BRITISH COLUMBIA REVIEW BOARD

IN THE MATTER OF PART XX.1 (Mental Disorder) OF THE CRIMINAL CODE R.S.C. 1985 c. C-46, as amended S.C. 2005 c. 22

REASONS FOR DISPOSITION
IN THE MATTER OF

EDMOND ALYER WHITE

HELD AT: Forensic Psychiatric Hospital
Port Coquitlam, BC
May 17, 2017

BEFORE: ALTERNATE CHAIRPERSON: A. MacPhail
MEMBERS: Dr. L. Grasswick, psychiatrist
A. Markwart

APPEARANCES: ACCUSED/PATIENT: Edmond Alyer White
ACCUSED/PATIENT COUNSEL: D. Abbey
DIRECTOR AFPS: Dr. M. Khan, P. Gill
DIRECTOR'S COUNSEL:
ATTORNEY GENERAL: L. Hillaby

INTRODUCTION AND BACKGROUND

[1] On May 17, 2017 the BC Review Board held an annual hearing to review the disposition of Edmond Alyer White. At the conclusion of the hearing the Board reserved its decision. On May 23, 2017, the Board granted Mr. White a conditional discharge, on the same terms and conditions as his previous order.

[2] Although we have considered all the evidence on the record, for the purpose of these reasons we refer only to that evidence which is necessary to our decision.

[3] Mr. White is now 51 years old. He is before the Board as a result of a verdict of not criminally responsible on account of mental disorder (NCRMD) dated May 6, 2011 in respect of charges of assault, assault with a weapon, and possession of a weapon. The index offences occurred on October 1, 2010. While waiting in a food line at a local church, Mr. White was yelling and disruptive. He became angry and aggressive when he was confronted by two other patrons of the food service. He pulled out a BB gun, pointing it at one of the people who confronted him, stating “I’ll blow you away”. He was subdued by persons at the scene and subsequently arrested.

[4] Mr. White’s mother died when he was seven years old years old. He and his three siblings were placed in foster care. Mr. White apparently had a good relationship with his foster mother, but moved out when he was 13 and lived independently. Since that time he has lived an itinerant life, working at various temporary jobs, and living on his own, often on the street or, as in the period before the index offence, camping in the bush or forest.

[5] Mr. White has a lengthy history of mental illness that likely emerged when he was about 19. He was first connected to the Surrey Mental Health team at that time. He attended appointments very infrequently and was habitually noncompliant with his medications. He has been admitted to hospital for psychiatric purposes many times over the ensuing years, usually after presenting himself or being brought to the hospital emergency room in a state of paranoia, experiencing auditory hallucinations, and accusing people of trying to harm him. At the date of the index offences, Mr. White was being followed by Surrey Community Mental Health services. He has been consistently difficult to engage in treatment, and has exhibited no insight into his mental health difficulties.

Consequently, he has been noncompliant with prescribed medication. Attempts to treat him under the extended leave provisions of the Mental Health Act have been unsuccessful.

[6] At the time of the index offence, Mr. White suffered from symptoms of persistent paranoia arising out of his primary diagnosis of schizophrenia. These included delusions concerning murdered women and fears of harm from gang members. He experienced delusions about hearing gunshots and was a frequent caller to 9-1-1 emergency services to report incidents that were delusional in nature. He also voiced numerous nonexistent physical complaints.

[7] Mr. White has only one conviction, for marijuana use, in addition to the index offences. There are no reports of other violent acts, but he had a longstanding practice of carrying weapons in order to protect himself from bears and dogs when he was living in the woods, but also to protect himself from attacks by other people. This practice was rooted in his chronic psychotic delusions.

EVIDENCE

[8] Mr. White has been in the community on a conditional discharge since May 8, 2013. He has resided in various phases of the Community Transition Care Program (CTCP) on the Riverview grounds. He has progressed quite slowly through these phases, as he has been anxious about moving to a less supported environment. He agreed to try the Community Training Apartment Program after being assured that he would be supported by daily visits, and could return to the CTCP at any time if he became overwhelmed. He had a number of month long stays in the “training apartment”, from July 2016 until April 2017. These stays went well. He remained compliant with his medications and attended programs both at the CTCP and in the community. He then moved to a semi-independent living apartment on May 1, 2017, just prior to this hearing. Even in this apartment, Mr. White has been visited daily by staff, and has managed the transition well.

[9] Mr. White’s diagnosis is schizophrenia, and alcohol, cannabis and cocaine use now in remission. He is also diagnosed with obesity, phrenic nerve and diaphragmatic paralysis related to past trauma. Over the past 1½ years, Mr. White has been investigated for a variety of physical symptoms, including being found unconscious and taken to hospital, feeling dizzy, fatigued and tired, with no specific cause or treatment identified. He has seen a cardiologist and his family doctor to try to address his physical health concerns.

[10] Mr. White's insight into his mental illness remains partial and fluctuates. While he sometimes acknowledges the positive impact of his medications on his mental illness, at other times he continues to believe that he suffered from schizophrenia because of his poor living conditions, lack of food and from mold poisoning, and that his schizophrenia has now been cured. Dr. Khan has referred Mr. White for a psychological assessment to determine his neurocognitive functioning.

[11] Dr. Khan testified that Mr. White is a gentle and pleasant person. However due to his limited insight into his mental illness, as well as the need for and benefits of medication, Dr. Khan was strongly of the view that Mr. White would be unlikely to continue with his medication without supervision. For over 25 years prior to the index offence, Mr. White had on-going contact with the civil mental health system and demonstrated his unwillingness to comply with treatment recommendations. Without the support that he now receives from forensic services, it is highly likely that he will be unable to cope with living alone, may well become homeless again and will stop taking his medications. He will then become psychotic, which will put him at risk for violence. Dr. Khan testified that Mr. White's psychiatric condition is stable but fragile. He has little insight into his mental illness and is only passively compliant with his medication regime, largely out of fear of being returned to FPH. At times Mr. White says that he would continue with his medications if he received an absolute discharge, but at other times says that he would discontinue them.

[12] Mr. White currently benefits from extensive support from the Surrey Forensic Psychiatric Clinic and the Cottages program. He has been very reluctant to move through the phases of gradual independent living, and has required significant support to do so. Mr. White has limited support in the community. He has some contact with a sister who lives in Abbotsford, but she is not able to provide a place for him to stay. He has a female friend who he sees once or twice a week. His relationship with her is unclear, but he does not want to live with her. In the past she has encouraged him not to take his medication, although this may have changed recently. Mr. White testified that he is very attached to his church. He attends regularly and reads from the Bible every day. It may be that his church could provide some support, but no support has been identified and it is not clear that this support would be entirely positive. One of the church members has previously advised Mr. White that he should stop his psychiatric medications as they may be affecting his heart and be causing his recent medical problems.

[13] Mr. White has no plans for living independently should he be given an absolute discharge. He would be connected to the Surrey Mental Health team, as he was at the time of the index offence. He would lose his access to a subsidized apartment, and has no strategy for finding an apartment that he can afford on his PWD benefit. No assistance from Surrey Community Mental Health has been explored.

[14] Mr. White gave evidence to the Board. He was tentative about his diagnosis, saying “apparently they said schizophrenia”, but that he was not sure what that was. He said that he does hear a voice once in a while, but it is God speaking to him. He thought that schizophrenia is “a bunch of voices talking to him”. Even though he is taking his medications, he still hears the voices once in a while. He goes to church and others at the church say that God speaks to them as well.

[15] Mr. White said that he would like to reduce the dose of Clozapine he takes at night as he believes that it is responsible for his breathing problems. He recognized that the medications reduce his ability to hear voices, but said that he doesn’t mind hearing God’s voice once in a while. He talked about the variety of medical problems he was experiencing at the time of the index offence and thought that they played a role.

[16] Mr. White said that he very much liked the apartment he was now in. He said it was the best place he had been in in his life. He is eating well and taking herbal medicines that he thinks contribute to his physical health and he is losing weight. He wants to stay on his mental health program and continue to access PWD benefits until he has dealt with his physical health problems. If he received an absolute discharge he didn’t know where he would live and would “most likely” continue to take his medications. He would like his dose of Clozapine lowered because he is concerned about his breathing problems.

ANALYSIS AND DISPOSITION

[17] All parties submitted that Mr. White should be conditionally discharged, on the same terms and conditions as his current disposition.

[18] Section 672.54 provides that in considering the appropriate disposition, the Board shall take into account the safety of the public, which is the paramount consideration, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused.

[19] The Board must first consider whether Mr. White constitutes a significant threat as defined by Section 672.5401 of the *Criminal Code.* A person is a significant threat if they are "a risk of serious physical or psychological harm to members of the public … resulting from conduct that is criminal in nature but not necessarily violent." If they do not pose such a threat, they are entitled to be absolutely discharged. If they do pose a significant threat to the safety of the public, we must then determine the necessary and appropriate disposition.

[20] We must first address the threshold question of significant threat. Dr. Khan testified that Mr. White continues to present with limited insight into his condition. He is not certain that he still has schizophrenia although he does recognize that his medication affects the voices that he used to hear. He expects to continue taking his medications, but would like to reduce them. Mr. White has not expressed any violent ideation or intent and does not endorse any psychotic or paranoid symptoms. He acknowledges that he continues to hear the voice of God, but not the multiple voices he used to hear. He reports a positive view about his future and a desire to progress towards living independently in the community. He has rejected his girlfriend's advice to stop taking his medication and indicates that while his ultimate goal might be to live with her, he does not wish to do so if she continues to push him too much to cease taking medication.

[21] As noted in previous Board decisions, Dr. Khan's risk assessment describes a long-term history of noncompliance and of multiple admissions to psychiatric hospitals. Management in the community was not successful. Since he came under Review Board jurisdiction in 2011, Mr. White's mental health has gradually and steadily, but slowly, improved. Dr. Khan's main concern continues to be Mr. White's lack of full insight into his medical condition and his belief that he has been cured. He is not taking medication out of any conviction that it will help maintain his present stability. His difficulty in learning and issues with his memory will make an immediate move to living independently in the community difficult and stressful.

[22] Mr. White has a lengthy history of serious mental illness, absence of insight, and noncompliance with treatment. He previously led an itinerant and marginal lifestyle that led to neglect of his mental and physical health. He has a history of acquiring weapons in order to protect himself from imagined threats. His insight into his illness remains markedly limited and he continues to experience residual symptoms.

[23] Living independently in the community, he would be exposed to drugs and alcohol, and consequently in danger of relapse. He will find sustaining full employment and living independently to be difficult and stressful, which will increase his risk of experiencing psychotic symptoms and the possibility of relapse to using illicit drugs.

[24] By history, when he decompensates, Mr. White lives a disorganized lifestyle. The index offences were psychotically driven. His propensity to arm himself for self-defence purposes poses a serious risk of grave physical or psychological harm to any victim who becomes enmeshed in his delusional belief system. He still does not have a good understanding of the risk he poses, or of the development of his illness.

[25] At the moment, Mr. White does not have any discharge plan. He is content to remain where he is and to work to implement the plan developed by his treatment team.

[26] We have concluded that Mr. White remains a significant threat as defined by s. 672.5401 of the *Criminal Code*. There is a real risk that he could decompensate if absolutely discharged, and return to psychotic behaviour that constitutes a serious risk of harm to members of the public. Mr. White is doing well in his present environment and is expected to continue his gradual improvement.

[27] At the same time, the Board acknowledges that should Mr. White continue to incrementally move forward toward stability in his transition to the community he will likely approach the point of no longer meeting the threshold of risk required to maintain Review Board jurisdiction. His only violent offence occurred in 2010, since then he has had no further violent criminal behaviour. He is now moving towards the stability he needs to maintain stable mental health. In the next year it would be highly desirable if he could move to a stable independent living situation with a referral made for ongoing support from community mental health services.

[28] In the circumstances, a conditional discharge as proposed by the parties, on the same terms presently in force, is necessary and appropriate.

Reasons written by A. MacPhail, with A. Markwart concurring

DISSENT – Dr. L. Grasswick

[29] Despite the joint submissions of the parties that Mr. White should be discharged on conditions, the Board is not bound by the recommendations of the parties. My colleagues found that Mr. White remained a significant threat to the safety of the public.

Based on the totality of the evidence, I respectfully disagree. I am unable to find that Mr. White meets the jurisdictional threshold and would have granted an absolute discharge.

[30] Although Mr. White was praised by his treatment team for his cooperative attitude, for attending appointments, compliance with medications, participation in groups, and attendance at church, Dr. Khan noted in his psychiatric report (tab 29) that Mr. White was “stable but fragile” and “marginally stable” (paragraph 32).

[31] In summarizing the risk variables at page 8 of his report (tab 29), Dr. Khan wrote the following:

> “The treatment team does anticipate that if he is given an absolute discharge and if he had to live alone he won’t be able to cope with the day-to-day stress. He will discontinue his medication. He will start having psychotic symptoms and he will start living in the bushes again and that will result ultimately in him to be in a very serious situation where his health and life will be at stake. His risk of getting psychotic is high if he discontinues his medication that will ultimately put him at risk of violence.”

[32] In his *viva voce* evidence, Dr. Khan was of the opinion that Mr. White might not follow through with voluntary treatment with a civil mental health team. Mr. White is compliant because he is given structure. If the constant support is withdrawn, Mr. White might attend one or two sessions at civil mental health. He might not get the same support as is provided by forensic services. Dr. Khan noted there has been no contact with civil mental health. It was the treatment team’s plan to support Mr. White and see how he does in the next year while he is residing in SIL (semi-independent living).

[33] When asked about Mr. White’s negative and antisocial attitudes respecting treatment, Dr. Khan stated there were none. Mr. White follows directions. Dr. Khan described him as a gentle person. He is not a very vocal or assertive person. Dr. Khan acknowledged that Mr. White does not have a long-standing history of aggressive behaviour, and he has not demonstrated any violence for 7 years.

[34] Dr. Khan was asked about Mr. White’s criminal history. Dr. Khan noted that the index offence, which took place when Mr. White was 45 years old, was his first violence offence. He was arrested in his 20’s for possession of marijuana. When psychotic and disorganized, Mr. White called 911 on multiple occasions. Mr. White also didn’t show up for a bail hearing.

[35] Dr. Khan was asked about the level of risk Mr. White poses. Dr. Khan was of the opinion that if Mr. White was compliant with his medications, his risk of violence was mild to moderate. Dr. Khan wasn't sure if the risk was significant. If Mr. White lacked support, because of his mental illness and lack of insight, Dr. Khan opined Mr. White might pose a mild to moderate risk to the public in the future.

[36] Mr. White testified that the reason he asked for a conditional discharge was so he could continue with his mental health treatment. He said his oral medication (clozapine) and the injectable medication (Consta) make him feel normal. While he believes the clozapine causes breathing problems, it also lowers his ability to hear the voice, and it gets louder if he doesn't take it. He did express a desire to reduce the night time dose of clozapine. He had no objection to the Consta. Mr. White has a family physician and sees her for physical problems. He is committed to managing his physical health.

ANALYSIS

[37] The Board is obliged by law (s. 672.54, *Criminal Code*) to absolutely discharge Mr. White unless he is a "significant threat", defined by s. 672.5401 of the Criminal Code as:

> "…a risk of serious physical or psychological harm to members of the public – including any victim of or witness to the offence, or any personal under the age of 18 years – resulting from conduct that is criminal in nature but not necessarily violent."

[38] There are two appellate decisions from Ontario which have endorsed the interpretation of jurisdictional threshold as sent out in Winko.

[39] In **R. v. CARRICK**, 2015 ONCA 866, the Ontario Court said:

> [T]he threat posed must be more than speculative in nature; it must be supported by evidence. The threat must also be "significant", both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A minuscule risk of a grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold. Finally, the conduct or activity creating the harm must be criminal in nature. [Citations omitted.]

[40] In short, the "significant threat" standard is an onerous one. An NCR accused is not to be detained on the basis of mere speculation. The Board must be satisfied as to

both the existence and gravity of the risk of physical or psychological harm posed by the appellant in order to deny him an absolute discharge. (*paras 16-17*)

[41] In **R. v. MARZEC**, 2015 ONCA, 658, the Court commented:

> The Board's concern seems to be that because the appellant has not yet lived outside of the hospital, he is "untested" in the community. Having him live outside of the hospital would indeed allow for the Board to assess the degree to which the appellant's hospitalization is responsible for his stability.

[42] Such an approach, however, would erroneously place the onus on the appellant to prove that he is not a risk before he is entitled to an absolute discharge. *(paras 29-30)*

[43] The Court concluded that:

> The only reasonable conclusion – one that is supported by the totality of the evidence – is that the appellant does not pose a significant risk of harm. **The Board appears to have ordered a conditional discharge out of an abundance of caution. That is not the legal test**. As per *Winko,* if the appellant does not pose a significant risk to the public, the Board must order an absolute discharge. *(emphasis added*) *(para 33)*

[44] Mr. White was first granted a conditional discharge on May 28, 2013. He started residing at the CTAP (Community Training Apartment Program) on May 1, 2017. Dr. Khan wants to see him tested in SIL for the next year. Mr. White has already been tested in the community for 4 years. He has demonstrated that, with mental health support, he can maintain his mental stability.

[45] Mr. White is appreciative of the assistance forensic services have offered him. He has worked with his treatment team. He testified at the hearing that he wanted to continue with his mental health treatment. There was no evidence to suggest that Mr. White would not establish a similar therapeutic relationship with a civil mental health team.

[46] If given an absolute discharge, Mr. White would not be evicted from the SIL placement. Dr. Khan testified that Mr. White might be there up to 3 months. It was Ms. Gill's testimony that he could be housed there for 3 months.

[47] Mr. White should be commended for the significant progress he has made. He is in a vastly different situation now than at the time of the index offence with respect to his mental state, compliance to medication, cooperation with his treatment team, financial situation, and accommodation. During the approximately 25 years he was burdened by psychotic illness, the only known incidence of violence was the index offence. Mr. White

was known to carry replica handguns and reportedly had a preoccupation with weapons. There were no references in the treatment team's reports about current fascination with weapons.

[48] That Mr. White will become psychotic again is quite possible. Whether violence flows from the psychosis and he poses a real risk of significant psychological or physical harm that is criminal in nature, based upon his history of violence, is speculative. Given the totality of the evidence, I find that Mr. White does not meet the jurisdictional threshold and as such would have granted an absolute discharge.

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