decisions, but it seems not to be the most effective tool for a lawyer to use in challenging the legal merits of a commitment. We reiterate, commitment is a legal decision and is perhaps most effectively challenged in a court of law.

A problem identified by many of the people interviewed was the length of time it took to resolve cases involving the hospital. Almost half these cases required in excess of two months from file opening to resolution. It would be to everyone's benefit if legal issues could be speedily resolved. One can understand the hesitation of therapeutic staff to begin a course of treatment which may, once in process, be terminated by the release of the patient. One can also clearly see the advantages for the patient of having his status clarified as soon as possible so that he is either released or forced to reconcile himself to the status of mental patient and, ideally, voluntarily submit to therapy.

The delays were not due to difficulty in getting court dates but primarily to the difficulties encountered in the work of the Mental Patients' Advocates themselves. This is in part a result of the heavy caseload carried by the

Mental patients' Advocate and perhaps thought should be given to a stricter system of priorization in accepting cases if resources cannot be expanded. However, a large part of the delay is inevitable. Because of the novelty and particular difficulties of this area of law, cases are not easily prepared. Clients are not always in a condition to be interviewed and assisted quickly. Documents cannot always be obtained speedily. And, the collection of evidence, especially in the form of medical testimony, is very time - consuming. Because commitment does not require due process, it is speedy. Perhaps as due process for mental patients becomes more common, access to evidence and the procedures for building cases will become more efficient. In any case, it appears that, at present, some delay is inevitable. But it is also clear that any means to minimize delay, without jeopardizing the integrity of patients' legal rights, should be vigorously sought.

Case Outcomes

Of patients seeking release, 63% received full discharge and an additional 18% were given extended leave (See Table 3). Five percent of the cases were dropped by the client and only about 3% resulted in continued commitment. In the remaining 11% of the cases, the outcome was unknown, either because the case was still in process or the Advocates lost contact with their clients.

For all other types of cases, which at the time of writing had proceeded to resolution, 74% had achieved the outcome desired by the client.[25] In short, it would appear that the patients bring to the lawyer fully legitimate cases quite apart from the question of commitment itself. And

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25 This excludes cases for which outcome was unknown.

Table 3: Outcomes of Cases

Type of case	Outcome: Clients objective achieved	Outcome: Clients objective not achieved or case dropped	Outcome: Outcome Unknown*
Release/ discharge	81%**	8%	11%
All others	74%	19%	7%

* Excluding cases in progress
** Including "extended leave" (when this is accepted by client) and discharge

clearly, many of the patients are able to use and benefit from legal services if they are made available and accessible to them. Perhaps we should re-emphasize the benefits for the mental patients of the resolution of these legal issues. As we have indicated, they are thus freed from the extra burden of such pressing but unresolved issues as divorce, custody, criminal matters and so on.

Representation of Group Interests and Community Education Activities

The rationale for this type of work was described earlier in this paper. Both of the Project's lawyers are active members of the Committee on Corrections and Institutions of the B.C. Branch of the Canadian Bar Association. The Committee is preparing a proposal for reform of the Mental Health Act which may take the form of a Bill to amend the Act. The Committee includes lawyers in private practice, members of the legal aid bar, members of the Law Faculties of the University of British Columbia and the University of Victoria, and lawyers employed by the Ministry of the Attorney General of British Columbia. One of the Project's lawyers is preparing an agenda of issues and law reform alternatives and is assembling and distributing the background materials for each meeting of the Committee.

A description of "test cases" undertaken by the project is included as Figure 2. It should be noted that the first two of these established the foundation on which much of the later individual casework was based. They established the clients' right to use counsel to question his committal and to use hospital records as evidence.

Many opportunities for establishing precedents have however been missed because of the hospital's willingness to discharge patients. If the courts never have an opportunity to render a judgement, fundamental issues may then be left unresolved.

As well as handling casework, the legal staff of the Project have had and are continuing to have considerable involvement with public legal education. The Project's lawyers have taught courses and given seminars for the Vancouver People's Law School (both in person and on videotape), the Canadian Mental Health Association, the Mental Patients' Association, the Ministry of Health of the Province of British Columbia, and the B.C. Association of Adlerian Psychology. The legal staff of the Project have also taught individual sessions of both undergraduate and graduate courses at Simon Fraser University and the Faculty of Law at the University of British Columbia, as well as a seminar to a group of Introductory Psychology students at a Richmond high school.

The activities of the Project in the area of public legal education have also included:

1. Mental Patients & the Law, a pamphlet published by the Vancouver People's Law School;
2. Law and Psychiatry in the Canadian Context, a two-volume school textbook edited by Professor David N. Weisstub of Osgoode Hall Law School and the Clarke Institute of Psychiatry;

3. The chapter on mental health law in the Law Students' Legal Advice Manual, a manual used by the law students who give summary legal advice to people who cannot afford private counsel at eighteen neighbourhood advice clinics throughout the Lower Mainland. These clinics are operated by the Greater Vancouver Law Students' Assistance Society under the supervision of a staff lawyer for the Vancouver Community Legal Assistance Society;
4. Civil Admissions to Mental Institutions in British Columbia, a copyrighted but unpublished manuscript;
5. Law Talk, a serial column published in numerous newspapers throughout British Columbia by the Vancouver People's Law School.

Representatives of the Project have appeared on cable television and radio open-line programs to discuss the issues in mental health law and are continuing to make such appearances on request. In addition, both the Project and individual cases handled by the Project have been the subject of segments of the CBC National News and the nationally-televised program "Ombudsman".

Figure 2

Test Cases Brought by Mental Patients' Advocate Project

1. A case establishing that a civilly-committed mental patient who has been deemed incapable of managing his affairs by the Director of the institution in which he is being held retains the right to apply to the Supreme Court for his release from the mental institution in his own name and without the approval of the person who has been appointed to manage his affairs.

2. Cases establishing that full discovery of their hospital files and medical records are available to persons seeking to be discharged from mental institutions by court order and that such persons can present live testimony (in addition to and instead of evidence by affidavit) at the hearing of their application for court-ordered release from custody.

3. The first Canadian case known to the legal staff of the Project in which a Supreme Court Justice ordered the release of a civilly-committed mental patient on an application for habeas corpus because the committal certificates were defective both in form and in substance.

4. A case challenging the right of an institution for the criminally insane to make acceptance of work assignments by patients a precondition of advancement to less restrictive forms of custody and challenging the right of the institution to pay patients who work within the institution far less than the Provincial minimum wage. In

the last funding year the case survived a battery of motions by the Government of British Columbia and the other Defendants seeking to have the action dismissed. The case also proceeded through discovery of documents and one day of examination for discovery. (One more day of examinations for discovery will be necessary before the case can be set for trial.)

5. A case testing the right of the doctors at an institution for the criminally insane to give non-emergency drug treatment to Order-in-Council patients without their consent.

6. A case testing whether it is lawful to keep a person apprehended for committal to a mental institution in jail until the committal can be perfected and arrangements made for a hospital bed to be available.

7. A case testing whether the staff of an institution for the criminally insane can intercept and open outgoing mail deposited in mail receptacles by patients. Apparently this practice was discontinued shortly after the advocate wrote a letter to the Executive Director of the institution saying that the client would sue for an injunction and damages unless the practice of intercepting and opening outgoing mail were to be discontinued immediately.

8. The first case seeking judicial review of the decision of a review panel constituted under the B.C. Mental Health Act to hold a hearing to determine whether a civilly-committed patient should continue to be detained. The

review panel had found that there was no evidence of mental disorder but had nonetheless ordered the continued detention of the patient. A Justice of the British Columbia Supreme Court quashed the decision of the panel saying that it was wrong in law, but sent the case back to the panel for further consideration rather than ordering that the patient be discharged. The Project is considering an appeal to the B.C. Court of Appeal against the decision to send the case back to the panel instead of ordering that the patient be discharged.

9. A case testing whether a person committed civilly from an institution for the criminally insane to a regional psychiatric centre with a population consisting primarily of prison inmates has the same rights of access to a review panel and to judicial review of his committed status as person committed to mental institutions from society at large.

Alternative Models for Service Delivery

Could the same service be provided through some other model for delivering legal aid? Prior to the initiation of the Mental Patients' Advocates Project the legal needs of the patients were served by a panel of volunteer private lawyers, one of whom visited the hospital every two weeks. They interviewed clients, provided summary legal advice and information, assisted with the filling out of legal aid application forms and occasionally represented patients.

Members of the hospital staff, members of the administration of the hospital and representatives of the Attorney General's Department of British Columbia indicated that they preferred this type of advocate. Accordingly, interviews were conducted with two lawyers now on the legal aid staff who had functioned as volunteer counsel at the hospital before the initiation of the Mental Patients' Advocates' Project. It was clear from the interviews that they had adopted a different model of advocacy from that of a mental patients' advocate. They tended most often to negotiate rather than litigate and to consult rather than confront. Where there were no clear problems on the face of a committal they expected the therapeutic judgement of the hospital to prevail and they did not litigate on the part of the patients. Their strategy of negotiation and consultation as a means of obtaining release for patients who sought it was based upon the erroneous belief that under existing legislation it would be extremely difficult to win release for these clients by way of Section 30 applications. Having had an opportunity to observe the Mental Patients' Advocates Project's success in securing release via Section 30, they now acknowledge that if they were to undertake this service again, they would change their past strategy. It seems clear that in terms of legal strategy a full-time specialist has, not surprisingly, many advantages over a part-time volunteer counsel.

As a matter of practical strategy the volunteer counsel in effect adopted primarily a therapeutic rather than a legal model for their practice. This is precisely what one would expect from people who, only periodically,

come into contact with a whole new field - that is, to work within the paradigm which characterizes that field. However understandable this may be, it compromises the independence of the advocacy and consequently confuses the role of the lawyer with that of the therapist or social worker.26

For cases not involving disputes with the hospital, the volunteer counsel obviously provided otherwise isolated mental patients with access to legal representation. It is a clear disadvantage, however, that those providing the representation are not practised and expert in dealing with these "peculiar" clients, and the problems associated with their status - in all areas of law from real estate to family. Without this expertise, they cannot provide their clients with the same level of service as a person who specialized in mental health law would be likely to provide.

A further disadvantage of the volunteer counsel system is its limited accessibility. The Mental Patients' Advocates' office is staffed at all working hours with a secretary/ receptionist. Access to counsel does not depend upon the patient making an appointment in advance, then organizing his schedule - largely determined by hospital routine - so as to be certain that he does not miss the bi-weekly clinic.

In retrospect, it is not surprising that the hospital staff and administrators and the Attorney General - who provides legal counsel to the hospital - prefer the

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26 Other studies have found the service of rotating duty counsel rather perfunctory.

volunteer counsel system. The volunteer counsel adapted to and co-operated with the therapeutic community in the hospital. However, in an adversarial relationship, as when a patient believes that he is illegally detained and the state wishes to continue to detain him, the approval of one's adversaries is not always the mark of the most effective of advocacy.

SUMMARY AND CONCLUSIONS

General Issues

We have argued that mental patients are in particular need of legal aid services. Civil commitment places in jeopardy people's fundamental rights, their liberty and physical autonomy; it denies them their status as full adult citizens. The consequences of hospitalization (what some have called a process of "mortification" - Goffman, 1961) and the stigma attached to the mental patients may serve to amplify rather than treat their "disorders".

Hospitalization, then, will raise new and important legal issues for the committed - issues concerning consent and treatment, rights to information, freedom of movement, freedom from job discrimination, and so on. In addition, mental patients are likely to have a wide range of legal problems, not directly related to their medical status, but which resulted from or, perhaps, precipitated their committal.

At the same time, the mental patient is almost completely powerless to voice his point of view. His designation, "mentally ill", challenges his credibility. The professionals who deal with the patient, psychiatrists, nurses, social workers, do not take his point of view, they do not base their actions on his determination of what is in his best interests. Instead, they impose their professional therapeutic judgment on the patient. Of course, this is

precisely their job. But we have reviewed some of the abundant literature which challenges the validity and reliability of psychiatric diagnosis, which makes evident the fact that mental illness is a complex and ill-defined phenomenon and which points inescapably to the possibility of improper detention as a normal, rather than exceptional, occurence. In any case, involuntary commitment is a legal procedure which cannot be determined, by fiat, by a medical diagnosis alone. That the commitment is involuntary signifies that there exists a dispute - a legal dispute - between the medical personnel and the patient.

We have also argued that the mental patient requires a special form of legal aid to ensure effective representation. The legal aid lawyer must have sufficient knowledge of the world of the mentally ill that he can, at least to some extent, empathize with his clients. And, of course, he must understand the Mental Health legislation and the mental patient's unique legal problems. In short, he must be a specialist. He must also be readily accessible, given the obvious physical and psychological constraints on the mental patients, their limited physical mobility and their lack of awareness of their legal rights and alternatives. In fact, he must be immediately available, certainly before the possibly inhibiting and repressive impact of hospitalization takes hold of the patient. Finally, he must be fiercly independent, a zealous advocate of the patient's self-defined interests. We have stressed this throughout the report because of our concern that the distinction, even the tension, between the medical/ therapeutic and legal/advocacy models be maintained. The

lawyer, however tempted he may feel, cannot select his cases upon a "medical" assessment of his clients. First, this is not his area of professional competence. Second, and most important, he would not be acting in accord with the canons of his own profession; that is, he would no longer be acting in behest of his clients. Indeed, by adopting the medical model, the lawyer would be "begging the question", failing his obligation. The lawyer must select his cases on their legal merits; he must act within the legal model. Only in this way will the legal representative stand as an effective counter-control, a constraint, to the relatively unrestrained power of the psychiatrist. And, only in this way are the psychiatrist and other mental health professionals freed from what is no doubt an unwelcome and disruptive obligation to act as judges and gaolers. Justification in terms of parens patriae may often mask the exercise of state "police powers". Zealous and independent legal advocacy may help ensure fair and proper procedure. Further, such advocacy may lead us toward identifying and remedying the many contradictions and ambiguities inevitable in mental health legislation. In summary, we concluded that the interests of all parties - mental patients, hospital staff and legal community - would be best served by an on-site, specialized and independent legal advocate. The active project in Vancouver provided the opportunity to test this general hypothesis.

The Vancouver Mental Patient's Advocate Project

Our evaluation of this project was concerned with both the general question of providing legal aid to mental patients and the more specific question of the appropriateness of the particular model instituted in

Vancouver, a pioneering project which provided, through the Vancouver Community Legal Assistance Society, free, on-site, specialized and independent advocacy (individual and group) to mental patients.

The very large caseload and the variety of cases dealt with confirmed that there existed a substantial and wide-ranging need for legal services among mental patients. Apart from the major category of cases pertaining to discharge and the few criminal (OIC) cases, the distribution and range of cases probably do not differ substantially from normal practice in civil legal aid clinics. This seems true as well for the range of actions taken by the advocates.

Furthermore, the high success rates achieved by the advocates, not only for release but also for all other matters, seem to indicate that the mental patients were able to make appropriate and effective use of the legal services offered them. The success of the advocates in achieving discharge (through Section 30) came as something of a surprise to the volunteer counsel who had provided legal services prior to the project. This may be taken as an indication of the importance of a) specialization and familiarity with the hospital setting, and b) fiercely independent advocacy - both of which serve to distinguish the project's approach from that of the volunteer counsel who preceeded them. No doubt this expertise and familiarity with the problems also enabled the project to pursue group advocacy through test litigation, direct suggestions for changes in the written law and community education. In particular, we pointed out some of the significant precedents established by the senior advocate through several test cases, cases which helped to clarify and fortify the Mental Health Legislation in B.C.

Overall, our data seem overwhelmingly to point to the need among mental patients for legal aid services and, generally, the appropriateness of this model of delivery. Nevertheless, a number of problems, some rather unexpected, demand attention if the project is to maximize its contribution to the patient, the therapeutic community and the legal community. The problems stem mainly from two sources: a) the perceptions of the hospital staff of the project; and b) the particular demands placed on the advocates by the nature of their practice.

While the hospital staff did apparently see many advantages to the project and shared many of its objectives, they also voiced concern about the intrusion of "unnecessary legalism" into the therapeutic setting and its potentially disruptive effect on the therapeutic relationship. As we have pointed out, perhaps even belaboured, such concerns stem from a lack of awareness or appreciation of the inevitable and probably desirable tension between medical and legal models. The hospital staff and the advocates are doing different jobs and they must do them differently. To some extent these concerns might be mitigated by more visible legal counsel for the hospital and by greater communication between hospital staff and project staff (something which has been improving over the past months).

While these problems were predictable, less predictable was the hospital's reluctance to allow cases to go to court; the vast majority of cases seeking release were discharged or given extended leave by the hospital. This has meant that the project's potential to achieve important

law reform, the clarification and improvement of Mental Health legislation, has not been fulfilled. Issues of fundamental human rights remain unresolved. Again, greater communication to hospital staff of the role of the advocates and more visible and accessible legal representation for the hospital may contribute to a fuller appreciation of the possible benefits of the project for all parties.

The second and perhaps even more difficult problem in implementing the model stems from the unique pressures on the project staff. As we indicated, one full-time lawyer has already been lost to the project largely because of the unique pressures associated with the job. The staff are isolated: their clients are unique at least in some ways and, sometimes difficult to handle or simply socially inept or unattractive; the hospital professionals are working within a very different framework; and few law colleagues have experience or expertise in the area. The director emphasized the moral and social support gained through the project's association with its carrier agency and the importance of the advocates' participation on the Committee on Corrections and Institutions of the B.C. Branch of the Canadian Bar Association. Nevertheless, it seems clear that the advocates must have unique personal and interpersonal skills to withstand the rigours of their practice.

The lack of collegial advice and support, the lack of precedent and the special demands of the client group also seem to mean long case-preparation time and, therefore, inevitable delay in seeing cases to their completion. The

project staff indicated, in particular, the delays involved in securing out-of-hospital psychiatrists to serve as expert witnesses. To a large extent, the problem of delay, while certainly unfortunate, may be unavoidable - until, at least, such projects receive more widespread acceptance, thereby creating a community of mental health law specialists.

In summary, the problems encountered are in large part the inevitable "growing pains" of a pioneering and fledgling project. Our findings, supported by a now large body of literature, lead us first to recommend that the project continue to pursue its very important objectives and, second, to hope that such projects become an accepted part of legal aid delivery more generally.

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LEGAL SERVICES SOCIETY ACT

CHAPTER 227

Interpretation

1. In this Act

"board" means the board of directors of the society;

"Crown" means the Crown in right of the Province;

"funded agency" means a person who receives money from the society to provide legal services but does not include a practising lawyer or notary public;

"law society" means the Law Society of British Columbia;

"lawyer" means a person entitled to practise under the *Barristers and Solicitors Act;*

"society" means the Legal Services Society established by this Act.

1979-15-1.

Society established

2. (1) A corporation called Legal Services Society is continued.

(2) The members of the society shall be the directors appointed under section 5.

1979-15-2.

Objects

3. (1) The objects of the society are to ensure that

(a) services ordinarily provided by a lawyer are afforded to individuals who would not otherwise receive them because of financial or other reasons; and

(b) education, advice and information about law are provided for the people of British Columbia.

(2) The society shall ensure, for the purposes of subsection (1) (a), that legal services are available for a qualifying individual who

(a) is a defendant in criminal proceedings that could lead to his imprisonment;

(b) may be imprisoned or confined through civil proceedings;

(c) is or may be a party to a proceeding respecting a domestic dispute that affects his physical or mental safety or health or that of his children; or

(d) has a legal problem that threatens

(i) his family's physical or mental safety or health;

(ii) his ability to feed, clothe and provide shelter for himself and his dependents; or

(iii) his livelihood.

1979-15-3.

Powers and capacity

4. (1) For the purposes of this Act, the society shall have all the powers and capacity of a natural person.

(2) The society is not an agent of the Crown or of the law society.

1979-15-4.

Board of directors

5. (1) The board shall consist of 14 directors.

(2) Seven directors, at least 2 of whom shall not be lawyers, shall be appointed by the Lieutenant Governor in Council, on the recommendation of the Attorney General.

(3) Seven directors, at least 2 of whom shall not be lawyers, shall be appointed by the benchers of the law society after consultation with the executive of the British Columbia branch of the Canadian Bar Association.

(4) The term of office of a director is 2 years after the date on which his appointment becomes effective.

(5) Notwithstanding subsection (4), 3 of the first appointments by the Lieutenant Governor in Council and 4 of the first appointments by the benchers of the law society shall be for a term of one year.

(6) A director shall not hold office for more than 6 consecutive years.

(7) Notwithstanding anything else in this section, a director whose term of office has expired may continue to hold office until his successor is appointed, and where a vacancy on the board exists for any other reason, the person or body who appointed the director to be replaced shall appoint a successor, and the person so appointed may hold office for the residue of the term for which his predecessor was appointed.

(8) The board shall control and direct the business of the society and may, by resolution, determine its own procedure.

(9) A director shall be reimbursed for his reasonable out of pocket travelling and other expenses incurred in the discharge of his duties and may be paid a fee for his services.

1979-15-5.

Executive committee

6. (1) The board shall at its first meeting in each fiscal year by resolution appoint an executive committee of not more than 5 directors, and may by resolution reconstitute the committee.

(2) The executive committee shall have between the meetings of the board all the powers of the board except

(a) the power to fill vacancies on or change the membership of a committee of the board; and

(b) powers excluded by resolution of the board.

1979-15-6.

Executive director

7. (1) The board may appoint an executive director and shall fix his salary.

(2) The executive director shall supervise, manage and administer the business of the society in accordance with the policy of the board and subject to its control and direction.

1979-15-7.

Staff

8. (1) The board or, if authorized by the board, the executive director, may appoint officers and employees and engage and retain specialists and consultants required to carry out the business of the society and may determine their remuneration and benefits.

(2) The *Public Service Act* and the *Public Service Labour Relations Act* do not apply to the society or its officers and employees appointed under this section.

(3) The Lieutenant Governor in Council may, by order, direct that some or all of the provisions of the *Pension (Municipal) Act* apply to some or all of the officers and employees of the society or of any funded agency designated by the society for the purposes of this section and the provisions of that Act shall apply accordingly, but the society may establish, support or participate in any one or more of

(a) a pension or superannuation plan; or

(b) a group insurance plan

for the benefit of its officers and employees and their dependents.

1979-15-8.

Persons providing legal services

9. Notwithstanding the *Barristers and Solicitors Act*, the society or a funded agency may employ, with or without remuneration, an individual who is not a lawyer or an articled student to provide services that would ordinarily be provided by a lawyer so long as the individual is supervised by a lawyer, but the individual may not appear as counsel in a court except with leave of the court.

1979-15-9.

Priorities and criteria

10. The society has authority to determine the priorities and criteria for the services it or a funded agency provides under this Act.

1979-15-10.

Privilege

11. (1) Information disclosed by a client or an applicant for legal services to a director, employee or agent of the society or funded agency is privileged and shall be kept confidential in the same manner and to the same extent as if it had been disclosed to a solicitor pursuant to a solicitor and client relationship.

(2) Where a civil or criminal proceeding is or may be brought against a person respecting his eligibility for legal services, subsection (1) does not apply to information respecting his eligibility.

1979-15-11.

Costs

12. (1) The court may award costs to an individual in a proceeding in which he has received legal services from the society or a funded agency notwithstanding that he has not paid and will not be liable to pay his counsel.

(2) Where costs are awarded under subsection (1) those costs shall be deemed to be assigned to the society and recoverable by it.

1979-15-12.

Company Act

13. (1) The *Company Act* and the *Society Act* do not apply to the society.

(2) Notwithstanding subsection (1), the Lieutenant Governor in Council may order that one or more provisions of the *Company Act* apply to the society.

1979-15-13.

Audit

14. The Auditor General or a person designated by him shall, at least once in each fiscal year, audit the books, accounts and financial affairs of the society.

1979-15-14.

Reports

15. The society shall, in respect of each fiscal year ending March 31, prepare a report respecting the operation of the society and an audited financial statement and shall, within 180 days after the end of the fiscal year, forward the report and financial statement to the Attorney General, who shall as soon as practicable lay them before the Legislative Assembly.

1979-15-15.

Offences

16. A person who by false representation of a material fact obtains a service under this Act that is ordinarily provided by a lawyer commits an offence and is liable to the fine specified in section 4 of the *Offence Act*.

1979-15-16.

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MENTAL HEALTH ACT

CHAPTER 256

PART 1

Interpretation

1. In this Act

"approved home" means a home selected and approved under the regulations made under this Act;

"court" means the Supreme Court;

"director" means a person who is appointed in charge of a Provincial mental health facility and includes a person authorized by a director to exercise a power or carry out a duty conferred or imposed on the director under this Act;

"father" includes the husband of the mother of a mentally disordered person born in wedlock;

"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 welfare or for the protection of others;

"mentally retarded person" means a person

(a) in whom there is a condition of arrested or incomplete development of mind, whether arising from inherent causes or induced by disease or injury, that is of a nature or degree that requires or is susceptible to medical treatment or other special care or training; and

(b) who requires care, supervision and control for his own protection or welfare or for the protection of others;

"mother" includes the wife of the father of a mentally disordered person born in wedlock;

"near relative" means a grandfather, grandmother, father, mother, son, daughter, husband, wife, brother, sister, half brother or half sister and includes the legal guardian of a minor and a committee having custody of the person of a patient under the *Patients Property Act;*

"observation unit" means a public hospital or a part of it designated by the minister as an observation unit;

"patient" means a person who, under this Act,

(a) is receiving psychiatric care and treatment; or

(b) is received, detained or taken charge of as a mentally disordered person or as an allegedly mentally disordered person;

"physician" means a medical practitioner;
"private mental hospital" means an establishment licensed under section 5;
"Provincial mental health facility" means a Provincial mental health facility designated under this Act;
"psychiatric unit" means a public hospital or a part of it designated by the minister as a psychiatric unit;
"public hospital" means an institution designated as a hospital under section 1 or 25 of the *Hospital Act*;
"resident of the Province" means a person who has resided in the Province for a period determined by the Lieutenant Governor in Council;
"society" means a society incorporated or registered under the *Society Act* to establish or operate facilities or services designed for the mental welfare of residents of the Province.

1964-29-2; 1968-27-2; 1969-17-1; 1973-127-3; 1974-106-Sch; 1976-33-96; 1979-22-22.

PART 2

Establishment of facilities and services

2. The Lieutenant Governor in Council may establish and maintain facilities and services for the examination, diagnosis and treatment of mentally disordered persons and the rehabilitation of patients and for that purpose may, by order, authorize the minister, for and on behalf of Her Majesty the Queen in right of the Province, to acquire, manage and operate property.

1964-29-3.

Designation of mental health facilities

3. (1) The minister may designate a building or premises as a Provincial mental health facility.

(2) The minister may designate a public hospital or a part of it, not being a Provincial mental health facility, as an observation unit or a psychiatric unit.

1973-127-4.

Transfer of facilities

4. The Lieutenant Governor in Council may by order transfer a Provincial mental health facility or service or a part of it to a society and shall in the order designate

(a) the conditions of the transfer of the property that constitutes the Provincial mental health facility or service or part of it;
(b) the number of persons who are to be appointed to the board of management of that society by the Lieutenant Governor in Council; and
(c) the requirements of inspection;

and he shall, in the order, give any necessary direction for the transfer of officers and employees who are public servants under the *Public Service Act* from the Provincial mental health facility to a society; but he may direct that, notwithstanding the transfer, the officers and employees shall continue in the public service of the Province.

1964-29-5; 1969-17-2; 1973-127-5.

Licensing of private mental health facilities

5. (1) The Lieutenant Governor in Council may, on application, license as a private mental health facility

(a) any private hospital licensed under the *Hospital Act;* and

(b) any community care facility licensed under the *Community Care Facility Act.*

(2) No person shall receive into or cause or permit to remain in a private house for gain or payment, a mentally disordered person unless the house is licensed under subsection (1).

1973-127-6.

Persons entitled to service

6. Subject to sections 12 and 18, every resident of the Province is entitled to receive service and accommodation in the facilities provided under this Act in accordance with this Act and its regulations.

1964-29-7.

Staff

7. For each Provincial mental health facility, a director, medical officers and other staff required may be appointed pursuant to the *Public Service Act.*

1964-29-10; 1973-127-22.

Powers and duties of directors

8. (1) A director shall ensure that

(a) each patient in a Provincial mental health facility is provided with professional service, care and treatment appropriate to his condition and appropriate to the function of the Provincial mental health facility and, for those purposes, may sign consent to treatment forms for a person admitted under section 20;

(b) standards appropriate to the function of the Provincial mental health facility are established and maintained; and

(c) the orders and directives of the minister are observed and performed.

(2) Subsection (1) (a) and (b) applies, with the necessary changes,

(a) to a person appointed under the regulations as an officer in charge of a psychiatric unit; and

(b) to a psychiatric unit.

1973-127-8; 1974-87-28; 1974-106-Sch.

Charges

9. The Lieutenant Governor in Council may fix daily charges for care, treatment and maintenance provided in a Provincial mental health facility.

1964-29-12.

Assessment committee

10. (1) The Lieutenant Governor in Council may appoint an assessment committee, consisting of 3 members, who shall hold office during pleasure and without remuneration.

(2) On the recommendation of the assessment committee, the charges levied for the care, treatment and maintenance of a patient may be modified or fully remitted for whatever period of time is designated in the recommendation.

1964-29-13.

Guardians and committees

11. (1) A guardian, committee or other person liable for payment for a patient's care, treatment or maintenance shall, on demand from the director of a Provincial mental health facility in which the patient is or has been receiving care, treatment or maintenance, make payments to the director in accordance with the rates fixed under this Act.

(2) The director may demand from a guardian, committee or other person liable to pay for a patient's care, treatment or maintenance any sum due at any time and may in default of payment sue on behalf of Her Majesty the Queen in right of the Province for the recovery of the sum in a court of competent jurisdiction.

(3) An action under this section shall be taken in the name of the director.

1964-29-14; 1973-127-22.

Admissions from penitentiaries

12. The director of every Provincial mental health facility shall ensure that no mentally disordered person is admitted into any Provincial mental health facility from a penitentiary, prison, jail, reformatory or institution under the jurisdiction and administration of Canada unless Her Majesty the Queen in right of Canada, by or through an officer having authority to act on her behalf, undertakes to pay all charges for care, treatment and maintenance of that person.

1964-29-15; 1973-127-22.

Expenses of conveyance

13. (1) When a patient is unable to meet the expenses of his examination, the procedures for his admission to a Provincial mental health facility or his conveyance to a Provincial mental health facility, the expenses are a charge on the local area in which he has residence.

(2) When a local authority for a local area in which a patient does not reside has advanced money to meet the expenses of the examination, the procedures for his admission to a Provincial mental health facility or the conveyance of the patient to a Provincial mental health facility, the local authority may recover the money as a debt from the local area in which the patient resided immediately before his admission.

(3) When any dispute arises as to the liability of a local area under this section, the board of arbitration appointed under the *Residence and Responsibility Act* shall hear the dispute and make a final decision on it.

(4) When a municipality incurs expenses for the examination, procedures for admission or conveyance of a patient to a Provincial mental health facility, the municipality may recover its expenses as a debt due from the patient.

(5) When a director incurs expenses for the examination, procedures for admission or conveyance of a patient to a Provincial mental health facility, that amount shall be converted to and may be recovered as a charge in an equal amount for care and treatment in the Provincial mental health facility.

(6) Section 1 of the *Residence and Responsibility Act* applies for the interpretation of this section.

1964-29-16; 1973-127-22.

Reciprocal arrangements

14. (1) The minister, with the approval of the Lieutenant Governor in Council may, on behalf of Her Majesty the Queen in right of the Province, enter into or cancel a reciprocal arrangement with the government of any other province of Canada for the assumption of all or part of the charges incurred by a resident of one province hospitalized in a public mental hospital or provincial mental health facility in another.

(2) The Lieutenant Governor in Council may, on behalf of Her Majesty the Queen in right of the Province, enter into or cancel an agreement with Canada for the sharing of costs of eare and treatment of mentally disordered persons.

1964-29-17; 1974-87-28.

Conveyance of patients

15. (1) The person who applies for the admission of a female person to a Provincial mental health facility shall arrange for a near relative or a female person to accompany the patient between the time of the application and her admission to a Provincial mental health facility.

(2) A person who is being conveyed to a Provincial mental health facility for admission and who is not detained or being conveyed under the *Criminal Code* (Canada) or under section 25 shall be kept separate from any person who is detained or being conveyed under the *Criminal Code* (Canada) or under section 25.

1964-29-18.

Saving

16. No person is liable in damages as the result of

(a) signing an application or laying an information;

(b) signing a medical certificate or making a report if he is a physician;

(c) signing an order if he is a judge;

(d) issuing a warrant if he is a justice; or

(e) transporting or taking charge of a person on the authority of applications and medical certificates which on their face are lawfully completed in good faith and with reasonable care.

1964-29-19; 1968-27-6; 1974-87-28; 1975-37-16.

Offence

17. (1) A person commits an offence punishable under the *Offence Act* who

(a) assists a patient to leave or to attempt to leave a Provincial mental health facility without proper authority;

(b) does or omits to do an act to assist a patient in leaving or attempting to leave a Provincial mental health facility without proper authority; or

(c) incites or counsels a patient to leave a Provincial mental health facility without proper authority.

(2) A person employed in a Provincial mental health facility or a private mental hospital or any other person having charge of a patient who ill treats, assaults or wilfully neglects a patient commits an offence punishable under the *Offence Act*.

1964-29-20; 1973-127-9.

PART 3

Accommodation

18. Notwithstanding anything in this Act, a director or person having authority to admit persons to a Provincial mental health facility shall not admit a person to a Provincial mental health facility if

(a) suitable accommodation is not available within the Provincial mental health facility for the care, treatment and maintenance of the patient; or

(b) in his opinion, the person is not a mentally disordered person or is a person who, because of the nature of his mental disorder, could not be cared for or treated appropriately in the facility.

1964-29-21; 1973-127-22.

Informal admissions

19. (1) The director of a Provincial mental health facility may admit any person to and detain him in the Provincial mental health facility where

(a) the person requests admission, if he has attained the age of 16 years; or

(b) on the request of a parent or guardian or, if a parent or appointed guardian is not available, of his nearest relative, if he is under the age of 16 years,

and the director is satisfied that the person has been examined by a physician who is of the opinion that the person is a mentally disordered person.

(2) A nurse in charge of a ward in a Provincial mental health facility shall

(a) ensure that each patient in the ward who was admitted under this section is enabled to communicate without delay to the director of the facility any desire that he may form to leave the facility; and,

(b) on learning that a patient in the ward who was admitted under this section desires to leave the facility, promptly notify the director of the facility of that desire.

(3) Within 72 hours of the receipt of notification, in any way,

(a) of the desire to leave the facility of a patient over the age of 16 years who was admitted under subsection (1); or

(b) of a request for the discharge from the facility of a patient under the age of 16 years who was admitted under subsection (1), made by any person entitled to apply for the patient's admission,

the director shall discharge the patient from the facility.

(4) Subsections (2) and (3) do not apply if the requirements for detention of the patient under section 20 have been fulfilled.

(5) A person who has attained the age of 16 years and who has been admitted to a Provincial mental health facility on his own application under subsection (1) (a) is, notwithstanding any rule of law relating to minors, deemed to have the capacity to make the application and an agreement for payment for maintenance and treatment in the facility and to authorize his treatment in the facility.

1964-29-22; 1968-27-7; 1973-127-10,11,12,22.

Involuntary admissions

20. (1) The director of a Provincial mental health facility may admit a person to and detain him in the Provincial mental health facility where he receives a written application that is accompanied by 2 medical certificates completed by 2 physicians in accordance with subsection (3) and is made

(a) by a near relative of the person;
(b) if there is no near relative of the person capable of acting and willing to act, anyone who has knowledge of the circumstances and the antecedents of the person or who has charge of the person at the time;
(c) a peace officer; or
(d) anyone who has reason to believe that the person is mentally disordered,

and signed not more than 14 days prior to the date of admission.

(2) An application under subsection (1) is not valid unless the applicant is 19 years of age or more and there is set forth in it

(a) the full name and address of the applicant;
(b) the relationship of the applicant, if any, to the person whose admission is applied for;
(c) the full name and address of the person whose admission is applied for; and
(d) the signature of the applicant and the date of the signature,

together with whatever other information may be required by the text of the form of application, which shall be prescribed and may be altered by the Lieutenant Governor in Council.

(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 applied for 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 applied for 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 applied for
    (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 welfare 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 applied for;
(b) the applicant;
(c) a partner of the applicant;
(d) engaged in the practice of medicine in partnership or associated with the physician who completes the other certificate;
(e) a person employed as an assistant by the applicant or the physician who completes the other certificate; or
(f) except as provided in subsection (5), a person who receives or who has an interest in the receipt of payments made on account of the maintenance of the person whose admission is applied for.

(5) A physician on the staff of the Provincial mental health facility to which a person is to be admitted or a consultant or other physician employed there is not

disqualified from giving a valid medical certificate by reason only of subsection (4) (f) unless the other certificate is given by such a physician or consultant.

(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.

Duration of detention

21. (1) A patient admitted under section 20 may be detained in a Provincial mental health facility until the anniversary of the date of his admission and he shall be discharged on that day 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 year; and

(b) from the expiration of any period of renewal under paragraph (a) for a further period of 2 years;

and so on for periods of 2 years at a time.

(3) Within a period of 2 months ending on the day on which a patient who has been detained in a Provincial mental health facility would cease under this section to be liable to detention in default of renewal under subsection (2), the director of the Provincial mental health facility or a physician authorized by him shall examine the patient and either discharge the patient or record a written report of the examination and include in it his reasons for concluding that the detention of the patient should be renewed and the report is a renewal of the authority for the detention of the patient.

(4) A person admitted to a Provincial mental health facility under section 20 shall, at any time after the expiration of 30 days from the date that he was admitted, on his request or on the request of a person on his behalf, be entitled to receive a hearing, of which he shall have at least 2 days' written notice, to determine whether or not he should be detained.

(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) the hearing shall be heard by

(i) a chairman who shall be appointed by the minister;

(ii) a physician who is appointed by and is on the medical staff of 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.

(6) The minister may reimburse a person appointed under subsection (5) 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 prescribe.

1964-29-24; 1973-127-14,22.

Temporary admissions to psychiatric unit

22. (1) The provisions of section 20 apply, with the necessary changes and so far as they are applicable, to the admission of a person to and his detention in a psychiatric unit.

(2) Section 20 (7) applies, with the necessary variations, to the apprehension and conveyance of a person to a psychiatric unit.

(3) Sections 19, 21, 26, 27, 28, 29, 30 and, so long as he may be detained therein, section 35 apply, with the necessary variations, to a patient in a psychiatric unit.

1968-27-9; 1973-127-15; 1974-87-28.

Emergency admissions with one medical certificate

23. Where

(a) the form of application referred to in section 20 has been completed in accordance with that section for a person; and

(b) a medical certificate has been completed by a physician; but

(c) there is no other physician qualified to give a second medical certificate by whom the person can be examined practising in the vicinity or within a reasonable distance of the place where the person resides,

the completed certificate, endorsed by the physician who gave it with a statement in the terms of paragraph (c), is sufficient authority for a person to apprehend and convey the person to a Provincial mental health facility or a psychiatric unit, for the admittance of the person in the facility or unit and for his detention there for examination for a period which shall not, unless the detention becomes otherwise authorized, exceed 72 hours.

1968-27-9.

Emergency procedures

24. (1) Where a police officer or constable is satisfied from his own observations or from information received by him that a person

(a) is acting in a manner likely to endanger his own safety or that of others; and

(b) is apparently suffering from mental disorder,

he may take the person into custody and take him immediately to a physician; and if the physician is satisfied that that person is a mentally disordered person and in need of care, supervision or control for his own protection or welfare or for the protection of others, he may be taken, on the certificate of the physician, to a Provincial mental health facility, a psychiatric unit or an observation unit; otherwise he shall be released.

(2) Where an application is made to him by anyone who appears to have good reason to believe that a person is a mentally disordered person and dangerous to be at large, a Provincial Court judge or, if there is no judge then available, a justice may, if he is satisfied that the procedures for the admission of the person to a Provincial mental health facility or psychiatric unit or for conveying him there for examination, cannot be

utilized without dangerous delay, issue a warrant in the form A in the schedule and that warrant shall be authority for the apprehension of the person concerned and for his conveyance and admission to a Provincial mental health facility, a psychiatric unit or an observation unit.

(3) The director of a Provincial mental health facility or the officer in charge of a psychiatric unit or an observation unit may admit a person in respect of whom he is satisfied a certificate has been issued under subsection (1) or a warrant has been issued under subsection (2) and may detain him in the facility or unit for a period which shall not, unless the detention becomes otherwise authorized, exceed 72 hours.

1964-29-27; 1968-27-10; 1970-24-1; 1973-84-12; 1973-127-22.

Prisoners and child care resource inmates

25. The Lieutenant Governor in Council, on receiving 2 medical certificates completed in accordance with section 20 concerning the mental condition of a person imprisoned or detained in any jail or lock up in the Province established under any Act, or in any child care resource as defined in the *Family and Child Service Act*, may order the removal of the person to a Provincial mental health facility, on which

(a) the warden or other person in charge of the jail, lockup or child care resource shall, in accordance with the order, cause the person to be conveyed to the Provincial mental health facility named in the order and send to the director of the Provincial mental health facility an application for admission in the form prescribed by the Lieutenant Governor in Council by regulation, together with copies of the medical certificates; and

(b) the person shall be detained in that or any other Provincial mental health facility the Lieutenant Governor in Council may order until his complete or partial recovery or until other circumstances justifying his discharge from the Provincial mental health facility are certified to the satisfaction of the Lieutenant Governor in Council, who may then order him back to imprisonment or detention if then liable thereto or otherwise to be discharged.

1964-29-28; 1973-127-17,22.

Direction and discipline of patients

26. Every patient detained in the Provincial mental health facility is, during detention, subject to the direction and discipline of the director and the members of the staff of the Provincial mental health facility authorized in that behalf by the director.

1964-29-29; 1973-127-22.

Application to court for discharge

27. (1) A person for whose admission to a Provincial mental health facility an application is made under section 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 application;

(b) an order prohibiting the admission of the person to a Provincial mental health facility pursuant to that application or any other application 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 applied for 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 application 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 an application 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 or 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.

Advice regarding reviews

28. (1) Immediately after the admission of a patient to a Provincial mental health facility under section 20, the director of the facility shall send in writing to the next of kin of the patient a notice setting forth the rights of the patient under section 27.

(2) If the director has no information with regard to the identity of the next of kin of the patient, subsection (1) is sufficiently complied with if the notice is sent to the Public Trustee.

1964-29-32; 1973-127-22.

Transfers

29. (1) When a transfer to another Provincial mental health facility is considered beneficial to the welfare of a patient, the director of the facility may, by agreement with the director of the other Provincial mental health facility, authorize the transfer and cause the patient to be transferred in accordance with his direction.

(2) Notwithstanding subsection (1), a patient detained in a Provincial mental health facility under section 25 may be transferred to another Provincial mental health facility only in accordance with an order of the Lieutenant Governor in Council made under section 25.

(3) A director of a Provincial mental health facility to whose facility a patient has been transferred under this section has authority to detain the patient and the time limited by this Act for the doing of any thing shall run as if the patient's detention were continuous in one facility.

1964-29-33; 1968-27-13; 1973-127-19,22.

Discharge

30. (1) The director of a Provincial mental health facility or the officer in charge of an observation unit may discharge a person from the facility or unit.

(2) An application or medical certificate made under this Act is not effective for use for the purposes of this Act after the discharge of the person with respect to whom the application or certificate is made.

(3) When a person is discharged from a Provincial mental health facility or observation unit other than by the operation of section 35 (3), the director of the facility or officer in charge of the observation unit shall, on receiving an application by or on behalf of the person, furnish the person with a certificate of discharge, signed by the director, in the form prescribed by the Lieutenant Governor in Council.

1964-29-34; 1973-127-22.

Leave

31. Subject to section 34, the director of a Provincial mental health facility may release a patient detained in the Provincial mental health facility on leave for designated

purposes for stipulated periods of time on the conditions the director may prescribe to the care of relatives of the patient or others capable of assuming responsibility for his care.

1964-29-35; 1973-127-22.

Approved homes

32. Subject to section 34, where the director of a Provincial mental health facility considers it beneficial to a patient he may cause the patient to be transferred from the Provincial mental health facility to an approved home on conditions the director may prescribe. The Lieutenant Governor in Council may make regulations for the selection and approval of approved homes and for the payment of the cost of the maintenance of the patients in them.

1964-29-36; 1973-127-22.

Continuance of detaining authority of patients on leave, etc. and recall

33. (1) For clarity, it is declared that the release of a patient on leave or his transfer to an approved home under section 31 or 32 does not, of itself, impair the authority for his detention and that authority may be continued, according to the same procedures and to the same extent, as if the patient were detained in a Provincial mental health facility.

(2) A patient who is on leave or has been transferred to an approved home shall, until discharged, be liable to recall either to the facility from which he was released or transferred or, if the transfer is authorized by the director pursuant to section 29, to some other facility, and the director of either facility may issue a warrant in the form B in the schedule for the apprehension of the patient and his conveyance to the facility to which he is recalled, provided that where a patient escapes from the custody of a person to whose care he has been released on leave or from an approved home, section 35 (3) applies.

1968-27-15; 1973-127-22.

Exception

34. Except as provided by order of the Lieutenant Governor in Council, sections 31 and 32 do not apply to a patient

(a) who was admitted to a Provincial mental health facility under section 25 or under the *Criminal Code* (Canada) and remains liable to imprisonment or detention in a jail, prison or training school; or

(b) who is detained in a Provincial mental health facility by reason of the *Criminal Code* (Canada).

1964-29-37.

Escapees

35. (1) Where a patient detained in a Provincial mental health facility leaves the facility without having been discharged under any other section of this Act, the director may, within 60 days after the date on which the patient leaves the facility, issue a warrant in form B in the schedule for the apprehension of the patient and his conveyance to the Provincial mental health facility and the warrant is authority for the apprehension of the patient and his conveyance to the facility.

(2) Where a warrant is issued under subsection (1), all peace officers and other persons designated by the director shall render any assistance required in the apprehension of the patient or the conveyance of the patient to the Provincial mental health facility.

(3) Except as provided in subsection (4), after the expiration of 60 days from the date on which the patient leaves the Provincial mental health facility under the circumstances set forth in subsection (1), he shall be deemed to have been discharged from the Provincial mental health facility.

(4) Where a patient detained in a Provincial mental health facility escapes from the facility under the circumstances set forth in subsection (1) while charged with an offence or liable to imprisonment or considered by the director to be dangerous to himself or others, notwithstanding that the period of 60 days has elapsed since the date on which he left the Provincial mental health facility, the director may issue a warrant in form B in the schedule for the apprehension of the patient and his conveyance to a Provincial mental health facility and the warrant is authority for the apprehension of the patient and for his conveyance to the Provincial mental health facility.

(5) Where a person escapes during the course of his removal or transfer to a Provincial mental health facility, both the director of the facility to which he is being removed or transferred and the director or officer in charge of the facility or unit from which he is removed or transferred have power to issue a warrant under this section.

(6) A patient detained in a Provincial mental health facility who leaves the facility, otherwise than on release on leave or transfer, without being discharged may be apprehended for the purpose of returning him to the facility, within 48 hours of his escape, notwithstanding that no warrant has been issued under this section and the person apprehended shall be conveyed in custody to the facility from which he escaped or to some other facility to which the director has authorized his transfer.

1964-29-38; 1968-27-16; 1973-127-22.

Transfer from other jurisdictions

36. On receipt of a written notification from the appropriate mental health authority of another province that a resident of the Province is in that other province and has been certified as being mentally disordered under legislation corresponding to this Act, the director of the Provincial mental health facility notified may agree that the person be returned to the Province for care and treatment and he may receive the person and detain him for 72 hours, during which time he shall either admit him to the Provincial mental health facility under this Act or release him at the end of that period.

1973-127-20.

PART 4

Regulations

37. The Lieutenant Governor in Council may make regulations including regulations

(a) prescribing forms;

(b) for the selection, approval and operation of approved homes;

(c) governing the establishment, development, maintenance and management of Provincial mental health facilities for the examination, diagnosis and treatment of mentally disordered persons and the rehabilitation of patients;

(d) governing the reports to be made in respect of, and the protection and custody of, patients detained involuntarily in psychiatric units and observation units;
(e) governing the transfer of patients to and from reciprocating jurisdictions;
(f) concerning the acquisition of property under this Act and its management;
(g) for standards for buildings designated as Provincial mental health facilities and for their furnishings and equipment;
(h) concerning the establishment and operation of a mental health clinic or service by a society, the standards of care to be observed in the clinic or in the provision of the service, their inspection and the rates or fees charged by the society;
(i) concerning the licensing of premises as private mental hospitals, the conditions of the licence and the designation of the provisions of this Act that are applicable to private mental hospitals;
(j) concerning follow up and after care services and rehabilitation programs for patients;
(k) governing boarding home care services;
(l) concerning the admission of patients to Provincial mental health facilities or a particular Provincial mental health facility, the care, treatment and maintenance of patients and the discharge of patients; and
(m) prescribing rules respecting the conduct of hearings under section 21.

1964-29-39; 1968-27-18; 1969-17-4; 1974-87-28.

SCHEDULE

FORM A

MENTAL HEALTH ACT

WARRANT FOR APPREHENSION OF A PERSON BELIEVED TO BE MENTALLY DISORDERED AND DANGEROUS TO BE AT LARGE

PROVINCE OF BRITISH COLUMBIA:
DISTRICT, COUNTY OR CITY OF .

To all Peace Officers in this District, County or City of

Application has been made to me this day by a person who appears to have good reason to believe that [*name of person*] is a mentally disordered person and dangerous to be at large.

You are therefore commanded, in Her Majesty's name, forthwith to apprehend [*name of person*] and to convey that patient to a Provincial mental health facility or an observation unit for admission to it.

Given under my hand and seal [*month, day*], 19 , at , in the district, county or city aforesaid.

(*Signed*) .....
(*Official qualification*) .....

FORM B

MENTAL HEALTH ACT

WARRANT FOR APPREHENSION OF PATIENT

PROVINCE OF BRITISH COLUMBIA:
DISTRICT, COUNTY OR CITY OF .

To all Peace Officers in this District, County or City of

[*Name of person*], who is a patient who is authorized to be detained and has been detained in a Provincial mental health facility, left the Provincial mental health facility without having been discharged.

You are therefore commanded, in Her Majesty's name, forthwith to apprehend [*name of person*] and to convey the patient to the Provincial mental health facility known as [*name of facility*].

Given under my hand and seal [*month, day*], 19 , in the district, county or city aforesaid.

(*Signed*) .....

(*Official qualification*) .....

1964-29-Sch.

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(b) each of the parties to the marriage in the presence of the marriage commissioner and the witnesses declares, "I solemnly declare that I do not know of any lawful impediment why I, *A.B.*, may not be joined in matrimony to *C.D.*", and

(c) each of the parties to the marriage says to the other, "I call on those present to witness that I, *A.B.*, take *C.D.* to be my lawful wedded wife (or husband)".

39. Section 19 is amended by striking out "on payment of $2.50, for the use of Her Majesty." and substituting "on payment of the prescribed fee,".

40. Section 30 is repealed.

41. Section 34 is amended by striking out "is under the influence of intoxicating liquor," and substituting "is impaired by drugs or alcohol,".

42. Section 40 is amended

(a) in subsection (3) by striking out "statutory declarations" and substituting "affidavits", and

(b) in subsection (4) by striking out "subsection (3)" and substituting "subsections (2) and (3)".

Medical Practitioners Act Amendment

43. Section 44 (2) of the *Medical Practitioners Act*, R.S.B.C. 1979, c. 254, is amended by striking out "subsection (5)" and substituting "subsection (1)".

Mental Health Act Amendments

44. Section 8 (1) (a) of the *Mental Health Act*, R.S.B.C. 1979, c. 256, is amended by adding ", 23, 24, 25 or 25.1" after "under section 20".

45. Section 23 is amended by adding "and for psychiatric treatment" after "detention there for examination".

46. Section 24 is amended

(a) in subsection (2) by adding "and psychiatric treatment in" after "conveyance and admission to", and

(b) in subsection (3) by adding ", examine and treat him for his condition" after "may detain him".

47. Section 25 is amended

(a) by renumbering it as 25 (1),

(b) by striking out "any jail or lockup in the Province established under any Act, or in any child care resource as defined in the *Family and Child Service Act*," and substituting "a correctional centre or youth containment centre under the *Correction Act* or a prison or lockup operated by a police force",

(c) in paragraph (a) by striking out "warden or other" and by striking out "jail, lockup or child care resource" and substituting "correctional centre, youth containment centre, prison or lockup", and

(d) by adding the following:

(2) Notwithstanding that no order has been made under subsection (1), the person in charge of a correctional centre or youth containment centre under the *Correction Act*, or prison or lockup operated by a police force, on receiving 2 medical certificates in accordance with section 20 concerning the mental condition of a person imprisoned or detained in the correctional centre, youth containment centre, prison or lockup, may authorize the transfer of the person to a Provincial mental health facility and the director of the Provincial mental health facility may admit the person to the facility where he receives from the person in charge of the correctional centre, youth containment centre, prison or lockup an application for admission in the form prescribed under subsection (1) (a) together with copies of the 2 medical certificates.

(3) Where a person is authorized to be transferred and is admitted under subsection (2), he shall be detained in the Provincial mental health facility until his complete or partial recovery or until other circumstances justifying his discharge from the facility are certified to the satisfaction of the director who shall,

(a) where the person is not liable to further imprisonment or detention, discharge him, or

(b) where the person is liable to further imprisonment or detention, return him to the correctional centre, youth containment centre, prison or lockup from which he was transferred.

(4) Where a person is detained in a Provincial mental health facility under subsection (1) or (3), the director may authorize that the person receive care and psychiatric treatment appropriate to his condition.

48. The following is added after section 25:

Detention under *Criminal Code*

25.1 Where, under the *Criminal Code*, a person is found to have been insane at the time that he committed an offence or is found unfit on account of insanity to stand his trial and the person is ordered to be detained in a Provincial mental health facility, he shall receive care and psychiatric treatment appropriate to his condition as authorized by the director.

Deemed consent

25.2 Where a person is detained in a Provincial mental health facility under section 20, 23, 24, 25 or 25.1, and notwithstanding that no order respecting the person has been made under the *Patients Property Act*, treatment authorized by the director shall be deemed to be given with the consent of the person.

49. Section 29 (2) is repealed and the following substituted:

(2) Notwithstanding subsection (1), a person detained under section 25 may be transferred to another Provincial mental health facility only with the approval of the Lieutenant Governor in Council or, where the person is detained under section 25 (2), with the authorization of the person in charge of the correctional centre, youth containment centre, prison or lockup from which he was transferred.

Mineral Resource Tax Act Amendments

50. The definition of "mine" in section 1 of the *Mineral Resource Tax Act*, R.S.B.C. 1979, c.263, is repealed and the following substituted: