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Havens (No. 2), 2009 BCHRT 61

IN THE MATTER OF THE *HUMAN RIGHTS CODE*
R.S.B.C. 1996, c. 210 (as amended)

AND IN THE MATTER of a complaint before
the British Columbia Human Rights Tribunal

B E T W E E N:

J and J on behalf of R

COMPLAINANT

A N D:

Her Majesty the Queen in right of the Province of British Columbia as
represented by the Ministry of Children and Family Development (Community
Living British Columbia) and Cari Havens

RESPONDENTS

REASONS FOR DECISION

Tribunal Member:	Lindsay M. Lyster
Counsel for the Complainant:	Peter T. Busch
Counsel for the Respondents:	Robert Horricks
Dates of Hearing:	April 16 – 17, 2007, and May 21 – 23, 2008

I INTRODUCTION

[1] J filed a complaint against Her Majesty the Queen in right of the Province of British Columbia as represented by the Ministry of Children and Family Development (Community Living British Columbia) and Cari Havens. J alleged that the respondents discriminated against her son, R, on the basis of mental disability in respect of a service customarily available to the public, contrary to s. 8 of the *Human Rights Code*, when they denied R support services. R has a chronic neurodevelopmental disability, but the respondents determined that he did not meet the eligibility criteria employed by them.

[2] In a preliminary decision, the Tribunal decided to refer to J and R by initials, and I have continued that practice in this decision: *J and J obo R v. B.C. (Min. of Children and Family Development) and Havens*, 2006 BCHRT 449 (the “preliminary decision”).

II OUTLINE OF DECISION

[3] In this decision, I first set out the allegations made by J in the complaint and representative complaint forms she filed with the Tribunal. I then note the respondents’ denial of any discrimination, but address the substance of their response to the complaint as necessary in the course of the analysis.

[4] I then set out the statutory provisions relevant to this complaint, first from the *Code*, and then from the *Community Living Authority Act*. Having done so, I summarize the evidence about those policies and practices of the respondents that are relevant to the complaint.

[5] Next, I set out the evidence about J and R, and J’s application to Community Living British Columbia (“CLBC”) for services on R’s behalf. I then review the expert evidence about the concepts relevant to the complaint, especially “developmental disability” and “mental retardation”, and the many assessments of R’s condition.

[6] The next section of the decision constitutes the discrimination analysis. In it, I determine if J has established that the respondents discriminated against R on the basis of mental disability in denying the benefits sought. For the reasons given in that part of the

decision, I conclude that discrimination has been established as against the Ministry and CLBC, but not Ms. Havens.

[7] Finally, I determine what remedies should be ordered to remedy the discrimination established.

III THE COMPLAINT

[8] In her complaint, J states that R has a “chronic health (mental disability) problem” known as Noonan Syndrome (also referred to as “Noonan’s Syndrome”). She alleges that the respondents refused to provide R with support services for social and community development skills because R has an IQ over 70. She alleges that support services are only provided to children with Noonan Syndrome if they have an IQ of 70 or lower, but that support services are not withheld from other children with other “chronic mental health problems”, such as autism and Asperger’s Syndrome, who have an IQ over 70. As a result, J alleges that children such as R are denied the full benefits of the programs delivered by CLBC.

[9] J further alleges that the respondents failed to consider other information, such as R’s Individual Education Plan (“IEP”), that indicated that R had weak social skills, was very immature, and experienced anxiety in social situations. She further alleges that the standard employed by the respondents fails to consider the individual characteristics of children with Noonan Syndrome which make them particularly vulnerable in social and community situations. Those characteristics include short stature, widely spaced and down-slanted eyes, and other distinctive facial features.

[10] J alleges that the standard applied by the respondents acts as a disincentive to parents and children with Noonan Syndrome to maximize their IQ potential, because if they do so, and their IQ exceeds 70 as a result, services are withdrawn.

IV THE RESPONSE TO THE COMPLAINT

[11] The respondents deny any discrimination. I address their response and defences to the complaint as necessary in the course of my analysis.

V APPLICABLE LEGISLATION

The Human Rights Code

[12] The complaint is filed under s. 8(1) of the *Code*, which provides:

- 8(1) A person must not, without a bona fide and reasonable justification,
- (a) deny to a person or class of persons any accommodation, service or facility customarily available to the public, or
 - (b) discriminate against a person or class of persons regarding any accommodation, service or facility customarily available to the public

because of the race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex, sexual orientation or age of that person or class of persons.

[13] This, and all provisions of the *Code*, must be interpreted in light of its statutory purposes, which are set out in s. 3:

- 3 The purposes of this Code are as follows:
- (a) to foster a society in British Columbia in which there are no impediments to full and free participation in the economic, social, political and cultural life of British Columbia;
 - (b) to promote a climate of understanding and mutual respect where all are equal in dignity and rights;
 - (c) to prevent discrimination prohibited by this Code;
 - (d) to identify and eliminate persistent patterns of inequality associated with discrimination prohibited by this Code;
 - (e) to provide a means of redress for those persons who are discriminated against contrary to this Code.

The Community Living Authority Act

[14] CLBC is a Crown Agency which was created by the *Community Living Authority Act*, S.B.C. 2004, c. 60 (the “*Act*”). CLBC (referred to in the *Act* as the “authority”) provides “community living support services” under the authority of the *Act* and the *Community Living Authority Regulation* (B.C. Reg. 231/2005) (the “*Regulation*”). CLBC

took over responsibility for the provision of such services effective July 1, 2005, prior to which, they had been provided by the Ministry of Children and Family Development.

[15] “Community living support” is defined in s. 1 of the *Act* to mean any of the following:

- (a) support and services to children and adults with developmental disabilities;
- (b) support and services to families to assist them in caring for a child or an adult with a developmental disability;
- (c) support and services to adults, other than those described in paragraph (a) or (b), who, on the date that this Act comes into force, are receiving community living services ...;
- (d) support and service to other prescribed persons.

[16] “Developmental disability” is defined in the same section of the *Act* as follows:

“developmental disability” means significantly impaired intellectual functioning that

- (a) manifests before the age of 18 years,
- (b) exists concurrently with impaired adaptive functioning, and
- (c) meets other prescribed criteria.

[17] CLBC’s duties are set out in s. 11 of the *Act*. It provides, in part, that:

The authority must do all of the following:

- (a) provide for the delivery in British Columbia of community living support identified by the minister and of administrative services ...
- (c) manage the delivery of community living support and administrative services, including, without limitation, developing policies, setting priorities and allocating resources, in accordance with its service plan, budget plan and capital plan

[18] Section 29 of the *Act* authorizes the Lieutenant Governor in Council to make regulations, including:

- (2) Without limiting subsection (1), the Lieutenant Governor in Council may make regulations as follows:

- (a) prescribing additional persons for the purposes of paragraph (d) of the definition of “community living support” in section 1;
- (b) prescribing additional criteria for the purpose of paragraph (c) of the definition of “developmental disability” in section 1

[19] Section 5 of the *Regulation* has been amended over time. At the times relevant to this complaint, it stated:

- (1) Until December 31, 2006, the authority must provide for the delivery in British Columbia of
 - (a) support and services that are the same as community living support in respect of children and their families
 - (i) to a child who
 - (A) is diagnosed with Autism Spectrum Disorder, or
 - (B) would have been eligible for the At Home program of Community Living Services in the Ministry of Children and Family Development according to eligibility criteria for the program as it existed on June 30, 2005, and
 - (ii) to the family of a child referred to in paragraph (a) to assist the family in caring for the child, and
 - (b) administrative services that are related to the support and services referred to in paragraph (a).

[20] Cabinet has not exercised its authority pursuant to s. 29 of the *Act* to “prescrib[e] additional criteria for the purpose of paragraph (c) of the definition of ‘developmental disability’ in section 1” of the *Act*. It has, through s. 5 of the *Regulation*, specified that children with Autism Spectrum Disorder and children in the “At Home” program, and their families, are to be provided with community living support services.

VI CLBC POLICY AND PRACTICE

[21] In applying the *Act*, CLBC has interpreted “developmental disability” as the equivalent to “mental retardation” as that term is defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., published by the American Psychiatric Association

(the “DSM-IV”). The expert evidence with respect to these terms is reviewed in detail below.

[22] For present purposes, suffice to say that “mental retardation” is a medical diagnosis, the criteria for which are set out in the DSM-IV. There are three criteria:

- A. Significantly subaverage intellectual functioning; an IQ approximately 70 or below on an individually administered IQ test ...;
- B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person’s effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety; and
- C. The onset is before age 18 years.

IQ measurements are recognized to be subject to a measurement error of approximately 5 points, meaning that a person with a measured IQ of up to 75 might be diagnosed as mentally retarded if the other two criteria are satisfied. An individual must fulfill all three criteria in order to be diagnosed as “mentally retarded”: see DSM-IV, pp. 41 – 49.

[23] According to CLBC’s Policy Manual, updated June 2005, under the heading “Eligibility for Service”:

Community Living Services are available for families with a child who meets at least one of the following criteria:

- Diagnosis of Developmental Disability
- Diagnosis of Autism Spectrum Disorder
- Assessed as eligible for the At Home Program

A child must meet all three of the following criteria to be considered as having a Developmental Disability:

- 1) A formal diagnosis of an intellectual disability occurring before age 18;

- 2) An IQ score or cognitive skills score that is significantly sub-average;
- 3) Accompanying deficits in adaptive behaviour.

(emphasis in original)

[24] An undated CLBC document, entitled “Eligibility for C.L.B.C. Supports and Services”, addresses some of these issues. It refers to the statutory criteria for “developmental disability”, reproduced above at paragraph 16, and states that, to be eligible for services, an individual must meet all of those criteria. It notes that, as of the date of the policy, no further criteria had been prescribed. It states that CLBC “confirms the presence of a developmental disability through assessments provided by registered psychologists”, and that, in doing so, they apply the DSM-IV criteria for intellectual functioning and adaptive behaviour.

[25] A memorandum dated January 22, 2001 from the then Assistant Deputy Minister, Community Services and Program Support Division, entitled “Children’s Community Living Services: Eligibility for Services”, to Regional Executive Directors and Community Living Managers, also speaks to these issues. The stated intention of the memorandum is to clarify an earlier memorandum. Under the heading “Eligibility for Children’s Community Living Services”, it states that:

MCF has a broad mandate to provide services and supports to children and youth with special needs and their families. These programs and services have different eligibility requirements. Some of the programs and services offered through Children’s Community Living Services require a diagnosis of mental handicap/developmental disability. This is defined* as:

- *Significantly sub-average intellectual functioning*
- *Existing concurrently with related limitations in two or more adaptive skills areas*
- *Manifested before age 18*

** (“mental retardation” - DSMIV)*

(emphasis in the original)

[26] This memorandum goes on to state that children with Autism Spectrum Disorder are eligible for all community living services regardless of intellectual functioning.

[27] In practice, CLBC, like the Ministry before it, defines “developmentally disabled” as including a criterion that the child have an IQ of 70 or below. Persons with Autism Spectrum Disorder, and those in the At Home Program, are not subject to this criterion. Persons in the former category require a medical diagnosis of Autism Spectrum Disorder, while the At Home Program provides respite services for families with children with complex medical needs. The latter category is not relevant to the issues raised in this complaint and will not be considered further.

[28] According to the Policy Manual, CLBC provides a range of community living services to eligible children and families, including child and youth care workers, homemaker/home support workers, behavioural support of children with autism, funding for autism intervention services, parental support, and professional support.

[29] Donna McNeill, a Social Worker, and CLBC’s Manager for the East and West Kootenays region at the time of the events giving rise to this complaint; Ms. Havens, a Social Worker and later a Quality Service Analyst in the same office; and Frank van Zandwijk, since March 2007 the Director of the CLBC liaison office in the Ministry, all testified about CLBC’s policy and practice. Both Ms. McNeill and Ms. Havens had previously been employed by the Ministry performing substantively the same work delivering community living services prior to the creation of CLBC as a separate Crown agency in July 2005. Ms. McNeill and Ms. Havens also gave some evidence about their participation in the decision to deny services to R, and, to the extent necessary, I deal with that aspect of their evidence in that context below. In this part of my decision, I address all three witnesses’ evidence about CLBC practice and policy.

[30] In their direct evidence, both Ms. McNeill and Ms. Havens confirmed the application, in practice, of CLBC’s policies as I have described them above. In particular, they confirmed that CLBC treats “developmentally disabled” in the *Act* as the equivalent to a DSM-IV diagnosis of “mental retardation”, requiring all three criteria set out therein, including the requirement of an IQ of 70 or below. Ms. McNeill called an IQ of 70 “our guiding point”. Ms. Havens was asked why, if “mental retardation” and

“developmental disability” are equivalent, not use the diagnostic term “mental retardation”. She responded that it was deemed “more polite” to say “developmentally disabled”, and that “mental retardation” reflected an “old-school”, medical model.

[31] Ms. McNeill also confirmed that children with Autism Spectrum Disorder are not subject to an IQ criterion in order to be eligible for services.

[32] Ms. McNeill testified in cross-examination that the criteria to be eligible for services were sent to staff by the Ministry in January 2001, a reference to the memorandum of that date referred to above at paragraph 25, which she said they clearly went by in assessing applications. She testified that she and her colleagues had no flexibility in terms of whether they followed the criteria set out in the memorandum. Ms. Havens’ evidence, that they had no flexibility in assessing someone like R, was to the same effect. Ms. McNeill also testified that she “guessed” they had discretion to deviate from those criteria, but they did not exercise it. Ms. McNeill testified that she believed it was her professional responsibility to follow the established criteria. She also testified that she and her colleagues had no input into the criteria or policy development more generally for CLBC.

[33] In cross-examination, Ms. McNeill testified that CLBC was delivering services to about 350 children in the West and East Kootenays region when she left her employment there in July 2007. She was not directly involved in budget and funding issues, which were the responsibility of her manager. She was aware that the region was allocated an annual block of funding, out of which all services were provided. Individual applications were assessed for eligibility according to CLBC’s criteria. Once an application had been approved, the person might be placed on a waitlist, depending on whether funding was available to provide the service. Ms. McNeill testified that the budget was very tight, and they were under very strict guidelines, but if a person who met CLBC criteria had a critical need, they could request extra funding to meet that need. Both Ms. McNeill and Ms. Havens denied that there was a “roster” or maximum number of clients CLBC could provide services to, but they agreed that qualified children might have to go on a waiting list until funding was available.

[34] Mr. van Zandwijk's function is to provide oversight of CLBC on behalf of the Ministry. He ensures that CLBC is providing services in accordance with the *Act*, the Shareholder Agreement and other relevant criteria. Before taking on this function in March 2007, Mr. van Zandwijk had worked with persons with developmental disabilities in a number of capacities and settings.

[35] In his evidence, Mr. van Zandwijk provided some history of the community living movement since the 1950s. The movement originated out of the desire of parents of developmentally disabled children to have their children live in the community. As such, it is intertwined with deinstitutionalization. He called it a movement to accord developmentally disabled people their rights as citizens.

[36] Mr. van Zandwijk testified about the creation of CLBC. He said that it came out of the voices of parents, advocates and persons with developmental disabilities, who are known as "self-advocates", and the realization that government did not have all of the answers. The process began in 2001, when government recognized those "voices" by consulting with them in a process to design a new governance model, and culminated in the creation of CLBC as a Crown Agency in 2005. CLBC has a Board of Directors, which is made up of parents, advocates, and two self-advocates.

[37] Mr. van Zandwijk explained that CLBC provides services to children and youth with developmental disabilities, as well as others previously served by the Ministry, including some adults with physical disabilities. In addition, by regulation, CLBC also provides services to children with Autism Spectrum Disorder and in the At Home program. Today, children with special needs may receive services from CLBC, the Ministry, or both.

[38] Mr. van Zandwijk was asked about the terms "developmental disability" and "mental retardation". He testified that the "interpretive" term is usually "mental retardation", and that it is "usually understood that developmental disability is mentally retarded". When asked why CLBC uses the term "developmental disability", Mr. van Zandwijk said that it goes back to the history of the community living movement, and difficulties associated with labels such as mental retardation or mental handicap. He thought "the drafters probably had something to do with it". In general, however, he

testified that it is used to refer to the group previously served by the Ministry, as defined by the DSM-IV.

[39] Mr. van Zandwijk was asked about a September 2002 document to “Community Living Service Stakeholders” from the “Community Living Transition Steering Committee”. That Committee appears to be the vehicle through which government consulted with the community living movement about the creation of CLBC. The document refers to the Committee’s hope that the yet to be created Agency would “provide an opportunity for the creation of an innovative, community-based service delivery system that empowers individuals and families, and offers a range of choices, including individualized funding.” Mr. van Zandwijk said that there were perhaps different perspectives on what “individualized funding” meant in this context, but that it is now a funding mechanism by which services can be delivered after eligibility has been established. Ideally, he said, CLBC provides money so the client or their family can direct their own service. It does not mean that there are no eligibility criteria, or that the pre-CLBC eligibility criteria have changed.

[40] Mr. van Zandwijk testified that CLBC currently provides services on the basis of a medical diagnosis model, but acknowledged that there is a debate about whether a different model should be adopted. He testified about a consultation process recently underway involving three Ministries: Children and Family Development, Health, and Education. Through this process, a need to do further research into a functional model that would focus on needs rather than diagnosis has been identified. Mr. van Zandwijk’s evidence about this process was vague and unspecific, likely reflective of it being at an early stage.

[41] In cross-examination, Mr. van Zandwijk testified that the Ministry provides about \$600 million on an annual basis to CLBC. The Ministry does not look at the details of how the money is spent by CLBC, and Mr. van Zandwijk was not sure what criteria CLBC uses to determine how funding is allocated internally.

[42] Mr. van Zandwijk was also asked in cross-examination about how many people have a developmental disability in British Columbia. He said that the prevalence is estimated at about 1% of the population. Given his other evidence, I assume that Mr. van

Zandwijk meant, in making this estimate, people diagnosed with mental retardation as defined by the DSM-IV, rather than people with developmental disabilities more broadly defined. CLBC serves about 11,000 adults province-wide, which would mean that it is currently serving about 30% of that 1% of the adult population. CLBC serves about 20,000 children with special needs province-wide, including both developmentally disabled children and those in the other funded categories. Mr. van Zandwijk did not know the cost of the services provided to CLBC clients on average, saying that it depends on individual needs, and would fluctuate significantly. He also did not know what the cost of the youth worker J applied for on R's behalf would have been.

[43] Mr. van Zandwijk acknowledged in cross-examination that a person with a relatively high IQ might require assistance with adaptive functioning. However, they would "not necessarily be a person with a developmental disability". He declined to offer an opinion on whether it is appropriate to use the DSM-IV criteria to determine who is eligible to receive benefits, confining himself to saying that he thought government has the prerogative to decide who receives services.

VII J AND R

[44] J testified about R and their lives together. Also testifying about J and R, and the challenges R faces, were Nancy Dyck, a teacher and family friend, and David Perry, an Educational Assistant who works with special needs students, including R, at school. R attended the first day of the hearing, but did not testify.

J's adoption of R and R's characteristics

[45] J is a former nurse who has been a foster parent for many years. She describes herself as working with, and liking, challenged people. R was born in 1992, making him 15 years of age at the time the hearing commenced. R originally came to J as infant foster child or "child in care". At the time, he was not expected to live, but he did unexpectedly well under J's care. J and R live in a small community in the Kootenays, where R attends public school.

[46] R was diagnosed with Noonan Syndrome shortly after birth. Several of R's biological relatives, including his birth mother and two of her siblings and one of his biological brothers, have also been diagnosed with Noonan's. As is typical of persons with Noonan Syndrome, R has short stature – 4' 8" at the time of hearing, significantly shorter than his age peers. He also has some facial characteristics typical of people with Noonan Syndrome, such as protruding eyes, slightly lower set and rotated ears, and a small jaw. He is also nearly deaf in one ear. R's health is generally fairly good, but he receives periodic follow-up care from specialists in endocrinology, genetics and cardiology.

[47] J chose to adopt R because she wanted to ensure he would maintain the stable family life she had created for him; the process was complete by the time he was five. It was an "assisted adoption".

[48] Because R's is an "assisted adoption", J receives monthly maintenance payments from the Ministry under a Post Adoption Assistance Agreement. Initially, J received \$500.00 per month, and under the Post Adoption Assistance Agreement in effect at the time of the hearing, she received \$805.68 per month. J testified that the social workers she has dealt with in relation to the assisted adoption have always been helpful.

[49] One of J's concerns has been based on her belief that, had R remained in foster care, he would have been entitled to the services he required, but was denied those services, because she had adopted him. These concerns are reflected in her correspondence with CLBC, reproduced below. She says that when she adopted R she was told by the social workers that, if she needed help, she should apply. No one, she said, mentioned IQ.

[50] Ms. McNeill testified that, had R remained a child in care, he would not necessarily have been entitled to services from CLBC. Her evidence on this point was somewhat difficult to understand. Given that J did not pursue any argument that R would have been entitled to services as a child in care that he was not entitled to as an adopted child, or that any difference in treatment between adopted children and children in care is discriminatory, I need not consider this issue further. It remains relevant only insofar as it explains some of J's concerns about the services R was entitled to.

[51] J described many of R's challenges, from infancy to date. Ms. Dyck corroborated many of J's observations about R. Their evidence about R's behaviours and the challenges he faces was not probed in cross-examination. R's characteristics and challenges are described below in dealing with the expert evidence about R, and J's and Ms. Dyck's evidence about R was generally consistent with it.

[52] In summary, and described in lay terms, R has significant adaptive functioning deficits, meaning that he has many difficulties with the activities of daily living as compared to other children his age. His behaviour is very immature as compared to his age peers – J compared him to a five or six year old in terms of maturity. He often engages in repetitive inappropriate behaviours, including repeating nonsense words or words out of context. He also has some motor control-related difficulties. He has difficulties following directions, especially if more than one task is involved. R's difficulties, especially in terms of adaptive functioning, have revealed themselves at home, in school, in his attempts to form social relationships, and in the community.

[53] While R has some comparative intellectual strengths, including reading and information retrieval about subjects of special interest to him, he also has many significant intellectual weaknesses. As described in detail below in considering the expert evidence, he has been the subject of many assessments, which, in general terms, show him to be in the "borderline" range of intellectual or cognitive ability, variously tested at somewhere between the 2nd and 6th percentile in comparison to his age peers. The most reliable assessment of R's full-scale IQ, which is a blend of the assessment of his performance on a number of sub-tests measuring particular aspects of his cognitive functioning, puts him at 77, plus or minus 5. As will be described in detail below, R's results on some sub-tests are far below this level, while others are above, which is reflective of his disparate intellectual strengths and weaknesses.

[54] As a result of both his adaptive functioning and intellectual deficits, R is in modified and adapted programs at school. His IEPs, as of about December 2004 and June 19, 2006, were entered into evidence. At the time of the first IEP, R had successfully complete grade 6, and plans were in place to assist him to continue at school with adapted and modified programs. R was provided with a Student Support Service

worker, and other assistance, including a special education teacher and an educational assistant, Mr. Perry. R is one of a group of students often taken out of the regular classroom to receive small group and one on one attention from Mr. Perry.

[55] R's immature and inappropriate behaviours, intellectual deficits, small stature, and somewhat unusual appearance have led to him being teased and ostracized by his age peers. J testified that R has no friends, and gave examples both of R's sometimes very inappropriate behaviour and the bullying he has experienced from others. Mr. Perry and Ms. Dyck both confirmed the nature of R's inappropriate behaviour at school, including attention-seeking acting out and social isolation. Efforts have been made by J and the school to address R's difficulties in social interaction, including having R go home for lunch to avoid certain problems occurring.

[56] There is no question that J loves R, and has been a tireless advocate for him. J has done everything she can to provide him with the care and support he needs, including ensuring he has obtained appropriate therapeutic interventions, and providing him with a weekly tutor since Kindergarten, which she pays for directly. Many of R's achievements directly relate to that love and support. J has serious concerns about R's future, and his ability to function independently, especially when she is no longer able to care for him.

J's nephew

[57] J has a nephew, M, who is autistic. J referred to M's experience in the letter, reproduced in part below, that she wrote to Ms. Havens appealing the decision not to provide services to R. J could not understand or accept that M, who has done well in school, and clearly has an IQ substantially greater than 70, qualified for services from CLBC, while her son, R, who has had much greater struggles in school, did not. The parties agreed that M and his mother, S, would be referred to by initials in this decision.

[58] Evidence about M was entered, with the parties' agreement, by way of two affidavits: one from his mother, S, and one from a Quality Service Manager with CLBC. Those affidavits establish that M is autistic. He has received various kinds of support in school, but has not required a modified academic program, and has performed above average academic work in many courses, resulting in Honour Roll status in grade 11. He

graduated from high school, and has gone on to attend college and live independently. M has been assessed as have a full-scale IQ of 102.

[59] In or about 2000, S applied to the Ministry, which was then responsible for community living services, for a recreational worker for M to assist him with socialization skills. Because of his autism, M was deemed eligible for services by the Ministry, and he was assigned a worker starting in 2001. M became an adult in 2005, and as a result is no longer eligible for, and does not continue to receive, funding from CLBC. It will be recalled that, under the *Act*, persons with autism who are not otherwise developmentally disabled are entitled to receive services only until their 19th birthday.

VIII THE APPLICATION FOR SERVICES

[60] Near the end of the 2004-05 school year, R's Student Support Worker, who functions as his case manager at school, suggested to J that she apply to CLBC for services, specifically, a youth worker to assist R in developing social skills. J was concerned about R's social skills, and the widening "gap" that she was observing in terms of his behaviour as compared to his age peers, and anticipated he would have increased difficulties that fall entering grade 8, so she decided to apply. J hoped that a youth worker would work with R one on one and as a part of group, helping him to learn how to act in social situations, where he experiences a lot of difficulty. J testified that R's social interactions were essentially limited to family, mostly her, and she thought that it would be important to have someone else work with R on these issues.

[61] In or about June 2005, J spoke to Ms. Havens, at that time a Social Worker with CLBC in its office in J and R's community, about applying for such services. At Ms. Havens' suggestion, J submitted all of the assessment documents from the Alberta Children's Hospital, where R had undergone an extensive multi-day, multidisciplinary assessment in June 2003. One part of that assessment, a Psychology Assessment performed by a psychologist, is discussed in greater detail below in considering the expert evidence. No formal written application was required or submitted.

[62] Ms. Havens discussed the application with Ms. McNeill, and they decided to send the Psychology Assessment alone to Dr. O. Gary Deatherage, a Registered Psychologist,

for him to review to determine R's full-scale IQ. As Ms. Havens testified, the applicant's full-scale IQ is one of the main eligibility criteria. Ms. Havens was asked whether she also asked Dr. Deatherage about R's adaptive functioning. She said she did not recall. In fact, as the documentary evidence to which I am about to refer shows, she only asked about IQ.

[63] In accordance with her discussion with Ms. McNeill, on July 4, 2005, Ms. Havens faxed a copy of the Psychology Assessment to Dr. Deatherage and his associate, A. W. Deatherage, a psychiatric nurse and Registered Clinical Counsellor. The Deatherages are in private practice, and often provided consulting services to CLBC.

[64] On July 11, 2005, Dr. Deatherage refaxed the July 4 fax cover sheet, with a handwritten note to Ms. Havens, stating that "while R is encountering difficulties [illegible] his Borderline to Low Average cognitive abilities, by this assessment he does not meet the eligibility criteria for CLS."

[65] It is evident there were difficulties in communication between Dr. Deatherage and Ms. Havens, who testified that she never saw Dr. Deatherage's July 11 fax before preparing for this hearing. This is consistent with the fact that, on September 7, 2005, Ms. Havens e-mailed Ms. Deatherage, asking:

Has the psychology report that I sent to you in July on R ever get looked at by Gary? I would like to get this intake off my plate if he is over the 70 IQ mark. Let me know what the status of this is....

[66] Ms. Deatherage responded by return e-mail, indicating that she did not recall seeing the report, and asking Ms. Havens to resend it. Ms. Havens e-mailed Ms. Deatherage that she had just sent it.

[67] A fax cover sheet, dated July 4, 2005, but shown as having been sent on September 7, 2005, from Ms. Havens to the Deatherages, was entered into evidence. It indicates it was part of a fax of six pages, although the other pages are not attached. It is reasonable to infer that the Psychology Assessment attached to Ms. Havens' July 4, 2005 fax was attached. There is a handwritten note from Ms. Havens to the Deatherages on the fax cover sheet that states "Can you please have a look at this and let me know what his full scale IQ would be."

[68] On September 9, 2005, Ms. Deatherage e-mailed Ms. Havens, stating, “Clearly the previous testing puts this young man in the borderline or low average range. Not a fit for your service.”

[69] Ms. Havens and Ms. McNeill consulted about the information received from the Deatherages. Their conclusion was that R was not eligible for services because of his IQ.

[70] J testified that it was in a meeting about an unrelated matter that Ms. Havens first told her R was ineligible for services. According to J, Ms. Havens told her that she had done “too good a job”, and that R was “way too smart” for CLBC’s services. In direct, J testified that she was shocked by what Ms. Havens had said, but in cross-examination, she accepted that this was a casual conversation, and that Ms. Havens was giving her a compliment as a mother. She also testified that she knew Ms. Havens, like her supervisor Ms. McNeil, were merely doing their jobs, and that she had nothing personal against them. In any event, Ms. Havens told J she had a letter which she was getting ready to send her to confirm the denial.

[71] On October 12, 2005, Ms. Havens wrote J the letter denying her application. The letter is brief, and states, in full:

As per our discussion around your request for support services for your son R with Community Living BC, R is not eligible for support services at this time. At this time his psychoeducational testing shows an overall score of above 85. If his psychoeducational testing prior to age nineteen shows an overall score of 70 or below he would be eligible for support services.

Thank you for providing all of the reports from Alberta Children’s Hospital. It allowed us easier determination of eligibility. If you require further information, please feel free to contact me at the number below.

[72] Ms. Havens testified that she could not recall where she obtained the information that R’s psychoeducational testing shows an overall score of above 85. As the expert evidence reviewed below shows, that information was inaccurate, as the Psychology Assessment reviewed by Dr. Deatherage reports a full-scale IQ in the range of 73 – 83, in the 6th percentile, still above CLBC’s 70 IQ cut-off, but substantially lower than 85.

[73] J testified that the letter “really sort of hit me”, and that she thought there was “something terribly wrong with the system”. As indicated above, she was particularly

struck by the fact her nephew M was eligible for services, but R was not. Until this time, she was unaware that IQ was part of the eligibility criteria. J decided to appeal the decision, which she did in a letter dated October 30, 2005, which stated, in part:

Thank you for your letter of October 12, 2005, in which it is stated that R is not eligible for support services because his number is 85 and he is therefore too smart. I do have some questions I would like answered.

1. If R was still a [Child in Care], he would be on the CLBC roster, not in the protection side. He would then get the support he needs and a number would not factor in. Why is he being denied that which would be his had he not been adopted? I was told he would still be able to access supports from CLBC, or whatever it was called prior to July 1st, 2005, when I was going through the adoptive process.
2. Why is the number 70 not being evenly applied across the board? My nephew, [M], who has Aspergers Syndrome (high functioning autism), made the honour roll at least once in his grade 12 year on the regular B.C. curriculum ... He qualifies for CLBC supports because of his autism and is definitely not below 70. On the other hand, R's core subjects are all modified because even the adapted courses were too hard for him ... But he is "too smart"!? to qualify?
3. How was the number 85 arrived at? ...

Because of his size and maturity level, R does not fit in with kids his age ... Different syndromes have different challenges but that doesn't mean that there should be different rules for one or the other. We're supposed to be trying to give all challenged kids an equal playing field and that can't happen if one syndrome is considered more challenging than another. And who will want to adopt special needs kids, if social workers are honest and tell prospective parents that the rules are changed once an adoption is done.

[74] Ms. Havens responded in a letter dated December 16, 2005:

... R's psychoeducational testing has placed him in the borderline to low average range which is a score between 80 to 90. This score along with R's adaptive behaviour make him ineligible for support services through Community Living BC.

As I stated on the telephone, the criteria for support services with Community Living BC is as follows:

- Diagnosis of Developmental Delay – which means a formal diagnosis of an intellectual disability occurring before age 18; an

IQ score or cognitive skills score that is significantly sub-average (under 70); and accompanying deficits in adaptive behaviour.

- Diagnosis of Autism Spectrum Disorder
- Assessed as eligible for the At Home Program

... At this time R's IQ scores exceed the criteria for receiving support services with Community Living BC.

If you require further clarification please contact Donna McNeill

[75] Again, the information contained in this letter to the effect that R's psychoeducational testing placed him in the range of 80 to 90 was incorrect on the face of the information then before the respondents. Ms. Havens did not remember the source of that inaccurate information. Further, the evidence does not support that R's adaptive behaviour rendered him ineligible for support services; to the contrary, the expert evidence clearly indicates that R's adaptive functioning deficits are sufficient to make him eligible for services.

[76] While J dealt directly with Ms. Havens in making the application, and it was Ms. Havens who wrote the two relevant letters, Ms. McNeill testified that it was she, as the manager, and her manager above her, who were responsible for making the decision about R's eligibility for services from CLBC. Both Ms. McNeill and Ms. Havens testified that, in determining if a prospective client met the criteria, they were reliant on the professional assessment of a psychiatrist or psychologist, such as Dr. Deatherage. Ms. McNeill testified that Ms. Havens consulted with her after she received the information from the Deatherages, and that they agreed that R was not eligible, and that J should be informed as soon as possible.

IX EXPERT EVIDENCE

[77] Expert evidence was introduced by the parties that went, broadly, to two issues. First, some of the expert evidence consisted of assessments made of R. Second, other expert evidence considered broader questions, including the validity and use of the DSM-IV as a diagnostic standard in determining "mental retardation"; the definition of "developmental disability" in the *Act*, and its relationship to "mental retardation"; and the

standards of practice in diagnosing and assessing “mental retardation” and “developmental disability”.

[78] In order to understand the expert assessments of R, some understanding of this terminology and these concepts is essential. I therefore consider the expert evidence relating to the general concepts first, followed by the expert evidence about R in particular. In the main, the expert reports focussed on only one or the other of these issues.

General

Dr. Patrick Bartel

[79] The respondents introduced the expert report of Dr. Patrick Bartel, a Registered Psychologist. Dr. Bartel has broad clinical psychology experience, including with the Forensic Psychiatric Services Commission and Youth Forensic Psychiatric Services. He is also a Clinical Associate at the Clinical Psychology Centre and an Adjunct Professor in the Department of Psychology, both at Simon Fraser University.

[80] In his report, Dr. Bartel outlines the historical derivation of the term “mental retardation”, which was first officially introduced in 1960 when the American Association on Mental Deficiency defined it as “significantly subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behaviour”.

[81] The introduction of the concept of IQ and the development of tests to measure it led to the use of IQ scores as a necessary component of classifying persons as mentally retarded. The adoption of an IQ score of 70 or below as indicative of mental retardation was largely based on statistical theory. Specifically, an IQ score of 70 or below represents two standard deviations below average.

[82] Dr. Bartel indicates that, concurrent with the development of testing for intellectual functioning, measures or scales to assess adaptive functioning have also been developed. He says that the relationship between IQ scores and adaptive functioning is strong but not perfect. In particular, low intellectual functioning does not necessarily

indicate poor adaptive functioning, meaning that some people with IQ scores of 70 or below will be able to demonstrate adequate functioning in society. Conversely, persons with deficits in adaptive functioning do not necessarily have intellectual deficits. He lists a number of conditions, including autism, traumatic brain injury, some mental illnesses, and fetal alcohol syndrome, in which affected persons may have adaptive functioning deficits, but not impaired intellectual functioning. Both persons with low IQ but adequate adaptive functioning, and persons with adaptive functioning deficits but no intellectual deficits, would not be considered as “mentally retarded”.

[83] CLBC and the *Act* do not use the term “mental retardation”. Dr. Bartel states that they use the term “developmental disability” to designate what is otherwise referred to as “mental retardation”. He sets out the definition of “developmental disability” found in s. 1 of the *Act*, reproduced above at paragraph 11.

[84] Dr. Bartel opines that the *Act*’s definition of “developmental disability” closely mirrors the definition of “mental retardation” found in the DSM-IV, the current standard reference in North America for diagnosing psychiatric and psychological disorders. As already stated, the DSM-IV defines “mental retardation” as:

- A. Significantly subaverage intellectual functioning ...;
- B. Concurrent deficits or impairments in present adaptive functioning in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety; and
- C. The onset is before age 18 years.

[85] In Dr. Bartel’s opinion, while the DSM-IV definition is more detailed and specific, it is very similar to the definition found in the *Act* in content and meaning. He notes the obvious difference that they use different terms to describe what he says is the same construct. Dr. Bartel says that the primary reason for this is that “mental retardation” has acquired a pejorative and negative connotation over the past few decades, with the result that the term is now used almost exclusively in technical and scientific contexts. “Developmental delay” is increasingly preferred by parents and caregivers, while “developmental disability” is preferred by many professionals.

[86] Dr. Bartel says that, in British Columbia, professionals in the field make essentially no distinction between “mental retardation” and “developmental disability”, and their respective definitions in the DSM-IV and the *Act*. At the same time, Dr. Bartel also says that “developmental disability” is a general term that is used by professionals to refer to a host of conditions and disorders, some of which do not necessarily involve either low IQ or impaired adaptive functioning, including Autism Spectrum Disorder, cerebral palsy, Noonan’s Syndrome, Down Syndrome, learning disabilities, epilepsy and fetal alcohol syndrome (also referred to as “FAS” or “FASD”), among others.

[87] Dr. Bartel observes that there is one other notable difference between the DSM-IV and CLBC definitions, in that the DSM-IV refers to “significantly subaverage intellectual functioning”, while the *Act* refers to “significantly impaired intellectual functioning”. He says that “impaired” is consistent with the language used in other countries, such as the United Kingdom. In Dr. Bartel’s opinion, even though the *Act* does not specifically identify an IQ of 70 or below in its definition of “developmental disability”, those practicing in the field understand that the DSM-IV IQ criterion is implied by the phrase “significantly impaired intellectual functioning”.

[88] Dr. Bartel states that there is a general consensus between international bodies around “the construct of mental retardation/impaired intellectual functioning”. The 70 or below IQ requirement is part of that consensus, although there is some recognition that that standard should not be used rigidly, and that the possibility of measurement error means that in some cases an IQ as high as 75 could still be indicative of mental retardation if accompanied by impaired adaptive functioning.

[89] Turning to the standards of practice in diagnoses and assessment, Dr. Bartel says that in British Columbia, only physicians and psychologists are qualified to make a diagnosis of mental retardation. Only Registered Psychologists and School Psychologists are qualified to conduct the required intellectual assessment, *i.e.* to administer one of the standardized IQ tests.

[90] Adaptive functioning is assessed by qualified professionals, including both psychologists and social workers, comparing the functional abilities of the child to those

of other children the same age. Structured interview instruments, through which information is gathered from someone familiar with the child, is used for this purpose.

Dr. Caron Byrne

[91] J filed two expert reports in response to Dr. Bartel's report. The first of these is from Dr. Caron Byrne, who is a psychiatrist working in Community Psychiatry, with a sub-specialty in the mental health needs of persons with developmental disabilities. Her psychiatric practice includes being the Psychiatric Consultant and Clinical Director for the Island Mental Health Support Team and the Psychiatric Consultant to the Interior Mental Health Team. She is a Clinical Assistant Professor in the University of British Columbia Faculty of Medicine.

[92] Dr. Byrne was asked to review Dr. Bartel's opinion.

[93] Dr. Byrne largely agreed with Dr. Bartel's opinion that "developmental disability" is one of a number of terms used to indicate delayed cognitive and functional development, but it is not a diagnostic, medical or psychiatric term with a consistent definition. Rather, Dr. Byrne says that it is a new and evolving term which has different meanings for different professionals.

[94] Dr. Byrne states that, in her experience, the term "developmental disability" is often used by health professionals to indicate someone who has mental retardation because it is seen as less pejorative. She also says that health professionals who are unfamiliar with the Community Living movement may not understand what is meant by the term "developmental disability". She uses the two terms interchangeably to refer to a person who meets the DSM-IV criteria for mental retardation, but in diagnosis, she employs the DSM-IV terminology exclusively, because "developmental disability" is not an accepted psychiatric term.

[95] For the last mentioned reason, Dr. Byrne disagrees with Dr. Bartel's opinion that essentially no distinction is made by professionals in British Columbia between the two terms.

[96] In Dr. Byrne's opinion, flexibility is important in defining disability.

[97] Turning to “mental retardation”, Dr. Byrne states that its definition has also changed over time. In her opinion, the definition of “mental retardation” is arbitrary, and she states that “the difficulties of condensing many test scores into a single number (IQ) to define a person ‘can obscure specific facets of a subject’s neuropsychological status or misrepresent it generally’”.

[98] Dr. Byrne specifically disagrees with Dr. Bartel that professionals in the field would understand “developmental disability”, as used in the *Act*, to imply an IQ of 70 or below. She says that she does not know what is meant by “significantly impaired intellectual functioning” because it is non-specific. It is not a diagnostic term, and its meaning could vary according to the context and person using it. She would need concrete information about a person’s actual degree of impairment before she could draw any conclusion about their cognitive ability.

[99] Dr. Byrne does agree with Dr. Bartel’s statement that “developmental disability” is a more general term. In other words, most people with mental retardation have a developmental disability, but not everyone with a developmental disability has mental retardation. For example, Dr. Byrne regards autism as a developmental disability, but mental retardation may or may not be present in a person with that disorder. Similarly, persons with Noonan’s Syndrome may or may not have mental retardation.

[100] Dr. Byrne refers to legislation in the United States, especially Oregon, which defines “developmental disorder” more broadly to include mental retardation and other disorders, including autism, and FASD.

[101] Dr. Byrne summarizes her opinion as being that the term “developmental disability” in the *Act* is more similar to the broader definition used in Oregon than to the more restrictive definition used in the DSM-IV.

Dr. Diane L. Russell

[102] Dr. Diane Russell provided the second expert report in response to Dr. Bartel’s report. Dr. Russell is a Registered Psychologist whose practice centres on the assessment, interpretation, diagnosis and remediation of neuropsychological dysfunctions in school-aged children, as well as persons with developmental disabilities and others.

[103] In her report, Dr. Russell outlines the areas in which she agrees and disagrees with Dr. Bartel. She agrees with the definitions he provides of CLBC and DSM-IV criteria. She also says that his discussion of the standards of practice with respect to assessing intellectual functioning and adaptive functioning is generally appropriate.

[104] Dr. Russell notes that Dr. Bartel appears to have equated “mental retardation” and “developmental disability”, and goes on to state that CLBC appears to have taken the DSM-IV diagnosis of “mental retardation”, and applied it to define the term “developmental disability” in the *Act*. Thus, there is only one “developmental disability” within CLBC, namely “mental retardation”.

[105] Dr. Russell disagrees that “developmental disability” and “mental retardation” are the same construct. She refers to various definitions of “developmental disability” in the United States which are broader in scope. She opines that there is a great deal of confusion and controversy regarding the two terms, but they are not synonymous. She also suggests that Dr. Bartel’s opinion is internally inconsistent on this point.

[106] Dr. Russell disagrees with what she reads as implicit in Dr. Bartel’s opinion, namely, that a person’s cognitive impairments are necessarily the cause of a person’s adaptive functioning difficulties. She says this is not true in many people. For example, she says that in persons with FASD, there is little or no relationship between IQ and adaptive functioning.

[107] Dr. Russell disagrees with Dr. Bartel that those practicing in the field understand that an IQ of 70 or below is implied by the use of the term “significantly impaired intellectual functioning” in the *Act*. In this regard, she refers to the Court’s decision in *Fahlman*, discussed in detail below, and argues that the absence of a specific IQ level in the *Act* indicates that IQ should not be used to determine eligibility.

[108] Dr. Russell closes her report by saying:

Dr. Caron Byrne and I have advocated for the use of an “umbrella” model of developmental disabilities that would encompass all of the various disabilities included in the various definitions (e.g., mentally handicapped/retarded, FASD, learning disabled, Autism Spectrum Disorder, epilepsy, traumatic brain injury, etc.). I would suggest that the criteria for services should be based on functional needs, as opposed to any

arbitrary cut-off scores on any specific tests (e.g., intelligence, adaptive functioning, academic, etc.). This would then allow all individuals with any type of disability to access the services that each person requires.

Noonan's Syndrome

[109] There is no dispute that R has Noonan's Syndrome. No expert testified specifically about Noonan's Syndrome, but J entered into evidence, without objection from the respondents, an information sheet from Cedars-Sinai Medical Centre, entitled *Aspects of Noonan Syndrome*, by Dr. John M. Graham. According to this document, Noonan's Syndrome has a genetic component. Its incidence at birth has been estimated at 1 in between 1000 and 2500.

[110] As I have said, there are physical characteristics typically associated with Noonan's Syndrome. These include: lack of growth resulting in short stature; distinctive facial features, including widely spaced and down-slanted eyes, low-set and rotated ears, a highly arched palate and small jaw, among others; congenital heart defects; irregularities with respect to development at puberty; and some skeletal differences.

[111] There may also be psychological characteristics associated with Noonan's Syndrome. However, according to this document, "it is commonly stated that many individuals with Noonan syndrome will be mildly mentally retarded", but "the existing data do not currently support this strong a claim", and there are a "growing number of reports of average to superior intelligence among individuals with Noonan syndrome". The author cites a number of studies which have come to inconsistent conclusions on this issue, and states that further investigation is necessary before "commonalities in cognitive profile can be proposed with any degree of certainty". The document also states that "there is no evidence that specific behavioural characteristics, a specific behavioural disability or psychiatric disorder are consistently associated with this condition".

[112] The document indicates that 40% of infants with Noonan's Syndrome "fail to thrive", and that 25-30% of younger children with the Syndrome have motor and language delays. It also states that "there is wide variability in the intellectual and adaptive functioning of individuals with Noonan syndrome". The author recommends that, if developmental delays are apparent in young children, appropriate intervention in

the form of speech and language therapy, audiological testing or special education services may be required. Individualized assessment is necessary.

Assessments of R

[113] R has undergone a number of assessments by psychologists and others, both before and during the hearing of this complaint. In this part of my decision, I summarize the salient aspects of those admitted into evidence.

Dr. Gary Deatherage

[114] As discussed above, it was Dr. Deatherage who provided Ms. Havens with the opinion that R's IQ was too high to entitle him to receive services from CLBC. Dr. Deatherage was also asked by the respondents to provide a summary of his involvement in this matter, which was entered into evidence.

[115] Dr. Deatherage is a Registered Psychologist in practice in the Kootenays. He provides clinical consultation services to a number of organizations in the Kootenays, including CLBC, which he does under the auspices of his role as consulting psychologist for the Developmental Disabilities Mental Health Services – Kootenays (“DDMHS-K”) team.

[116] Dr. Deatherage says that one of his roles with the DDMHS-K team was to conduct formal psychological assessments, including determining if a person met the DSM-IV criteria for mental retardation, and providing an opinion as to whether such a person qualified for services from CLBC. A less frequent role was to review other psychologists' reports to advise social workers on their interpretation, including whether a person was probably eligible for services.

[117] Dr. Deatherage discusses the DSM-IV, which he says provides clear diagnostic criteria for the mental disorders defined in it. He states that:

the use of diagnostic criteria ensures consistency among professionals using the system because each professional defines each disorder identically with other psychologists or psychiatrists. This de-politicizes the process of diagnosis

[118] Dr. Deatherage explains that he has never met R, nor is R his client. He outlines his involvement in J's application for services for R, as I have already discussed.

[119] Dr. Deatherage refers to the Alberta Children's Hospital Psychology Assessment Report, which was provided to him by Ms. Havens. That Assessment had been conducted by Lori Henriksson, a chartered psychologist, on June 23, 2003, when R was 11 years of age. As set out by Dr. Deatherage in his summary of the Assessment, R had been referred for a multi-disciplinary assessment by his family physician. At the time, he was already diagnosed with Noonan's Syndrome, a condition shared by a number of his biological relatives. R was in grade 5, and was reported to be meeting academic expectations. He was reported to have same age friends, and to function normally socially with peers.

[120] A Wechsler Intelligence Scale for Children – Third Edition (WISC III) was administered to R as part of that Assessment. His numeric IQ scores were not provided, but the psychologist administering the test reported R's verbal IQ to be at the 10th percentile, with an IQ of 76 – 88, placing him in the Borderline to Low Average range of functioning. Dr. Deatherage notes that IQs are often reported in “ranges of confidence due to the statistical nature of the test instruments”. Performance IQ was placed at the 6th percentile, with an IQ of 72 – 87, also in the Borderline to Low Average range. R's Full Scale IQ was also reported to be at the 6th percentile, with an IQ of 73 – 83, again in the Borderline to Low Average range. Dr. Deatherage reports that none of R's scores was in the range of mental retardation.

[121] Dr. Deatherage reports that other test instruments administered as part of the Assessment indicated that R suffers worries, fears and anxiety, but that no significant deficits in adaptive functioning were reported.

[122] Overall, the psychologist conducting the Assessment concluded that R's intellectual abilities were in the Borderline to Low Average range, he suffered from anxiety, he was slower and less accurate in pen and paper tasks, he had some weaknesses in attention, and needed various modifications to his school program and classroom environment.

[123] It was on the basis of this Assessment that Dr. Deatherage advised Ms. Havens that R “did not appear to meet the DSM IV criteria for Mental Retardation required for CLBC services.”

Dr. Todd Kettner

[124] Following the complaint being filed, and before the hearing commenced, Dr. Todd Kettner conducted a psychological assessment of R, at the respondents’ request, and with J’s agreement.

[125] Dr. Kettner is a Registered Psychologist in private practice in the Kootenays. He performs psychological assessments for a number of organizations, the vast majority of which are for the purpose of determining if a developmental or learning disability is present.

[126] Dr. Kettner was asked by the respondents for “an assessment to determine whether R is developmentally disabled (mentally retarded)”. I observe that the question put to Dr. Kettner therefore assumed that “developmentally disabled” and “mentally retarded” were the same thing, an assumption the validity of which is at the heart of the dispute in this complaint. Despite this problem, I found Dr. Kettner’s evidence, both as contained in his expert report and in his oral evidence (he was the only expert to testify orally), both reliable and helpful. In this part of my decision, I review his expert report at length. Subsequently, I consider his oral evidence.

[127] As recounted in his December 11, 2006 expert report, Dr. Kettner was provided with a range of background information. As part of his assessment of R, Dr. Kettner spent the full day on December 11, 2006 at R’s school, where he met with R’s teacher and learning assistant, observed R and his classmates (unknown to them) in class, met J, and spent the afternoon with R conducting tests. He subsequently spoke with R’s former teacher and present tutor.

[128] Dr. Kettner reports the following collateral information obtained from R’s teacher and learning assistant. They informed him that R has been in a modified program at school since grade 7 because he has been unable to meet either the academic or social expectations of the regular program. R’s reading and writing skills are somewhat

stronger than other students in the modified program, but his math skills are quite weak. They reported that R is often “socially very inappropriate and interacts at a very developmentally delayed level”. Examples are provided, some of them quite harrowing in nature. I see no need to repeat the details in this decision. Both R’s teacher and learning assistant told Dr. Kettner that they considered R to be “an ‘at risk’ child who will face significant barriers and challenges in the high school environment”. They also expressed concerns about his long term prospects for occupational success. They both described R as “a ‘very likeable’ student who is generally polite, kind to other children, and curious about the world. They added that R’s mother is ‘amazingly supportive’ of him.”

[129] Dr. Kettner reports the following collateral information which he obtained from J. J told him about how she initially fostered R as an infant, and that, at the time, he was not expected to live. Dr. Kettner states that “somewhat miraculously, R survived and began to develop slowly with J’s caring and loving support”. At age five, J adopted R. Details of R’s early childhood development, and the assistance provided by speech and language therapists and infant development specialists, are provided.

[130] J reported to Dr. Kettner that her biggest concern for R is his social functioning. She described him as “a little boy who desperately wants friends but doesn’t know how to make friends”. She provided examples of his socially inappropriate behaviour and the cruel teasing to which he has been subjected by some peers. J also reported her concerns about R’s cognitive functioning, and gave examples of him having difficulty following directions. J told Dr. Kettner that the social, functioning, and cognitive “gaps” between R and his age peers continue to widen as he gets older.

[131] R’s tutor told Dr. Kettner that R is socially “very backward”. While he can read, and has great factual retention, his comprehension is very weak, as are his math skills. Her greatest concerns were R’s emotional and social deficits. She wondered if he had reached his limits in social functioning. She was terrified to think of him going to high school, and could not imagine him living independently as an adult.

[132] Dr. Kettner’s own observations include that R is a short teenager with wide set eyes, a protruding forehead, and tussled hair who appeared at least four to six years

younger than his chronological age. His affect was bright and he smiled easily. Dr. Kettner reports various socially inappropriate things that R repeatedly said during class. R was generally inattentive in class and “appeared to be daydreaming in his own mental world”. He engaged in repeated physical gestures. His attempts to engage his peers were silly and immature and generally ignored by them. In a group project, R did not meaningfully engage with the other members of his group. R was able to log onto a computer workstation, but another student gave him frequent help with his assignment. R did not participate in the physical education class he attended, instead wandering aimlessly about the gym.

[133] Dr. Kettner reports that in his one on one session with him, R continued to have a bright affect, and readily engaged in conversation, albeit in a silly and awkward manner. He engaged in some inappropriate behaviour. He provided limited and immature responses to some questions. Dr. Kettner states that some of R’s behaviours “were clear examples of his limited social skills and self-insight”.

[134] Dr. Kettner administered a battery of tests to R. He opines that the results provided an accurate and valid representation of R’s true ability and academic achievement.

[135] Dr. Kettner administered the Wechsler Intelligence Scale of Children, 4th Edition (WISC-IV) to assess R’s intellectual ability. R’s overall ability, also known as his Full-Scale IQ, was within the Borderline range, located at the 6th percentile, with a standard score of 72 – 84 at the 95% confidence interval. R’s verbal ability was also in the Borderline range, higher than only 3% of his peers, with a standard score of 66 – 80. The speed of his psychomotor testing was also in the Borderline range, faster than 6% of his peers, with a standard score of 72 – 89. R’s score on the Perceptual Reasoning Index, which evaluates the ability to reason nonverbally, was somewhat higher, in the Low Average range, higher than 16% of his peers, with a standard score of 78 – 95. R’s strongest ability was demonstrated on the Working Memory Index, which evaluates the ability to attend to and repeat numerical and letter-number sequencing, which was in the Average range, stronger than 42% of his peers, with a standard score of 89 – 105.

[136] Dr. Kettner had J complete the Scales of Independent Behaviour – Revised questionnaire, designed to measure R’s ability to function independently. The results indicated that R’s overall functioning is in the impaired range, at a level comparable to an average six year old. R’s motor skills are his area of greatest weakness, comparable to an average four and a half year old. His social skills, personal care taking and community living skills were at less than the 1st percentile compared to his peers, putting him at a level comparable to a four to nine year old.

[137] Dr. Kettner assessed R’s academic achievement using the Wide Range Achievement Test, 3rd edition. The results indicated that R’s single word reading and spelling skills are solidly within the Average range, at a level expected of a 14 year old in grade nine. R’s arithmetic skills, on the other hand, were within the Borderline range, at the 3rd percentile, or approximately a grade three level.

[138] Dr. Kettner tested R’s verbal memory using a “CVLT-C”. R’s performance was far below the average range for a child his age. The results indicated serious difficulties in learning and remembering verbal information, with most scores at less than the 1st percentile compared to his peers.

[139] Dr. Kettner tested R’s nonverbal memory using a “RCFT”. It was also in the impaired range, with impairments in both organization/planning and nonverbal memory. R was at less than the 1st percentile compared to his peers.

[140] Dr. Kettner administered a Behavioural Assessment System for Children test to R, J, and R’s teachers. There was a large degree of consensus among the three adults, indicating R was “within the clinical range of concern on a scale measuring social withdrawal”, and that R was “below or far below the average range in terms of his functional communication and adaptive living skills”. Two of the three adults, including J, reported “clinically significant levels of anxiety and depression”. The teachers rated R as significantly “atypical” in his presentation and behaviour.

[141] R’s own self-assessment was quite different, which Dr. Kettner opines likely reflects “a seriously compromised level of self-awareness and self-insight”.

[142] Dr. Kettner summarized his opinion as being that:

R's observed behaviour and results of adaptive functioning measures ... indicate serious impairments in his social interactions, communication skills, and functional living skills. Additionally, he exhibited serious impairments in memory and academic skills ... These results easily meet DSM-IV diagnostic criterion B for mental retardation. Quoting from the DSM-IV criterion B:

“Concurrent deficits or impairments in present adaptive functioning ... in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety.”

Criterion C of the DSM-IV diagnosis of mental retardation states that the onset of the individual's difficulties must be before the age of 18. R's challenges have been present since birth.

However, the current assessment, similar to prior assessments, indicates that R does not meet the DSM-IV criterion A which states that an individual's intellectual functioning must be “approximately 70 or below on an individually administered IQ tests.” An IQ score of 70 is at the 2nd percentile. R's intellectual functioning, as tested by the WISC-IV, is somewhat higher than this at the 6th percentile, within the Borderline range.

Thus, although he meets two of the 3 DSM-IV diagnostic criteria (B and C) for a diagnosis of mental retardation, he does not meet the primary criterion A of an IQ of 70 or below (2nd percentile or lower) and thus does not qualify for a diagnosis of mental retardation.

Although R does not meet DSM-IV diagnostic criteria for mental retardation, it is clear that he has significant and pervasive deficits in social, cognitive, academic and adaptive functioning. His difficulties in social functioning are compounded by his poor verbal comprehension, weak verbal reasoning, and impaired memory. He has great difficulty understanding what is appropriate, cannot accurately read social cues, and even if he does briefly comprehend what is expected of him, his memory deficits make it extremely challenging for him to apply information from one situation to a future situation. He is an “at risk” teen who will need ongoing academic and professional support.

(emphases in the original)

[143] Dr. Kettner concluded his report with the following recommendation:

Most psychological assessment reports include an extensive list of recommendations for intervention and treatment. However, the purpose of

this particular evaluation was limited to an “assessment to determine whether R is developmentally disabled (mentally retarded)” and thus an exhaustive list of recommendations has not been added. However, it is clear that the academic and community supports currently provided will need to be continued through his high school years and likely beyond. It is imperative that R be reassessed during his final year of high school, perhaps with an alternate and widely validated measure of intellectual functioning such as the Stanford-Binet. This re-evaluation is necessary because cognitive and social functioning fluctuate throughout adolescence and reassessment at the age of 18 or 19 will give a more accurate indication of how R will likely function as an adult.

Dr. Bruce Pipher

[144] Dr. Kettner thought it possible, as a result of his assessment, that R might have Autism Spectrum Disorder, also known as Pervasive Developmental Disorder. Dr. Kettner therefore recommended that R be assessed for this disorder. In the midst of the April 2007 hearing dates, the parties agreed to have R undergo such an assessment, and the hearing was adjourned to allow the assessment to occur, which happened on September 6, 2007. If R was assessed as having Autism Spectrum Disorder, he would have been entitled to services from CLBC on that basis.

[145] Dr. Bruce Pipher and the Interior Health Children’s Assessment Network performed the multidisciplinary assessment for Autism Spectrum Disorder. Dr. Pipher is a Child and Adolescent Psychiatrist. Also participating in the multidisciplinary assessment was Dr. Tavi R. Nicholson, a Registered Psychologist.

[146] On September 6, 2007, Dr. Nicholson wrote Dr. Pipher a letter, which forms part of the multi-disciplinary assessment. Dr. Nicholson begins by giving some of R’s history, which I will not review as I have done so elsewhere.

[147] Dr. Nicholson goes on to indicate that she interviewed J on September 6, 2007 using the Autism Diagnostic Interview – Revised (ADI-R). The ADI-R is divided into three major areas, corresponding to the areas addressed in the DSM-IV’s diagnostic criteria for autism spectrum disorders. Those areas are communication, social interaction and repetitive behaviours and stereotyped patterns.

[148] After recounting various behaviours described by J, Dr. Nicholson indicates that, overall, R’s scores in each of the three areas were well below the cut-off used to identify

problems associated with autism spectrum disorder. Dr. Nicholson summarized that there was little evidence based on what J had reported that suggested the presence of autism spectrum disorder.

[149] Dr. Pipher wrote a psychiatric assessment/consultation report, based upon a number of sources of information. Dr. Pipher begins by setting out some of R's history; again, I do not repeat this as its substance has been reviewed elsewhere.

[150] Dr. Pipher interviewed R, and reports that R was quite cooperative and made good eye contact. He showed a variety of gestures. R answered questions fully, and made social overtures. He had limited conversational skills, and his voice was sometimes difficult to decipher. R talked about other children whom he described as his friends, which he explained to mean they are nice to him. He reported bullying and teasing, which he felt were due to his small stature. R had a good ability to describe emotions, but was challenged in his self-reflective ability.

[151] As part of the interview, Dr. Pipher used the Autism Diagnostic Observation Scale. R's scores for communication and social interaction, alone and combined, were below the cut-off level for a diagnosis of autism spectrum disorder. R's demeanour was more typical of a child of eight or nine, rather than his chronological age, which was 15 at the time of the multidisciplinary assessment.

[152] Dr. Pipher provided the following diagnosis and impression:

- Axis I: No diagnosis
- Axis II: Borderline Intellectual Functioning
- Axis III: Noonan Syndrome
Right Conductive Hearing Loss
History of VSD and PDA
Short stature
- Axis IV: Stressors include:
Peer relationship difficulties
Academic challenges
- Axis V: Current Global Assessment of Functioning {GAF} = 52
(Moderate Functional Impairment)

[153] Dr. Pipher goes on to state that R is:

a delightful teenager who is socially very young and naïve. He presents as quite a vulnerable individual with significant developmental challenges in the area of social and personal skills and limited coping skills. He requires very regular supervision at home and has a history of previous delays in milestone development. Overall his interactions are consistent with a person with significant developmental delay appearing much younger than his stated age.

From this assessment using standardized measures and extensive review of previous evaluations, R was found not to have an Autism Spectrum Disorder. However, R clearly has developmental challenges as his overall adaptive functioning is significantly impaired as noted in Dr. Kettner's report. His overall language skills are delayed and ability to carry on conversations, along with social skills deficits. Clearly R is showing a desire for social interactions, but has difficulties making and maintaining peer relationships consistent with his chronological age. However, his overall development is delayed and his social interactions are consistent with these overall developmental challenges. There was no evidence of Axis I psychiatric diagnosis today.

[154] Dr. Pipher made a number of recommendations, including: ongoing individualized education planning at school, to help with coping, life and social skills development; prevocational and vocational skill development; and encouraging J to continue developing further supports and life skills training for R outside of school such as bowling, Special Olympics and a social skills group.

[155] Following receipt of Dr. Pipher's report, the parties asked to have the Tribunal schedule the continuation of the hearing, which occurred in May 2008.

Dr. Kettner's oral testimony

[156] As indicated above, Dr. Kettner was the only expert to testify in this hearing, which he did during the May 2008 continuation dates. He was qualified as an expert in the assessment and diagnosis of neurodevelopmental disorders, including mental retardation.

[157] Dr. Kettner went over some aspects of his report in his evidence. I do not repeat that evidence here, but have considered it in relation to his report.

[158] Dr. Kettner defined a neurodevelopmental disorder as one which impacts one or more spheres of intellectual functioning, adaptive functioning and social functioning.

[159] Dr. Kettner testified about his extensive experience in conducting assessments relating to neurodevelopmental disorders. He has conducted more than 300 such assessments, including more than 50 where the primary issue was mental retardation. He stated that any time one is conducting an assessment for mental retardation, one is also considering possible co-diagnoses or alternate diagnoses, such as autism.

[160] Dr. Kettner confirmed that R does not have mental retardation. R's full scale IQ, which is an arithmetical or statistical average of all 10 subtests administered to him, is 77. Because of the possibility of measurement error, psychologists are more comfortable talking about a range, in R's case, 72 – 84.

[161] Dr. Kettner testified that, in limited circumstances, it is possible to diagnose mental retardation in a person with an IQ over 70. Those circumstances would be where there is convergent evidence of both intellectual and adaptive functioning being significantly impacted. In such circumstances, the upper IQ limit could be stretched to 75. He emphasized, however, that this is not often done. He did not believe such a diagnosis was appropriate in R's case because of the consistency across his scores on the various sub-tests.

[162] Dr. Kettner testified that he has performed assessments, and reviewed other psychologists' reports for CLBC in the past. When assessing for "developmental disability", he uses the DSM-IV criteria for "mental retardation".

[163] Dr. Kettner gave some evidence about the length of time assessments of children remain valid. He said that for children younger than eight, an assessment would remain valid for two – five years; for children older than eight, an assessment would remain valid for three – five years, especially if assessments show consistency across time.

[164] Dr. Kettner gave some explanatory evidence about Dr. Pipher's and Dr. Nicholson's reports which I have considered in relation to their reports.

[165] In cross-examination, Dr. Kettner was asked about the general accuracy of IQ testing and scores. He testified that professionals still use IQ quite extensively, but he recognized that an IQ score is a blending of different strengths and abilities.

[166] Dr. Kettner was also asked in cross-examination what the difference was between a mentally retarded person and R. He said that the primary difference would be that R's cognitive abilities are higher. In "real life" terms, this would mean, for example, that he could read, understand and answer a written questionnaire. When asked if a person with an IQ of 70 or less could not read, Dr. Kettner testified that R reads at a substantially higher level than most mentally retarded people.

[167] Dr. Kettner was asked in cross-examination to forecast R's future progress. He testified that R would continue to have difficulties in school, social functioning and occupational functioning as compared to his age peers. By this he meant that R would continue to require assistance in school, such as special education teachers, a modified program, and adapted circumstances, such as going home daily for lunch. Projecting further into the future, Dr. Kettner testified that R would be able to work, but in a supervised, structured setting, at a low level.

[168] Dr. Kettner was asked in cross-examination why he had thought that R might be autistic. In response, he referred to "social oddities" he had observed, such as noises, repetitive greetings, and fairly restricted interests. While he thought R was probably not autistic, there were enough indicators present that he wanted to make sure he was not missing something. While Dr. Kettner is qualified to assess whether a person is autistic, making that assessment was not within the scope of his mandate as a medical-legal expert, and he thought it more ethically appropriate to recommend that someone else assess R for autism.

[169] In cross-examination, Dr. Kettner was asked how important early intervention is in addressing problems with adaptive functioning. He responded that the rule of thumb is the earlier, the better. He was also asked if the support J has given R, and his tutor, would have increased his IQ. Dr. Kettner said in response that that would not necessarily occur, and that he would expect a greater impact on R's academic and adaptive functioning, rather than his IQ.

[170] Dr. Kettner was asked in cross-examination to explain the difference between “developmental disability”, “mental retardation” and “adaptive functioning deficits”. He explained in response that “mental retardation” is an official diagnosis. The term has become pejorative in popular usage, and various groups have therefore lobbied for a neutral term, such as “developmental disability”. That term is not an exact diagnosis, and covers a broad range of neurodevelopmental disorders, including autism and FASD, which may or may not co-exist with mental retardation. Thus, “developmental disability” has been used both as a more “politically correct” term for the diagnosis of “mental retardation”, and as an “umbrella term” to cover a range of neurodevelopmental disorders. In “common usage”, Dr. Kettner testified that his understanding is that “developmental disability” is used to cover a range of DSM-IV diagnoses, including mental retardation, autism and FAS. He also said that it was fair to say that there are some developmental disabilities which are not included in the DSM-IV, such as cerebral palsy, because they are medical rather than psychiatric diagnoses. Overall, Dr. Kettner testified that he found “developmental disability” to be an imprecise and problematic term.

[171] Dr. Kettner went on to explain that mental retardation can be a cause of adaptive functioning deficits, but that such deficits may also have other causes. He was asked if adaptive functioning is more important than IQ, and disagreed, saying that the presenting symptoms noticed by people are more often adaptive functioning deficits, which will result in further investigation and testing, including IQ testing.

[172] Dr. Kettner agreed in cross-examination that it was possible a person might require assistance because of adaptive functioning deficits, but not receive services from CLBC because their IQ was too high.

[173] Dr. Kettner was asked what “significantly impaired intellectual functioning”, the term used in the *Act*, meant. He said that it would mean lower cognitive ability, reasoning, comprehension and understanding. Sometimes professionals will talk about “significant impairments” even in respect of someone in the Borderline IQ range.

[174] In re-examination, Dr. Kettner was asked why, if in making assessments for CLBC he uses the DSM-IV criteria, he testified in cross-examination that “developmental

disability” is an umbrella term. He testified that if he is asked the clinical question, he gives a clinical answer, using the DSM-IV criteria. He agreed that “developmental disability has different meanings in different contexts”. In the context of an assessment for CLBC, it would mean either mental retardation or autism.

[175] In response to a question from me, Dr. Kettner explained that there are four terms commonly used in all IQ testing, to describe different levels of intellectual ability, as follows: average, between 90 and 110; low average, between 80 and 89; borderline, between 70 and 79; and extremely low, less than 70.

[176] I also asked Dr. Kettner about two phrases used in Dr. Pipher’s report, where he said that R faced “significant developmental challenges” and is a person with “significant developmental delay”. He said that “significant” would probably mean from a statistical and clinical perspective. He said that such terms were a lot less precise than the DSM-IV categories. He could not rely on such terms in someone else’s assessment, but they would highlight to him something out of the average range.

Psycho-Educational Assessment performed by Trina Anderson

[177] Dr. Kettner also testified about a Psycho-Educational Assessment of R, dated June 12, 2006, conducted by Trina Anderson, a District Assessment Counsellor in R’s School District. I sought to introduce this document, and the respondents objected. Having heard from the parties, I ruled that the document was not an expert report, but would be admitted, with its ultimate use and weight to be determined in my final decision. I deal with that document here, in the context of Dr. Kettner’s evidence about it.

[178] According to the Assessment, the School Based Team at R’s Middle School referred R for an evaluation “due to widening gaps in social, communication, & academics”. The qualifications of the person responsible for the Assessment, Ms. Anderson, are not clear. She appears to have Bachelors and Masters Degrees in Education. Dr. Kettner could not tell from her title whether she is a Registered Psychologist or School Psychologist, who, along with psychiatrists, are the persons qualified to assess for mental retardation, and he testified that sometimes school districts will have persons without those qualifications perform such assessments.

[179] The Assessment states that it is intended to address the following questions: “what cognitive and/or academic strengths and weaknesses exist?”; “is there evidence for an ability/achievement discrepancy?”; and “what are R’s cognitive and developmental levels?”. Ms. Anderson took a report from J, which is consistent with what J has told others about R. She also took a report from R’s teacher, which is also consistent with what she has told others about R. Ms. Anderson administered two tests to R: a WISC-IV and a WIAT-II, the same intelligence scale and achievement tests administered to R by other examiners.

[180] The results of the WISC-IV administered by Ms. Anderson were similar but not identical to the results from other examiners. Overall R’s general cognitive ability was within the Borderline range. His full scale IQ result was slightly lower than on other occasions, at 70, or a range of 66 – 77. R performed slightly better on nonverbal than verbal reasoning tasks.

[181] The results of the WIAT-II were also similar but not identical to the results from other examiners. His sub-test scores ranged from 55 to 99. There are four composite scores given: reading, at 83, which Ms. Anderson thought may not be the most accurate way to summarize R’s reading skills given the disparity in his scores on the relevant sub-tests; mathematics, at 73, which is in the Borderline range; oral language, at 55, which is in the Extremely Low range; and written language, at 86, which Ms. Anderson again thought might not be the best summary of R’s overall writing skills, given the variability in R’s performance.

[182] Ms. Anderson observed that R’s conversational proficiency and activity level seemed typical for his age level.

[183] Ms. Anderson stated that R met the criteria for a student with “mild intellectual delay” as set forth by the Ministry of Education. In general, she recommended that, in planning R’s educational goals, it is crucial to continue to set realistic expectations, and that successful completion will require modifications and adaptations. Ms. Anderson provided an extensive list of recommendations in specific areas to assist R.

[184] Dr. Kettner was asked to what extent Ms. Anderson’s conclusions differed from his own. He testified that they were similar, in that they both assessed R’s cognitive

ability in the Borderline range, with an IQ between 70 and 79. They were different, in that Ms. Anderson's results were somewhat lower. More specifically, they were one half a standard deviation lower, which Dr. Kettner characterized as a "real difference", but "probably not a practical difference". Dr. Kettner explained that the 70 IQ found by Ms. Anderson is more accurately stated as an IQ in the range of 67 – 73, and the 77 IQ he found is more accurately stated as an IQ in the range of 72 – 84.

[185] Dr. Kettner testified that, as between the assessment performed by Ms. Henriksson at the Alberta Children's Hospital, and Ms. Anderson's assessment, he would have greater clinical confidence in the former, as it was performed by a qualified psychologist working in a tertiary referral centre. Comparing either with his own assessment, he would have the most confidence in his own assessment, as he saw and spoke with R himself.

X ANALYSIS

Introduction

[186] This is a complaint that R was discriminated against in relation to a service customarily available to the public on the basis of mental disability, contrary to s. 8 of the *Code*.

[187] The parties framed the issues I must decide in order to decide if the complaint is justified somewhat differently. It is clear that J bears the burden of establishing discrimination against R. It is equally clear that the respondents submit that she had not discharged that burden. They do not, however, rely on a *bona fide* reasonable justification defence. The complaint therefore stands to be decided solely on the basis of whether J has established discrimination on the basis of mental disability. If she has, then I must determine the appropriate remedies.

[188] Rather than proceeding directly to an analysis of whether J has established discrimination, it is helpful to begin by setting out the key elements of three decisions which form part of the legal backdrop to the complaint.

[189] First, I will discuss the Court of Appeal’s decision in *Fahlman*, a decision which upheld the decision of the British Columbia Supreme Court that CLBC’s restriction of “developmental disability” to “mental retardation” was invalid on administrative law grounds: *Fahlman v. Community Living B.C. and Others*, 2006 BCSC 900, upheld in *Fahlman, by his guardian ad litem Fiona Gow v. Community Living British Columbia et al*, 2007 BCCA 15. While not determinative of the ultimate question I must decide, which is whether the respondents discriminated against R on the basis of mental disability contrary to s. 8 of the *Human Rights Code*, the *Fahlman* decisions are nonetheless important in considering the legal issues before me.

[190] Second, I will discuss this Tribunal’s preliminary decision in this matter, which defined, to some extent, the scope of the complaint before me.

The *Fahlman* decisions

[191] Neil Fahlman was, at the time his adoptive mother initiated the proceeding, 19 years of age, with multiple developmental and intellectual disabilities. He was diagnosed with fetal alcohol syndrome, attention deficit disorder and pervasive developmental disorder (also known as Autism Spectrum Disorder). As a child, he received services from the Ministry and later CLBC. It will be recalled that children with Autism Spectrum Disorder are eligible for services, but not adults with this disorder; for adults to be eligible for services, they must be “developmentally disabled”, and, as they did in R’s case, CLBC applies the DSM-IV criteria for “mental retardation” to determine if adults and children are developmentally disabled and therefore eligible for services.

[192] As Mr. Fahlman’s 19th birthday approached, CLBC referred him to a psychologist to determine whether he would continue to be eligible for services as an adult. Specifically, the psychologist was to assess Mr. Fahlman’s IQ, as an IQ over 70 would, from CLBC’s perspective, disentitle him to services. The psychologist determined that Mr. Fahlman’s IQ was 79, but nonetheless recommended that he continue to receive services due to his adaptive behaviour deficits. CLBC rejected the psychologist’s recommendation, and advised Mr. Fahlman’s mother that, despite his adaptive behaviour deficits, he would no longer be eligible for services after his 19th birthday. The basis for

the decision was the application of the same criteria relied upon by CLBC in relation to J's request for R: the DSM-IV criteria for mental retardation.

[193] Mr. Fahlman's mother unsuccessfully sought internal review of CLBC's decision, and ultimately filed a petition for judicial review in Supreme Court.

[194] Mr. Fahlman was successful in Supreme Court. The Court granted judicial review on the basis that CLBC's policy of utilizing an IQ criterion of 70 – 75 was *ultra vires*. The heart of the Court's reasoning in reaching this conclusion is found in the following passage:

I have concluded that the CLBC's action following these two lines of authorities, was *ultra vires* on the basis that it was an unlawful delegation of the power to make regulations, which under s. 29 of the statute resides with Cabinet. In accordance with the statutory enactment, the Lieutenant Governor in Council alone has the ability to promulgate criteria to determine who meets the criteria for "developmental disability" as set out in s. 1 of the *Act*.

It is clear that the legislative intent was to expressly leave the important determination of criterion to cabinet. In this case the CLBC has denied on the basis of an unlegislated criterion. Further, I am of the view that in doing so, the CLBC has fettered its own discretion by adopting the IQ policy and then refusing to consider other factors that are relevant ... Therefore, in this case I find that CLBC has impermissibly structured its discretion using its own rigid criteria of IQ below the 70 to 75 range in a manner which precluded it from considering the merits of Neil's case. (paras. 27 – 28)

[195] In other words, CLBC's denial of services to Mr. Fahlman was invalid on two administrative law grounds: first, on the basis that it had utilized criteria which had not been legislated, amounting to an unlawful sub-delegation of Cabinet's authority to prescribe criteria; and second, on the basis that CLBC had fettered its own statutory discretion by the adoption of a rigid IQ criterion.

[196] In the result, the Court quashed CLBC's decisions denying Mr. Fahlman continued benefits and ordered CLBC to reconsider his eligibility on the basis of the criteria mandated by the statute.

[197] CLBC appealed to the Court of Appeal, which upheld the Supreme Court's decision. The Court addressed each of three grounds of appeal raised by CLBC.

[198] First, CLBC submitted that the Supreme Court erred in its interpretation of “developmental disability” by ignoring the requirement that applicants have “significantly impaired intellectual functioning”. CLBC submitted that “significantly impaired intellectual functioning” should be accorded its technical and scientific meaning, which it said was set out in the DSM-IV.

[199] The Court accepted this argument, in part. Specifically, it held that the Supreme Court had erred in finding only two statutory criteria for “developmental disability”, namely onset before age 18 and impaired adaptive functioning, and not recognizing “significantly impaired intellectual functioning” as a third statutory criterion: para. 28.

[200] The Court also rejected this argument, in part. Specifically, it rejected the submission that CLBC’s “IQ criterion falls under the rubric of ‘significantly impaired intellectual functioning’”: para. 29. The Court stated that “the *Act* does not support the construction of the term as meaning only, ‘measured intellectual functioning of approximately 70 or below’”: para. 29.

[201] Further, in relation to CLBC’s submission that reference should be made to the DSM-IV definition of “mental retardation” in this connection, the Court stated:

... it is apposite to note that the texts define “mental retardation”, as opposed to “developmental disability”. Further, the phrase “significantly impaired intellectual functioning”, appears in none of the texts: the DSM-IV alludes to “significantly subaverage intellectual functioning”. These factors limit the texts’ usefulness. (para. 29) (emphases in the original)

[202] Also in relation to this submission, the Court was not prepared to take judicial notice of the DSM-IV extracts placed before it, stating that they were properly characterized as expert evidence, only to be entered through an expert witness, which had not been done in that case: paras. 30 – 31.

[203] The Court noted CLBC’s reliance on certain extracts from Hansard as evidence that the legislature intended the use of an IQ benchmark to determine “significantly impaired intellectual functioning”: para. 33. The Court stated that “it would be imprudent to equate the apparent intention of certain individuals to the intention of the legislature as a whole”: para. 33. Further, the Court held that CLBC’s:

interpretation of the Hansard extracts is unsustainable: the extracts cannot be said to indicate the legislature’s endorsement of the IQ criterion ... the Hansard extracts more reasonably support the interpretation that the legislature decided against imposing an IQ criterion due to community concerns with a rigid guideline and the need for flexibility. The inclusion of an IQ or other rigid criterion was to be the subject of ongoing consultation and review. (para. 33)

[204] Finally in relation to this submission, the Court:

Emphasize[d] that the legislature could easily have provided by regulation, under s. 29 of the *Act*, that only individuals with an IQ of 70 or below are eligible for adult CLBC services. It did not. Therefore, IQ level cannot be determinative of the existence of “significantly impaired intellectual functioning”. In my view, the *Act* is unambiguous in this respect. In any event, it has been suggested that any ambiguity in a benefit-concurring statute should be resolved in favour of the claimant... In my view, the *Act* can fairly be characterized as a benefit-conferring statute that is protective of vulnerable persons in the community...

Ultimately, I do not consider that on any reasonable interpretation it can be said that the term “significantly impaired intellectual functioning” imports the IQ criterion employed by CLBC.... (paras. 35 – 36)

[205] Second, CLBC submitted that the Supreme Court erred in holding that its use of the IQ criterion constituted an unlawful sub-delegation of Cabinet’s statutory regulation-making power.

[206] The Court rejected this submission, accepting the Supreme Court’s conclusion on this point.

[207] Third, CLBC submitted that the Supreme Court erred in holding that its use of the IQ criterion constituted an unlawful fettering of its statutory discretion. Essentially, CLBC argued that the *Act* did not grant it any discretion, and that it was required to apply the specific criteria set out in the *Act*, which it had done.

[208] The Court also rejected this submission. It held that the *Act* clearly did grant CLBC discretion in determining eligibility for services, stating that:

whether an applicant has ‘significantly impaired intellectual functioning’ so as to have a ‘developmental disability’ and therefore warrant ‘community living support’ appears to be a discretionary decision. Application of the statutory criteria does not necessarily yield an incontrovertible result. CLBC’s duty to satisfy itself as to the presence of

the qualifying impairment is to be exercised on the facts of each case.
(para. 50)

[209] Further, the Court held that, “in adopting a policy interpreting ‘significantly impaired intellectual functioning’ as requiring a below-70 IQ, CLBC can fairly be said to have fettered its discretion”: para. 51.

[210] Again, the Court emphasized in this connection that:

Had the legislature intended IQ to be partially determinative of “significantly impaired intellectual functioning” and, therefore, “developmental disability”, it could have invoked s. 29 of the *Act*. Namely, the Lieutenant Governor in Council could have specifically prescribed the IQ threshold as an additional criterion “for the purpose of paragraph (c) of the definition of ‘developmental disability’ in section 1”. Instead, the legislature seemed reticent to impose rigid rules. Until the legislature decides to impose such rules, the Act as it currently reads confers discretion on CLBC to determine whether an applicant has “significantly impaired intellectual functioning” so as to be developmentally disabled and thus eligible for “community living support”. In exercising its discretion, CLBC is required to consider fully the facts, circumstances and merits of each application. The IQ policy precludes such consideration and application thereof gives rise to a fettering of discretion. (para. 55)

[211] In the result, the Court of Appeal upheld the Supreme Court’s orders quashing CLBC’s decisions and requiring CLBC to reconsider Mr. Fahlman’s eligibility for benefits in accordance with the statutory requirements.

[212] I will return to the *Fahlman* decisions, and their significance to the present complaint, in the course of my analysis of whether J has established discrimination contrary to the *Code*.

The Tribunal’s Preliminary Decision

[213] The respondents filed an application to dismiss this complaint on a preliminary basis. The Tribunal denied that application. In the course of doing so, the Tribunal made some statements which are relevant to the scope of the complaint and the issues before me.

[214] First, the respondents submitted that the complaint should be dismissed on the basis that R is not part of the public to whom CLBC's services are customarily available, with the result that the complaint is outside the Tribunal's jurisdiction.

[215] The Tribunal rejected this submission.

[216] In doing so, the Tribunal held that CLBC provides services, including community living support services to persons with developmental disabilities, and to other prescribed persons. On this basis, the Tribunal held that "thus, the category of individuals to whom CLBC may provide community living support services is not closed, and will vary depending on eligibility criteria and regulations that may be passed from time to time": para. 25. Further, the Tribunal held, relying on *Fahlman*, that "part of the 'service' provided by CLBC is the determination of eligibility for its services": paras. 26 – 27.

[217] The Tribunal went on to refer to the Supreme Court of Canada's decision in *University of British Columbia v. Berg* (1993), 18 C.H.R.R. D/310, and the discussion therein of who the "public" is for any given service, and stated:

In this case, given the somewhat changeable nature of the "public" to whom the services in question may be provided, the fact that part of the service provided by CLBC is to determine eligibility for its services, and the fact that the very essence of J's complaint relates to the criteria for a diagnosis of developmental disability (or the issue of whether the eligibility criteria are themselves discriminatory) and the manner in which those criteria were applied to R, I cannot find that the complaint is not within the jurisdiction of the Tribunal.... (para. 30)

[218] Second, the respondents submitted that the complaint should be dismissed either because it failed to allege acts or omissions which contravened the *Code* or because it had no reasonable prospect of success. The basis for these submissions was that R was determined to be ineligible because he did not meet the criteria for services, those criteria were based on the DSM-IV, and they were applied fairly and non-discriminatorily.

[219] In considering these submissions, the Tribunal held that some of the acts or omissions alleged in the complaint could contravene the *Code*, while others could not.

[220] Specifically, the Tribunal rejected J's submission that "the fact that children with other chronic mental health problems, such as Autism and Asperger's Syndrome are

provided services despite having an IQ score over 70 establishes a claim of discrimination”: para. 33. In addressing this submission, the Tribunal stated that:

The fact that the Ministry provides services to those with a variety of disabilities (in this case, including those with Autism Spectrum disorder and those with Developmental Disabilities) does not, in and of itself, constitute a violation of the *Code*. Nor does the fact that the respondents take into account the different characteristics of the different illnesses in determining eligibility. As noted by the respondent, the disorders included in Autism Spectrum Disorder have different hallmarks than developmental disabilities, and are assessed using different criteria. The fact that the two different types of disabilities are assessed on different bases could not constitute a violation of the *Code*. (para. 33)

[221] The Tribunal then noted J’s reliance on the British Columbia Supreme Court’s decision in *Fahlman*. The Tribunal held that that decision was not determinative of the issues then before it, stating, “the issue was not whether CLBC had statutory authority for the criteria which it employed, or whether it fettered its discretion with respect to eligibility for its services, but whether there is a reasonable prospect that the complainant will be able to show that the criteria used, or their application in this case, were discriminatory”: para. 34.

[222] The Tribunal held that “the relevant part of the complaint”, by which I take it to mean the part of the complaint that could contravene, and had a reasonable prospect of being held to contravene, the *Code*, was:

the allegation that the eligibility criteria used by CLBC were discriminatory, and that they were applied in a discriminatory manner. In effect, the complainants assert that R received differential treatment with respect to the services provided by CLBC because of the way in which his disability was viewed by CLBC. In my view, this constitutes an allegation that could be found to be a contravention of the *Code*. (para. 35)

[223] The Tribunal rejected the respondents’ submission that there could be no discrimination because the criteria used were those found in the DSM-IV. The Tribunal noted in this connection that it was not clear that the DSM-IV criteria for mental retardation were necessarily applicable to a definition of developmental disability. Further, the Tribunal stated that the fact that specific criteria were used did not provide any information about “the manner in which such criteria were developed, the manner in

which they are generally applied by medical practitioners, the weight given to each criterion, the inter-relationship of the criteria, and whether additional or alternative diagnostic criteria were available”: para. 40. Nor, the Tribunal stated, did the fact that specific criteria were used provide any guidance with respect to whether they were applied in a discriminatory manner in a given case: para. 40.

[224] For these reasons, and others, the Tribunal declined to dismiss the complaint as a whole. Further, it declined to dismiss the complaint as against Ms. Havens in particular: paras. 49 – 59. In the latter regard, the Tribunal held that there appeared to be acts alleged against Ms. Havens that could contravene the *Code*, and that it could not conclude on the information before it that it would not further the purposes of the *Code* to allow the complaint to proceed as against Ms. Havens.

[225] As a matter of law, only the Tribunal’s ultimate conclusion that the complaint should not be dismissed on a preliminary basis, either as a whole or as against Ms. Havens in particular, is binding for the purposes of this proceeding. In particular, no references the Tribunal made to the written information and evidence before it on the preliminary application to dismiss is determinative of the facts to be found on the basis of the evidence before me.

[226] That said, the Tribunal’s discussion of the complaint in the preliminary decision, in particular its discussion of which aspects of the complaint did or did not have a reasonable prospect of success, is very helpful in considering the scope of the complaint before me. In this regard, the respondents submitted that the Tribunal’s preliminary decision “refined” the scope of the complaint, and they relied upon it in the way they framed their submissions. I agree with the respondents’ characterization of the effect of the Tribunal’s preliminary decision. I find the legal analysis contained in the preliminary decision persuasive, and rely upon it in the course of my analysis.

The parties

[227] Before turning to my analysis of whether discrimination has been established, it is useful, for the sake of the clarity of that analysis, to address two issues with respect to the parties to this complaint.

Who are the proper complainants?

[228] J filed a complaint form which named herself as the complainant. In addition, she filed a representative complaint form indicating that she was filing the complaint on behalf of R. These are the appropriate means by which to file a representative complaint on behalf of another individual under s. 21(4) of the *Code*, and in particular, on behalf of another individual who is unable to file a complaint himself.

[229] The Tribunal has, throughout, styled the complaint as being filed by “J, and J on behalf of R”. That is, it has treated it as a complaint filed both on J’s behalf and on R’s behalf.

[230] In the course of closing submissions, I asked J’s counsel if he was alleging that J was discriminated against, and if so, how. Counsel indicated that he was making that allegation. In doing so, he conceded that CLBC was not providing J with a service, but submitted that the services R receives impact the family unit, and that J’s dignity was affected by CLBC’s conduct. On this basis, counsel sought remedies, in particular compensation for injury to dignity, on behalf of both J and R.

[231] In his submissions, counsel for the respondents stated that the respondents had never seen J as a complainant on her own behalf.

[232] In my view, it is clear that the complaint is solely on behalf of R, and not J. While it is true that CLBC provides some services to families, the service J applied for on R’s behalf was a youth worker, for his individual benefit. Any benefit the family unit as a whole would have obtained from R obtaining the services of a youth worker, and conversely any adverse effect suffered by J, is too remote to found a complaint of discrimination on behalf of anyone but R.

[233] Similarly, J was not part of the “public” to whom the service of a youth worker, or the determination of eligibility for the service of a youth worker, was customarily provided. R was part of that “public”.

[234] It is not clear to me that J originally intended this to be anything other than a representative complaint on behalf of her son R. All of the allegations of fact contained

in the complaint form relate solely to R. Properly construed, the complaint is solely on behalf of R.

[235] In the circumstances, I am not sure that it is necessary to dismiss the complaint on behalf of J, as I am not sure there ever was a complaint on behalf of J. I think it likely the Tribunal made an administrative error in ever treating the complaint as being on J's behalf. Out of caution, and in light of J's counsel's submissions, in order to ensure there is no misunderstanding or lack of clarity, I dismiss the complaint on behalf of J on the basis that J is not mentally disabled, was not a member of the public to whom the service sought was customarily available, and accordingly, was not denied or discriminated against in respect of any service on the basis of mental disability, contrary to s. 8 of the *Code*.

Who are the proper respondents?

[236] J filed the complaint against "Her Majesty the Queen in right of the Province of British Columbia as represented by the Ministry of Children and Family Development – Community Living British Columbia and Cari Havens".

[237] As indicated above in my discussion of the Tribunal's preliminary decision, the respondents applied to dismiss the complaint as against Ms. Havens. On the information before the Tribunal at that time, that part of the application was denied.

[238] Having had the benefit of hearing the evidence, it is clear to me that the complaint against Ms. Havens in her personal capacity ought to be dismissed.

[239] Ms. Havens was the person with whom J interacted in making the application for services on R's behalf. Contrary to J's counsel's submissions, there was nothing malicious or reckless about the manner in which Ms. Havens dealt with J and her application. In dealing with J and the application, Ms. Havens was a member of a team, including her manager Ms. McNeill, who were collectively responsible for making the eligibility decision. Further, in doing so, they relied on the professional advice they received from Dr. Deatherage about R's IQ and resulting eligibility. Finally, and most importantly, Ms. Havens, like the other members of her team and Dr. Deatherage, were acting in accordance with policy directives stipulated by the Ministry and CLBC. She did

not see herself as having any real discretion in the matter, but considered herself bound to apply the Ministry and CLBC's directives.

[240] In all of these circumstances, it is apparent that it is the Ministry and CLBC which are responsible for any discrimination which may have occurred. It would be unfair, and contrary to the purposes of the *Code*, to hold a person such as Ms. Havens, who was only doing her job within the parameters defined by her employer and the bodies responsible for setting policy, responsible for any discrimination which may have occurred as the result of the application of those policies.

[241] For these reasons, I dismiss the complaint as against Ms. Havens.

[242] As a result of these conclusions, the complaint of discrimination to be decided is made by J, on behalf of her son R, against the Ministry and CLBC. All references to the "respondents" henceforth in the decision should be taken to refer solely to the Ministry and CLBC, and not Ms. Havens.

Analytical structure to determine if discrimination has been established

[243] The parties' submissions with respect to the appropriate analytical structure to employ in determining if discrimination has been established reflected the varying approaches in the jurisprudence and resulting lack of certainty on this issue. Much of that uncertainty has related to the potential application of *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 571, to complaints of discrimination contrary to the *Code*.

[244] While I have considered all of the parties' submissions about this and all issues addressed by them, I do not repeat their submissions here.

[245] In this decision I follow the general approach to analyzing discrimination very recently set out by the Tribunal in *Miller v. BCTF (No. 2)*, 2009 BCHRT 34. In that decision, the Tribunal sought to synthesize the various strands of jurisprudence on this issue, including those referred to by the parties, in light of the comments of the Supreme Court of Canada about *Law* in its recent decision in *R. v. Kapp*, 2008 SCC 41. In *Miller*, the Tribunal stated that:

The debate about whether *Law* applies in considering whether *prima facie* discrimination contrary to the *Code* has been established has been largely overtaken by recent jurisprudence, both from the Supreme Court of Canada and this Tribunal.

In *Kapp*, the Supreme Court considered the application of *Law* in its original context of an alleged breach of s. 15 of the *Charter of Rights and Freedoms*. After discussing the Court's seminal decision in *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143, the majority stated:

A decade later, in *Law*, this Court suggested that discrimination should be defined in terms of the impact of the law or program on the "human dignity" of members of the claimant group, having regard to four contextual factors: (1) pre-existing disadvantage, if any, of the claimant group; (2) degree of correspondence between the differential treatment and the claimant group's reality; (3) whether the law or program has an ameliorative purpose or effect; and (4) the nature of the interest affected (paras. 62-75).

The achievement of *Law* was its success in unifying what had become, since *Andrews*, a division in this Court's approach to s. 15. *Law* accomplished this by reiterating and confirming *Andrews'* interpretation of s. 15 as a guarantee of substantive, and not just formal, equality. Moreover, *Law* made an important contribution to our understanding of the conceptual underpinnings of substantive equality.

At the same time, several difficulties have arisen from the attempt in *Law* to employ human dignity as a legal test. There can be no doubt that human dignity is an essential value underlying the s. 15 equality guarantee. In fact, the protection of all of the rights guaranteed by the *Charter* has as its lodestar the promotion of human dignity. As Dickson C.J. said in *R. v. Oakes*, [1986] 1 S.C.R. 103:

The Court must be guided by the values and principles essential to a free and democratic society which I believe embody, to name but a few, respect for the inherent dignity of the human person, commitment to social justice and equality, accommodation of a wide variety of beliefs, respect for cultural and group identity, and faith in social and political institutions which enhance the participation of individuals and groups in society. [p. 136]

But as critics have pointed out, human dignity is an abstract and subjective notion that, even with the guidance of the four contextual factors, cannot only become confusing and difficult to apply; it has also proven to be an additional burden on equality claimants, rather

than the philosophical enhancement it was intended to be. Criticism has also accrued for the way *Law* has allowed the formalism of some of the Court's post-*Andrews* jurisprudence to resurface in the form of an artificial comparator analysis focussed on treating likes alike.

The analysis in a particular case, as *Law* itself recognizes, more usefully focuses on the factors that identify impact amounting to discrimination. The four factors cited in *Law* are based on and relate to the identification in *Andrews* of perpetuation of disadvantage and stereotyping as the primary indicators of discrimination. Pre-existing disadvantage and the nature of the interest affected (factors one and four in *Law*) go to perpetuation of disadvantage and prejudice, while the second factor deals with stereotyping. The ameliorative purpose or effect of a law or program (the third factor in *Law*) goes to whether the purpose is remedial within the meaning of s. 15(2). (We would suggest, without deciding here, that the third *Law* factor might also be relevant to the question under s. 15(1) as to whether the effect of the law or program is to perpetuate disadvantage.)

Viewed in this way, *Law* does not impose a new and distinctive test for discrimination, but rather affirms the approach to substantive equality under s. 15 set out in *Andrews* and developed in numerous subsequent decisions. The factors cited in *Law* should not be read literally as if they were legislative dispositions, but as a way of focussing on the central concern of s. 15 identified in *Andrews* — combatting discrimination, defined in terms of perpetuating disadvantage and stereotyping.

The central purpose of combatting discrimination, as discussed, underlies both s. 15(1) and s. 15(2). Under s. 15(1), the focus is on preventing governments from making distinctions based on the enumerated or analogous grounds that: have the effect of perpetuating group disadvantage and prejudice; or impose disadvantage on the basis of stereotyping. Under s. 15(2), the focus is on enabling governments to pro-actively combat existing discrimination through affirmative measures. (paras. 19 – 25, footnotes omitted) (emphasis added)

I agree with the BCTF's submission that the Supreme Court's approach in *Kapp* is the approach this Tribunal has been taking in cases such as *Esposito v. B.C. (Ministry of Skills, Development and Labour) (No. 2)*, 2006 BCHRT 300; *Preiss v. B.C. (Ministry of Attorney General) (No. 3)*, 2006 BCHRT 587; *Stopps v. Just Ladies Fitness (Metrotown) and D. (No. 3)*, 2006 BCHRT 557; and *Stone v. B.C. (Ministry of Health) (No. 7)*, 2007 BCHRT 55.

In short, in order to establish a *prima facie* case of discrimination there must be discrimination in a substantive or purposive sense. In many cases, *prima facie* discrimination in this sense will be readily established on proof of the existence of adverse treatment related to a ground prohibited under the *Code*. In others, particularly those where competing valid public policies or values are in issue, something more may be required, and the *Law* factors, and the focus they bring on human dignity, may be of assistance in deciding whether *prima facie* discrimination has been established: see, for example, *Preiss* at paras. 234 – 235.

[246] In what follows, I therefore determine whether J has established that R was discriminated against by the respondents in a purposive or substantive sense, considering a number of factors which have been identified in the jurisprudence as relevant to that question, as I consider appropriate in the context of this particular complaint.

[247] For the purposes of this complaint, I propose to break the analysis of whether the respondents breached R's rights under s. 8 of the *Code* into the following constituent parts:

1. Is R mentally disabled within the meaning of the *Code*?
2. What services, if any, are in issue?
3. Who is the public to whom those services are customarily available, and is R a member of it?
4. Was R denied a service, or did he receive differential treatment in respect of such a service?
5. Was R's mental disability a factor in the denial or differential treatment?
6. Was the denial or differential treatment discriminatory in the substantive or purposive sense required to establish a violation of s. 8 of the *Code*?

[248] While there is some overlap between these questions, breaking the analysis down in this way should provide greater analytical clarity.

1. Is R mentally disabled within the meaning of the *Human Rights Code*?

[249] There is no dispute that R has a mental disability.

[250] R has been diagnosed with Noonan's Syndrome. R has a number of characteristics commonly associated with Noonan's Syndrome, both mental and physical.

[251] Further, R has been the subject of multiple assessments. Those assessments have consistently shown him to have Borderline Intellectual functioning, with a full-scale IQ tested at between 70 and 77. Those assessments, especially those of Dr. Kettner, upon whose evidence I place the greatest weight, as well as that of Dr. Pipher, upon whose assessment I also rely, have also consistently shown him to have serious impairments in his adaptive functioning.

[252] Dr. Kettner's summary of his opinion about R bears repeating in this connection:

R's observed behaviour and results of adaptive functioning measures ... indicate serious impairments in his social interactions, communication skills, and functional living skills. Additionally, he exhibited serious impairments in memory and academic skills ... These results easily meet DSM-IV diagnostic criterion B for mental retardation. Quoting from the DSM-IV criterion B:

“Concurrent deficits or impairments in present adaptive functioning ... in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety.”

Criterion C of the DSM-IV diagnosis of mental retardation states that the onset of the individual's difficulties must be before the age of 18. R's challenges have been present since birth.

However, the current assessment, similar to prior assessments, indicates that R does not meet the DSM-IV criterion A which states that an individual's intellectual functioning must be “approximately 70 or below on an individually administered IQ tests.” An IQ score of 70 is at the 2nd percentile. R's intellectual functioning, as tested by the WISC-IV, is somewhat higher than this at the 6th percentile, within the Borderline range.

Thus, although he meets two of the 3 DSM-IV diagnostic criteria (B and C) for a diagnosis of mental retardation, he does not meet the primary criterion A of an IQ of 70 or below (2nd percentile or lower) and thus does not qualify for a diagnosis of mental retardation.

Although R does not meet DSM-IV diagnostic criteria for mental retardation, it is clear that he has significant and pervasive deficits in social, cognitive, academic and adaptive functioning. His difficulties in social functioning are compounded by his poor verbal comprehension, weak verbal reasoning, and impaired memory. He has great difficulty understanding what is appropriate, cannot accurately read social cues, and

even if he does briefly comprehend what is expected of him, his memory deficits make it extremely challenging for him to apply information from one situation to a future situation. He is an “at risk” teen who will need ongoing academic and professional support.

(emphases in the original)

[253] It is clear, on all of the evidence, that R does not meet the criteria for a diagnosis of “mental retardation” under the DSM-IV. It is equally clear, on all of the evidence, that R has, as Dr. Kettner put it, “significant and pervasive deficits in social, cognitive, academic and adaptive functioning”. Dr. Pipher’s description of R is to the same effect:

He presents as quite a vulnerable individual with significant developmental challenges in the area of social and personal skills and limited coping skills. He requires very regular supervision at home and has a history of previous delays in milestone development. Overall his interactions are consistent with a person with significant developmental delay appearing much younger than his stated age.

... However, R clearly has developmental challenges as his overall adaptive functioning is significantly impaired as noted in Dr. Kettner’s report. His overall language skills are delayed and ability to carry on conversations, along with social skills deficits. Clearly R is showing a desire for social interactions, but has difficulties making and maintaining peer relationships consistent with his chronological age. However, his overall development is delayed and his social interactions are consistent with these overall developmental challenges.

[254] This is sufficient to establish mental disability for the purposes of the *Code*.

2. What services, if any, are in issue?

[255] I agree with the Tribunal’s preliminary decision that there are two aspects to the “service” potentially engaged by this complaint. First, CLBC provides a “service” in determining if an applicant is eligible to receive services. Second, there is the actual service applied for.

[256] In this case, J applied to CLBC for a youth service worker for R. CLBC assessed the application according to the criteria set out in the policies imposed both by the Ministry and itself. The assessment of that application was a service provided to persons applying for services from CLBC. It could be termed a “procedural service” or a

“selection service”. As such, it is analogous to the University admissions process which the Supreme Court of Canada held constituted a service subject to the *Code* in *Berg*, paras. 50 – 55. Potentially at least, the respondents could have discriminated against R with respect to that procedural or selection service.

[257] CLBC provides a wide range of what would more commonly be perceived as services to applicants who are deemed eligible for them. That range of services includes the services of a youth services worker, which is the service J applied for on R’s behalf. That service, the one actually sought, could be termed the “substantive service”. Again, R could potentially have been discriminated against in relation to this service.

[258] The respondents do not dispute that CLBC provides these two kinds of services. They do dispute whether R is part of the “public” to which at least the latter, substantive service, is customarily available. It is to that question that I turn next.

3. Who is the public to whom those services are customarily available, and is R a member of it?

[259] The notions of a “public” to whom a “service” is “customarily available” are conceptually difficult. Chief Justice Lamer’s decision in *Berg, supra*, remains the most authoritative discussion of these concepts. There, the Chief Justice stated:

... no service or facility is absolutely available to everyone who desires it. Most of the services and facilities listed in *Gay Alliance* [an earlier decision of the Court] would be insulated from scrutiny on this test, since, for example, restaurant service is not available to people with no money, nor is tavern service available to those under the legal drinking age. Such an absolute position, requiring the “public” to include every member of a “community”, cannot be maintained if human rights legislation is to have any impact.

Therefore, I would reject any definition of “public” which refuses to recognize that any accommodation, service or facility will only ever be available to a subset of the public. Students admitted to a university or school within the university, or people who enter into contracts of insurance with a public insurer, or people who open accounts with financial institutions, become the “public” for that service. Every service has its own public, and once that “public” has been defined through the use of eligibility criteria, the *Act* prohibits discrimination within that public. (paras. 54 – 55)

[260] Thus, the use of eligibility criteria may result in the selection of a “public” to whom a service is customarily available, and against whom discrimination contrary to the *Code* is prohibited. This does not mean, however, that such eligibility criteria and processes are themselves immune to scrutiny under the *Code*. As further stated by Chief Justice Lamer in *Berg*:

The proper significance of an eligibility or admission threshold in this context was recognized by the Board of Inquiry in *Rawala*, where such a selection process was not used “to establish an exclusive or private institution from which ordinary members of the public will generally be excluded”, but rather to insist “only on such educational qualifications as are necessary to permit the individual to take successful advantage of the services offered”.

... This reasoning is directly applicable to any selection process used by the School in this case. Eligibility criteria, as long as they are non-discriminatory, are a necessary part of most services, in that they ensure that the service reaches only its intended beneficiaries, its “public” thereby avoiding overuse and unnecessary depletion of scarce resources. The benefits of such screening tools, however, should not come at the cost of excluding the protection of human rights legislation.

...

Instead, in determining which activities of the School are covered by the *Act*, one must take a principled approach which looks to the relationship created between the service or facility provider and the service or facility user by the particular service or facility. (paras. 55 – 59)

[261] Lamer C.J. referred with approval to an article written by Professor Donna Greschner, in which she referred to this “relational” approach to defining the “public”. He concluded on this point:

The idea of defining a “client group” for a particular service or facility focuses the inquiry on the appropriate factors of the nature of the accommodation, service or facility and the relationship it establishes between the accommodation, service or facility provider and the accommodation, service or facility user, and avoids the anomalous results of a purely numerical approach to the definition of the public. Under the relational approach, the “public” may turn out to contain a very large or very small number of people. (para. 62)

[262] Applying these principles to the services in issue in this complaint, it is apparent that R was a member of the public to which CLBC customarily provides the procedural

or selection service of assessing their applications for substantive services. Any member of the public may apply for the services CLBC provides, and it is up to CLBC to provide the service of assessing such applications in accordance with law.

[263] While not entirely clear, I do not believe that the respondents take issue with the proposition that the process of assessing applications to determine eligibility is a service customarily available to the wider public, including R. The respondents clearly do take the position that the substantive services provided by CLBC are a service customarily available to the public, but that R is not a member of that public. The basis of this submission is that R does not meet CLBC's eligibility criteria, and therefore is not a member of the public it customarily serves.

[264] The difficulty with this submission is that it assumes that the criteria employed by CLBC to determine eligibility for services are non-discriminatory, which is a significant and perhaps determinative issue in this case. As stated in *Berg*, "eligibility criteria, as long as they are non-discriminatory, are a necessary part of most services, in that they ensure that the service reaches only its intended beneficiaries, its 'public' thereby avoiding overuse and unnecessary depletion of scarce resources. The benefits of such screening tools, however, should not come at the cost of excluding the protection of human rights legislation." In other words, the eligibility criteria employed by CLBC must themselves be examined to determine if they are non-discriminatory; they are not shielded from review under the *Code*.

[265] The evidence before me is clear that R is not part of the public CLBC considers itself obligated to serve. This position is the result of the policy directives emanating both from within CLBC and the Ministry, mandating the use of the DSM-IV criteria for a diagnosis of "mental retardation" to determine if an applicant is "developmentally disabled" and therefore eligible for services. But to allow this position to be determinative of the question of whether R was a member of the public to whom CLBC customarily provides services would be essentially circular, as it would mean that CLBC, by employing a set of eligibility criteria which have the effect of excluding R from services, is able to thereby define the public to whom it customarily provides services, and immunize the application of those eligibility criteria to R from human rights review.

Such a result would be contrary to fundamental human rights principles, including the principled and relational approach to determining the public for services established in *Berg*.

[266] I therefore provisionally conclude on this issue that R may be a member of the public to which CLBC customarily provides, or ought customarily to provide services, including the provision of youth worker services. The ultimate question of whether CLBC discriminated against R in denying him the services of a youth services worker, which, in the circumstances of this case, is inclusive of the question of whether he is a member of the public to which such services are customarily available, is properly answered through an assessment of the eligibility criteria employed, and whether they are discriminatory, an assessment which I make below.

4. Was R denied a service, or did he receive differential treatment in respect of such a service?

[267] R was not denied the service of having the application made by J assessed. Nor was he subject to differential treatment in respect of how his application was assessed. So far as the evidence before me shows, J's application for services for R was assessed in the same manner that CLBC assesses all such applications, and according to the same criteria.

[268] This, however, is not the end of the analysis. While the application for services for R was assessed in the same manner and according to the same criteria as all such applications, CLBC's decision was to deny R the services applied for. That was a denial of services, potentially in contravention, as the respondents submitted, of s. 8(1)(a), not s. 8(1)(b), of the *Code*.

[269] It will be noted that I have not found it necessary, in considering whether there was discriminatory differential treatment or denial, to engage in what the Court in *Kapp* called "an artificial comparator group analysis": para. 22. I found the parties' submissions with respect to the identity of an appropriate comparator group in this case most unhelpful. In making this observation, I do not mean to criticize counsel, as their submissions on this point reflected the very artificiality cautioned against by the Court in

Kapp. What will become apparent is, that to the extent it is helpful to discuss comparators at all in a case such as this, the appropriate comparison is between the respondents' treatment of R, as a person with a developmental disability with an IQ over 70, to their treatment of other persons with developmental disabilities who have IQs of 70 or below. This comparison is based on the terms of the *Act* itself, which mandates the provision of services to all children and adults with developmental disabilities, and the policies adopted by the respondents, under which only those developmentally disabled children and adults with IQs of 70 or below are deemed entitled to services. In essence, it is the *Act* that draws the defining line between those entitled to services and those who are not.

[270] The appropriate comparison is not, as suggested by J in some of the submissions made on her behalf, with children with autism or children with "chronic mental health problems".

5. Was R's mental disability a factor in the denial or differential treatment?

[271] As just indicated, R was denied services. The reason for that denial is clear on the evidence. CLBC denied the service on the basis that R did not meet the criteria it applies for receiving it, specifically, he did not have an IQ of 70 or lower, and therefore did not meet the DSM-IV criteria for mental retardation.

[272] Each person's abilities and disabilities are unique. In R's case, he does not meet one of the three criteria established in the DSM-IV for a diagnosis of mental retardation. He meets two of the criteria in that he has concurrent deficits or impairments in present adaptive functioning in at least two areas, and his condition onset before age 18, but, because he has an IQ slightly over the 70 threshold, he cannot be diagnosed as mentally retarded. In this regard, I note Ms. Anderson's testing results, which showed an IQ of 70, which would be sufficient for a diagnosis of mental retardation. Given that Ms. Anderson's qualifications are unclear, and the fact that she did not testify, I prefer Dr. Kettner's testing results, which showed an IQ of 77. Even with a 5 point margin of error, this result is marginally too high to permit a diagnosis of mental retardation.

[273] Yet it is clear that R is significantly disabled: he has Noonan's Syndrome, a recognized neurodevelopmental disorder, which, according to Dr. Bartel, falls within the umbrella definition of developmental disabilities; an IQ in the borderline range, somewhere around the 6th percentile; and what Dr. Kettner has called "significant and pervasive deficits in social, cognitive, academic and adaptive functioning", and Dr. Pipher has called "significant developmental delay".

[274] The decision of the Supreme Court of Canada in *Battlefords and District Co-operative Ltd. v. Gibbs*, [1996] 3 S.C.R. 566, conclusively established that, "in order to find discrimination on the basis of disability, it is not necessary that all disabled persons be mistreated equally": para. 27. Relying on its previous decisions in *Janzen v. Platy Enterprises Ltd.*, [1989] 1 S.C.R. 1252, and *Brooks v. Canada Safeway Ltd.*, [1989] 1 S.C.R. 1219, the Court stated that "discrimination against a subset of the relevant group, in the instant case, the mentally disabled, may be considered discrimination against the relevant group generally for the purposes of human rights legislation": para. 28.

[275] What the Court said in *Gibbs* in relation to discrimination as between mentally and physically disabled people is equally applicable in relation to discrimination as between different groups of mentally disabled people – the fact that only a subset of mentally disabled people may be discriminated against does not mean that the discrimination does not constitute discrimination on the basis of mental disability. As stated in *Chipperfield v. B.C. (Min. of Social Service)*, BCHRT decision dated September 5, 2007, discrimination on the basis of disability may occur "where some persons with disabilities are treated more disadvantageously than other persons with disabilities": p. 12.

[276] The unique nature of R's disability was clearly a factor in the denial of benefits. Had the constellation of the symptoms of his disability been only slightly different, he would have been deemed eligible for services. R, because of the nature of his mental disability, was denied benefits to which other mentally disabled people would be entitled. This is sufficient to establish that R's mental disability was a factor in the denial of benefits.

6. Was the denial or differential treatment discriminatory in the substantive or purposive sense required to establish a violation of s. 8 of the *Code*?

[277] As just stated, the discrimination alleged here is between different groups of mentally disabled people, namely, between those developmentally disabled people with an IQ above 70 and those with an IQ of 70 or below. In this part of the analysis, I determine whether the denial of benefits to R, by virtue of the unique nature of his disability, and in particular his IQ of about 77, was discrimination in the substantive or purposive sense necessary to establish a violation of s. 8 of the *Code*.

[278] In order to answer this question, one must consider the legislative provision authorizing the provision of benefits, and specifically, the legislative definition of “developmentally disabled”, found in s. 1 of the *Act*:

“developmental disability” means significantly impaired intellectual functioning that

- (a) manifests before the age of 18 years.
- (b) exists concurrently with impaired adaptive functioning, and
- (c) meets other prescribed criteria.

[279] The respondents have chosen to employ the diagnostic criteria for “mental retardation” set out in the DSM-IV in deciding who is “developmentally disabled”, and therefore entitled to benefits. The decision of the Court of Appeal in *Fahlman* makes it clear that, in doing so, the respondents have failed to comply with the statutory requirements of the *Act*, as the *Act* does not mandate or permit the use of the DSM-IV criteria in making this determination.

[280] The fact that the respondents have failed to comply with the relevant statutory criteria in determining whether applicants, such as R, are “developmentally disabled”, while relevant to the discrimination analysis, does not necessarily mean that they have discriminated in employing the DSM-IV criteria.

[281] For the reasons that follow, however, I am satisfied that the respondents have discriminated against R in employing the DSM-IV diagnostic criteria for mental

retardation in determining whether he is developmentally disabled and therefore entitled to benefits.

[282] The expert evidence from Dr. Bartel, Dr. Byrne, Dr. Russell and Dr. Kettner clearly established that the phrase “developmentally disabled” has at least two meanings. First, the phrase is sometimes used by professionals in the field as a more “politically correct”, less pejorative alternative to the DSM-IV medical diagnostic term of “mentally retarded”. Second, the phrase is used by both professionals and members of the larger community as an umbrella term to include a variety of what are variously called developmental disabilities, neurodevelopmental disorders, or forms of developmental delay, including mental retardation, FAS or FASD, autism and others.

[283] The respondents have adopted the former, narrower definition in applying the *Act* and determining who is entitled to benefits as “developmentally disabled”.

[284] On the evidence before me, I am satisfied that the adoption of this narrower definition is not justified on the face of the statute, and is discriminatorily underinclusive.

[285] As a matter of legislative interpretation, had the legislature intended to adopt the DSM-IV definition of mental retardation as the threshold test for eligibility for benefits for persons with developmental disabilities, there are a number of ways in which that intention could have been communicated, none of which was adopted.

[286] First, the legislature could have explicitly stated that the DSM-IV criteria for mental retardation would be applied. It did not.

[287] Second, the legislature could have used the phrase “mental retardation”, thereby implying that the diagnostic criteria applicable thereto would apply. It did not.

[288] Third, the legislature could have stated that an IQ of 70 or below was the threshold for benefits. It did not.

[289] Fourth, the legislature could have used the DSM-IV phrase of “significantly subaverage intellectual functioning” to define the cognitive component of the eligibility criteria. It did not, instead employing the different phrase “significantly impaired intellectual functioning”: see *Fahlman*, at para. 29.

[290] Dr. Kettner’s and Dr. Byrne’s evidence made clear that the phrase “significantly impaired intellectual functioning”, found in the *Act*, is much less precise than the phrase “significantly subaverage intellectual functioning” found in the DSM-IV. The legislature’s use of the former phrase, when the latter was available, suggests a legislative intention not to import the rigid DSM-IV criterion of an IQ of 70 or below, and instead to grant CLBC statutory discretion, to be exercised flexibly in accordance with the purposes of the *Act*, in determining whether an applicant has “significantly impaired intellectual functioning”, and is therefore entitled to benefits.

[291] The respondents submit that it is crucial, in drafting benefit-granting legislation, to establish clear, consistently applied criteria for eligibility for those benefits: Ann Seidman *et al*, *Legislative Drafting for Democratic Social Change: A Manual for Drafters* (London, UK: Kluwer Law International Ltd, 2001), pp. 348-9, 51. The establishment of clear legislative criteria for the exercise of statutory discretion provides for greater transparency and predictability in decision-making.

[292] I agree with these submissions of the respondents. The difficulty is that the legislature, in drafting the definition of “developmental disability”, chose not to draft the legislation in the manner necessary to establish the DSM-IV criteria for mental retardation as the statutory eligibility criteria for benefits. Instead, it adopted criteria which are open to a broader, more inclusive, definition.

[293] This is consistent with the definition of “community living services” found in s. 1 of *Act*, which refers to “support and services to children and adults with developmental disabilities”. If the legislature had intended “developmental disability” to have the singular and exclusive definition of mental retardation, rather than referring to a range of neurodevelopmental disorders, one would have expected that the singular term “developmental disability” would have been used throughout the *Act*, rather than the plural term “developmental disabilities”.

[294] That broader, more inclusive definition, under which mental retardation would be only one of a number of developmental disabilities, is consistent with the discussion in the legislature referred to and relied upon by the Court of Appeal in *Fahlman* as “more reasonably support[ing] the interpretation that the legislature decided against imposing an

IQ criterion due to community concerns with a rigid guideline and the need for flexibility”: para. 33. The legislature, the Court of Appeal stated, was “reticent to impose rigid rules”, and instead conferred discretion on CLBC to determine if an applicant has “significantly impaired intellectual functioning”, so as to be “developmentally disabled”, and entitled to benefits”: para. 55.

[295] Further, the legislature granted Cabinet the power to establish further criteria for “developmental disability”: s. 29. Cabinet has not, despite the clear ambiguity surrounding the phrase “developmental disability”, chosen to exercise that power to mandate the application of the DSM-IV criteria in determining eligibility for benefits.

[296] Thus, the legislature has chosen to employ the ambiguous term “developmental disability”, and not to employ any language which would import the DSM-IV diagnostic criteria, either explicitly or by necessary implication, and the Cabinet, despite being granted the power to do so, has not adopted any additional criteria which would limit “developmental disability” to “mental retardation”.

[297] In *Fahlman*, the Court of Appeal referred to the decision of the Supreme Court of Canada in *Canada Attorney General v. Abrahams*, [1983] 1 S.C.R. 2, para. 16, for the proposition that any doubt arising from the difficulties in language of a benefit-conferring statute should be resolved in favour of the claimant: para. 35. The Court went on to state that the *Act* “can fairly be characterized as a benefit-conferring statute that is protective of vulnerable persons in the community”: para. 35.

[298] In *Gibbs*, the Supreme Court stated that, in determining if discrimination is present, one must look to the purposes of, in that case, the disability plan. Here, that would be the legislation. It went on to state that if “benefits differ as a result of characteristics that are not relevant to this purpose, discrimination may well exist”: para. 33.

[299] The *Act* is, as stated by the Court of Appeal, a benefit-conferring statute that is protective of vulnerable persons in the community. Specifically, it mandates the provision of community living services to adults and children with developmental disabilities. The respondents have chosen to adopt a narrower definition of “developmental disability”, limited to mental retardation, when a broader one, including

other neurodevelopmental disorders, is reasonably available. In doing so, they have imported criteria not stated on the face of the legislation or created by regulation. The application of that definition and those criteria to R has resulted in the denial of benefits to him. That denial is based upon certain of R's characteristics, in particular a marginally higher IQ than required by the criteria adopted by the respondents, despite the fact that those characteristics are not relevant to the *Act's* purposes in protecting vulnerable persons in the community, and more specifically in providing community living services to persons with developmental disabilities, and despite R's obvious need for the services in question.

[300] Thus, this is not a case where the legislature or Cabinet has created, with statutory authority, a set of eligibility criteria, which excludes some persons with disabilities, and those excluded allege that the criteria are discriminatory. If it were, different principles might apply and the result might be different. Rather, this is a case where the legislature has created a set of eligibility criteria, and the respondents have chosen to apply a narrower set of eligibility criteria than the legislation demands, thereby excluding some persons with disabilities, who allege those criteria to be discriminatory. In my view, this imposition of a narrower and less inclusive set of eligibility criteria, without legislative or regulatory authority, which has the effect of excluding some disabled persons sharing characteristics relevant to the purpose of the statute, is discriminatory in the substantive or purposive sense.

[301] In this connection, the respondents submitted that this complaint was very similar to *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] S.C.J. No. 71, in that, in their words, R is "wanting a service that does not exist".

[302] I do not agree that the present complaint is analogous to the situation in *Auton*. In that case, a group of parents of autistic children filed a petition in British Columbia Supreme Court seeking funding from the provincial government for a form of early intervention autism therapy, known as Lovaas therapy. The basis for the claim was that the failure to provide funding for Lovaas therapy, which they submitted was a medically necessary service, breached s. 15 of the *Charter*. The petitioners succeeded at first

instance and in the Court of Appeal; the government was ultimately successful in its appeal to the Supreme Court of Canada.

[303] The Supreme Court overturned the decisions below on the basis that the *Medicare Protection Act* did not provide funding for all medically required treatment, and in particular, did not provide funding for Lovaas therapy. As a result, Lovaas therapy was not a benefit “provided by law”: para. 35. The legislature is entitled to make choices about to whom to provide particular benefits, absent a discriminatory purpose, and to target the social programs it wishes to fund, provided the benefit itself is not conferred in a discriminatory manner: para. 41.

[304] The focus of the Supreme Court’s decision in *Auton* was on the benefits actually provided by the legislative scheme in question, and whether Lovaas therapy fell within the scheme. The answer to that question was no, and the Court held that, as a result, Lovaas therapy was not a benefit provided by law: para. 47.

[305] That situation contrasts sharply with the situation in the present complaint where it is not the legislative scheme which has determined that the benefits sought are not provided, but a statutorily unauthorized underinclusive interpretation of that scheme. Quite simply, the benefits J sought for R are benefits which the *Act*, properly interpreted in accordance with *Fahlman*, does provide.

[306] The respondents’ reliance on the decision of the British Columbia Supreme Court in *British Columbia (Ministry of Education) v. Moore*, 2008 BCSC 264, appeal pending, is similarly misplaced. In that case, the Court overturned a decision of the Tribunal in which it had been held that the respondent Ministry and School District discriminated against learning disabled children, including the complainant, in not providing educational services necessary to provide them equal benefit of the public school system. In doing so, the Court, relying on *Auton*, stated that “a finding of discrimination cannot be based upon discrimination in the provision of services not provided under legislation as to do so is tantamount to dictating to the government what services should be provided”: para. 86.

[307] The benefits in issue here are ones which the legislation, properly interpreted, does provide. The Tribunal is not, anymore that the courts in *Fahlman* did, dictating to

the government what services should be provided. Rather, it is saying that the government, in the persons of the Ministry and CLBC, its Crown agency, must provide, in a non-discriminatory manner, the services the legislature has dictated. Should the legislature wish to provide services to a narrower range of persons, it is free to amend the legislation accordingly. Similarly, should Cabinet wish to prescribe narrower criteria, it is free, pursuant to s. 29 of the *Act*, to do so. Unless and until the legislature or Cabinet take one of those courses of action, the Ministry and CLBC must provide the services mandated by the statute in a non-discriminatory manner.

[308] The respondents submitted that a *Law* analysis was probably appropriate in this case. While, for the reasons stated above in considering *Kapp* and this Tribunal's case law, I do not consider a formal *Law* analysis to be necessary, a review of the four contextual factors considered by the Court in *Law* is helpful in deciding whether the denial of benefits to R was discriminatory.

[309] The first contextual factor is pre-existing vulnerability. As stated in *Law*:

probably the most compelling factor favouring a conclusion that differential treatment imposed by legislation is truly discriminatory will be, where it exists, pre-existing disadvantage, vulnerability, stereotyping, or prejudice experienced by an individual or group... These factors are relevant because, to the extent that the claimant is already subject to unfair circumstances or treatment in society by virtue of personal characteristics or circumstances, persons like him or her have often not been given equal concern, respect, and consideration. It is logical to conclude that, in most cases, further differential treatment will contribute to the perpetuation or promotion of their unfair social characterization, and will have a more severe impact on them, since they are already vulnerable: para. 63.

[310] R is a child with a neurodevelopmental disorder. He has borderline intelligence, and significant deficits in adaptive functioning. His intellectual, physical and psychological characteristics render him vulnerable. That vulnerability has been graphically demonstrated at school, where he has been subjected to teasing and bullying. As both the expert evidence and J's testimony show, R is likely to require assistance through his lifetime in order to live a meaningful life in the community.

[311] R is not "mentally ill", but statements from the Court describing the "particular historical disadvantage faced by persons with mental disabilities", including those with

mental illness, are apposite in considering the pre-existing vulnerability, disadvantage and stereotyping people like R are subject to: see *Gibbs*, and the authorities cited therein, para. 30. Indeed, the pejorative connotation associated with the label “mentally retarded”, referred to in the evidence of several experts in this case, is symptomatic of the prejudice and stereotyping that people with developmental disabilities more broadly have had and continue to face.

[312] The community living movement, which provided the impetus to the provision of community living services for developmentally disabled people, and the creation of CLBC itself, are positive responses to and attempts to ameliorate this historical disadvantage. In R’s case, however, the imposition of a rigid IQ criterion has served only to perpetuate his pre-existing disadvantage.

[313] The second contextual factor referred to in *Law* has to do with the relationship between the ground upon which the claim is based and the nature of the differential treatment. As stated by the Court, “some of the enumerated and analogous grounds have the potential to correspond with need, capacity, or circumstances”: para. 69. Disability is one such ground, “where the avoidance of discrimination will frequently require that distinctions be made to take into account the actual personal characteristics of disabled persons”: para. 70, and the reference therein to *Eaton v. Brant County Board of Education*, [1997] 1 S.C.R. 241.

[314] As the Court was careful to point out, “this is not to say that the mere fact of impugned legislation’s having to some degree taken into account the actual situation of persons like the claimant will be sufficient to defeat” the claim. “The fact that the impugned legislation may achieve a valid social purpose for one group of individuals cannot function to deny an equality claim where the effects of the legislation upon another person or group conflict with the purpose of the [equality] guarantee”: para. 70.

[315] Thus, the fact that *Act*, both properly construed and as erroneously interpreted by the respondents, achieves a valid social purpose in providing services to some individuals, does not mean that it does not, at least as interpreted by the respondents, also discriminate against others. As *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, a decision relied upon by the Court in this part of the *Law* decision makes

clear, government action which fails to take into account the actual circumstances and situation of a disabled claimant may well be discriminatory.

[316] Here, the respondents have chosen to rely upon and adopt the diagnostic criteria set out in the DSM-IV. The attraction of those criteria to the respondents is apparent: they provide a relatively clear set of criteria, which may be applied on a relatively consistent basis, requiring little discretionary judgment on the part of the personnel charged with their application. The difficulty, however, apart from the fact that those criteria, as established in *Fahlman*, are not mandated by the statute, is that they do not permit any meaningful consideration of the actual needs and circumstances of individual applicants. In R's case, his marginally higher IQ was held to disentitle him to services, forestalling any further consideration of his actual needs and circumstances, as measured against the criteria actually set out in the statute.

[317] The third contextual factor set out in *Law* is the ameliorative purpose or effects of the impugned legislation upon a more disadvantaged person or group in society. The Court stated that

an ameliorative purpose or effect which accords with the purpose of [the equality guarantee] will likely not violate the human dignity of more advantaged individuals where the exclusion of these more advantaged individuals largely corresponds to the greater need or the different circumstances experienced by the disadvantaged group being targeted by the legislation. I emphasize that this factor will likely only be relevant where the person or group that is excluded from the scope of the ameliorative legislation or other state action is more advantaged in a relative sense. Underinclusive ameliorative legislation that excludes from its scope the members of a historically disadvantaged group will largely escape the charge of discrimination. (para. 71) (emphasis added)

[318] The emphasized sentence in the preceding quotation is operative here. The *Act* is ameliorative legislation which, at least as interpreted and applied by the respondents, is underinclusive in that it excludes from its scope members of a historically disadvantaged group. That exclusion is not based on characteristics relevant to the purposes of the *Act*. No distinction that is relevant to the purposes of the *Act* can be drawn, on the evidence before me, between someone like R, who has an IQ in the borderline range, measured by Dr. Kettner at somewhere between 72 and 84, and has “significantly impaired intellectual

functioning” that “manifest[ed] before the age of 18 years”, and “exists concurrently with impaired adaptive functioning”, and a person with the same characteristics who happens to have an IQ measured at 70 or below.

[319] The fourth contextual factor in *Law* is the nature and scope of the interest affected by the legislation. In this regard, the Court relied upon the decision of L’Heureux-Dubé J. in *Egan v. Canada*, [1995] 2 S.C.R. 513, where she stated that “[i]f all other things are equal, the more and severe and localized the ... consequences on the affected group, the more likely that the distinction responsible for these consequences is discriminatory”, with the issue requiring an evaluation “not only of the economic but also the constitutional and societal significance attributed to the interest or interests adversely affected by the legislation in question”: para. 74. It is relevant, in this regard, to consider “whether the distinction restricts access to a fundamental social institution, or affects ‘a basis aspect of full membership in Canadian society’”: para. 74.

[320] Here, the services J sought on R’s behalf were designed, at the most basic level, to assist R in learning the social and life skills he needs in order to be able to participate in Canadian society. Mr. van Zandwijk testified about how the provision of community living services, such as those J sought for R, are intended to assist developmentally disabled people in achieving full citizenship. The denial of such benefits, to a person in R’s circumstances and with R’s characteristics, is a significant deprivation, likely to substantially and adversely affect his full participation in Canadian society.

[321] The respondents submitted that a consideration of the *Law* factors would lead to the conclusion that R was not discriminated against in a substantive sense. On my review of the *Law* factors, I come to the opposite conclusion. Unlike *Law*, this is not “one of the rare cases contemplated by *Andrews*, in which differential treatment based on one or more of the enumerated or analogous grounds ... is not discriminatory”: para. 110. To the contrary, a consideration of the *Law* factors only strengthens the conclusion that the denial of benefits to R was discriminatory in the substantive sense. The denial of benefits, beyond being not mandated by the statute, was inconsistent with the purposes of the statute; failed to take into account R’s membership in an historically disadvantaged group; failed to take into account R’s actual needs and circumstances, relying instead on a

rigid set of criteria imported without statutory authorization; and denied R benefits of profound importance to him and his ability to take his place as a full citizen in Canadian society. Contrary to the submissions of the respondents, a consideration of the *Law* factors therefore leads to the conclusion that the denial of benefits impaired R's human dignity in these sense contemplated by the Court in *Law*.

[322] The respondents also submitted that the fact that R has received other public assistance is a factor which should be taken into account in considering whether the denial of the services in issue in this complaint is discriminatory. Specifically, the respondents referred to the Post-Adoption Assistance Program benefits received by J; the learning assistance teacher and learning assistant who work with R in school, and the modified curriculum and adapted program he receives there; and J's eligibility for a federal Disability Tax Credit.

[323] While R's claim for the services in issue in this complaint must be considered within the broader context, including the other sources of income available to him and his mother, I cannot place any weight on these other benefits in determining whether R has been discriminated against. There are a number of reasons for this.

[324] First, and perhaps most importantly, there is no evidence that J or R's eligibility for other benefits was a factor taken into account by the respondents in denying this application for services. Nor is there any suggestion that there would be any statutory or other legal authority for doing so. There is not, for example, any means test set out in the statute which the respondents are required to apply in determining eligibility for benefits. I fail to see why, if other benefits were not and could not be taken into account by the respondents in assessing the application for services, the receipt of such benefits is relevant to the question of whether the denial of services was discriminatory.

[325] Second, the other benefits cited by the respondents are fundamentally different in kind from the services in issue in the complaint. J receives a monthly lump sum, as maintenance, under the Post-Adoption Assistance Program. This is different from the provision of a particular kind of service for a particular identified need. R receives various forms of assistance at school. Services received as part of a public school education are different from services received outside of the school system to assist in

community living. It is not clear on the evidence if J receives a federal Disability Tax Credit. If she does receive such a tax credit, such a credit, received from a different level of government, is again quite different from the targeted service J applied for on R's behalf. The respondents, with respect, are comparing apples and oranges.

[326] Considering the matter as a whole, I am satisfied that the respondents' adoption of the DSM-IV definition and criteria for mental retardation in determining whether applicants are developmentally disabled, and the application of that definition and criteria to J's application for services for R, resulted in discrimination on the basis of mental disability in the substantive and purposive sense. I therefore conclude that J has established that the respondents breached s. 8 of the *Code*.

XI REMEDIES

[327] J sought a number of remedies, as follows:

1. an order that the *Act* is contrary to the *Charter*;
2. a declaratory order;
3. an order that the respondents cease and refrain the contravention;
4. an order that the respondents implement a non-discriminatory policy with respect to the use of IQ in the delivery of services to "chronic mental health children";
5. an order that the respondents provide the services sought to R, *i.e.* the services of a youth worker to assist R with adaptive functioning deficits;
6. an order requiring the respondents to pay to J on R's behalf compensation equivalent to the monetary value of the services denied, from the time they were applied for until the time ordered; and
7. an order for compensation for injury to dignity for R in the amount of \$30,000, and an order for J in the same amount.

[328] I address the respondents' submissions with respect to remedy in considering each of these requested remedies.

1. Declaration of unconstitutionality

[329] For a number of reasons, an order that the *Act* is contrary to the *Charter* is inappropriate. No Notice of Constitutional Question was provided, and there are obvious difficulties with making such an order in light of s. 45 of the *Administrative Tribunals Act*.

[330] Grave as these problems are, there are others. Perhaps most fundamentally, what has been established in this case is that the respondents have adopted a discriminatorily underinclusive interpretation of the *Act*, and established the consequently discriminatory policy, which they applied to R, thereby breaching s. 8 of the *Code*. While the Tribunal has jurisdiction, as a result of the quasi-constitutional status of the *Code* (see *C.N.R. V. Canada (Human Rights Commission)*, [1987] 1 S.C.R. 1114), and pursuant to s. 4 of the *Code*, to determine that a statute is contrary to the *Code*, no such determination has been made in this case, nor has any determination been made that the *Act* is contrary to the *Charter*. Rather, the determination has been made that the *Act*, properly interpreted, is consistent with the *Code*, and that it was a breach of the *Code* for a narrower, underinclusive interpretation of the *Act* to be adopted and applied by the respondents.

2. Declaratory order

[331] Under s. 37(2)(b) of the *Code*, where a complaint is found to be justified, the member may make an order declaring the conduct complained of to be contrary to the *Code*.

[332] I consider such an order appropriate, and hereby declare the respondents' conduct in adopting the DSM-IV criteria for "mental retardation" as the criteria for "developmental disability" in applying the *Act* to be contrary to the *Code*. I further declare that the respondents' decision denying R benefits was contrary to the *Code*.

3. Cease and refrain order

[333] Under s. 37(2)(a) of the *Code*, when a complaint is found to be justified, the member must order the respondent to cease and refrain from the same or similar contravention.

[334] I have found the respondents to have contravened the *Code* in adopting the DSM-IV criteria for “mental retardation” as the criteria for “developmental disability” in applying the *Act* and in denying benefits to R on the basis of those criteria.

[335] I therefore order the respondents to cease and refrain from committing the same or a similar contravention. The effect of this order is discussed below.

4. Order requiring the implementation of a non-discriminatory policy

[336] J sought an order that “the respondents implement a non-discriminatory policy with respect to the use of IQ in the delivery of services to ‘chronic mental health children’”.

[337] Under s. 37(2)(c), where the complaint is found to be justified, the member

- (c) may order the person that contravened this Code to do one or both of the following:
 - (i) take steps, specified in the order, to ameliorate the effects of the discriminatory practice;
 - (ii) adopt and implement an employment equity program or other special program to ameliorate the conditions of disadvantaged individuals or groups if the evidence at the hearing indicates the person has engaged in a pattern or practice that contravenes this Code.

[338] While not referred to by counsel in submissions, I assume that it is this provision that is relied upon in seeking this remedy.

[339] Here, the order is clearly not appropriate in the terms sought because it is not consistent with the discrimination I have found. To be clear, I have not found that the respondents have discriminated by not providing services or by applying an IQ criterion to “chronic mental health children”. I have found that the respondents have contravened the *Code* in adopting the underinclusive DSM-IV criteria for “mental retardation” as the criteria for “developmental disability” in applying the *Act*, and in denying benefits to R on that basis. In order not to discriminate, the respondents were required to consider in a non-discriminatory manner whether R met the criteria for “developmental disability” set out in the *Act*. Those criteria are:

“developmental disability” means significantly impaired intellectual functioning that

- (a) manifests before the age of 18 years.
- (b) exists concurrently with impaired adaptive functioning, and
- (c) meets other prescribed criteria.

[340] The evidence is clear that the criteria employed by the respondents in R’s case are the same ones they always employ in considering applications for services on behalf of “developmentally disabled” persons. The use of the DSM-IV criteria for mental retardation in deciding if people are “developmentally disabled” will lead to discrimination in more cases than R’s. I did not, however, have any evidence of the actual application of the DSM-IV criteria in other cases, and therefore do not know the prevalence or impact of the respondents’ use of these criteria in cases other than R’s.

[341] Further, the evidence was that the respondents are currently engaged in a consultation and research process in regards to the implementation of a functional rather than the current medical diagnostic model to determine eligibility for services.

[342] In all of the circumstances, I do not consider it appropriate or necessary to order the respondents to implement a non-discriminatory policy. Such an order is inappropriate on the evidence before me because I have insufficient evidence to determine the parameters of an appropriate policy beyond the statutory criteria set out in the *Act*, and because to do so might work at cross-purposes with the consultation and research process in which the respondents are already engaged. Such an order is unnecessary because the effect of the cease and refrain order I have made is to require the respondents to apply the *Act*’s requirements in a non-discriminatory manner in future.

5. Order requiring services to be provided

[343] Under s. 37(2)(d)(ii) of the *Code*, when a complaint is found to be justified, the member may order the respondent to “make available to the person discriminated against the right, opportunity or privilege that, in the opinion of the member or panel, the person was denied contrary to this Code”.

[344] I have found that R was denied the services of a youth worker contrary to s. 8 of the *Code*.

[345] The respondents made no submissions about whether, in the event the complaint was found justified, I should make an order requiring them to provide the services denied. They did, however, in connection with the request for an order compensating R for the services denied, submit that R would be entitled to whatever he lost as a result of not having the service provided at a reasonable time after J applied. The respondents submitted that they would not “quibble” over whether R would have been placed on a wait list had J’s application been granted, but noted there was no concrete evidence of the loss. The respondents asked that, in the event of such an order, I remain seized in respect of the calculation of the quantum.

[346] CLBC had a statutory discretion to consider if R was entitled to services as a developmentally disabled child. The Court of Appeal described CLBC’s obligation, in exercising its discretion, as being “to consider fully the facts, circumstances and merits of each application”: para. 55. To this I would add only that, where such discretion exists, it must be exercised in accordance with the *Code*.

[347] On the evidence before me, I am satisfied that, had CLBC exercised its statutory discretion in accordance with the *Act* and the *Code*, rather than fettering its discretion by application of the rigid IQ criterion, it would have concluded that R is developmentally disabled and entitled to the services applied for.

[348] R met the criteria for “developmental disability”, as he has “significantly impaired intellectual functioning”, which “manifest[ed] before the age of 18 years”, and “exists concurrently with impaired adaptive functioning”. The expert evidence, especially the reports of Drs. Kettner and Pipher, makes clear that R met all three criteria. The latter two criteria are uncontroversial. The first is made out in light of the substantial body of evidence about R’s significantly impaired intellectual functioning.

[349] In these circumstances, I consider it appropriate to order the respondents to provide R the services he was denied, namely the services of a youth worker to assist him with his adaptive functioning deficits. An order requiring the respondents to provide the services applied for will further the purposes of the *Code*, by “foster[ing] a society in

British Columbia in which there are no impediments to full and free participation in the economic, social, political and cultural life of British Columbia”; “promot[ing] a climate of understanding and mutual respect where all are equal in dignity and rights”; “prevent[ing] discrimination prohibited by this Code”; “identify[ing] and eliminat[ing] persistent patterns of inequality associated with discrimination prohibited by this Code”; and “provid[ing] a means of redress for those persons who are discriminated against contrary to this Code”. In order to have the *Code’s* remedial purposes fulfilled, it is necessary and appropriate to require the respondents to provide R with the services he requires, and which were discriminatorily denied him.

[350] The respondents have 60 days from the date of this decision to begin providing R with the services applied for.

6. Order for compensation for services denied

[351] I further consider it appropriate, in order to fulfill the *Code’s* remedial purposes, to order the respondents to pay J on R’s behalf an amount equal to the monetary value of the services he was denied, starting from September 2005 and continuing until the date R is provided with the services of a youth worker. I have ordered compensation starting from September 2005 on the basis that the respondents should have been able to process the application by then, the lack of probative evidence that R would have been placed on a waiting list had he been deemed eligible at that time, and in reliance on the respondents’ submission that they would not “quibble” about whether R would have been placed on a waiting list.

[352] Such an order is necessary in order to put R, so far as monetary damages can, in the position he would have been had he not been discriminated against.

[353] In accordance with the respondents’ request, I will remain seized with respect to the calculation of this amount for 60 days following the date this decision is released. If the parties are unable to agree to the quantum of compensation for services lost, they are to advise the Tribunal in writing within that 60 day period, in which case I will consult with the parties and establish an appropriate process to determine the quantum of compensation.

7. Order for compensation to injury to dignity

[354] Counsel sought order for compensation to injury to dignity on behalf of both J and R. I have already dismissed any complaint that J might have filed on her own behalf, with the result that no remedial orders can be made in respect of her. For R, \$30,000 was requested as compensation for injury to dignity, feelings and self-respect, pursuant to s. 37(2)(d)(iii) of the *Code*.

[355] The respondents submitted that this was not a case which called for such a large award. They noted that the larger awards from the Tribunal have arisen in the employment area, in response to egregious behaviour on the part of the respondent. They submitted that the failure to provide a service in this context was not outrageous, but rather the good faith result of the adoption of a different model, albeit one found to be discriminatory. The respondents did not suggest an appropriate figure for compensation for injury to dignity.

[356] No direct evidence was provided about the impact on R of not receiving the services applied for. While I do not fault counsel for not leading this evidence from R, given his age and disabilities, it is a matter about which J or one of the experts might have testified.

[357] In any event, it is reasonable to infer from the evidence that R would have benefited significantly from the services applied for, given his serious and growing deficits in adaptive behaviour. I refer, in this regard, to the more severe adaptive behaviour problems identified by Dr. Kettner and Dr. Pipher in 2006 and 2007, as compared with those identified in the 2003 Alberta Children's Hospital assessment, as well J's evidence about the growing "gap" between R's behaviour and that of his age peers.

[358] The services sought and denied are the very kind of service Dr. Pipher recommended for R to assist him with crucial life and social skills development. Further, it is reasonable to infer that it will be difficult if not impossible for R to obtain now the full advantage he would have obtained had he received the services at an earlier, and crucial, stage in his development. This inference is consistent both with common sense and with Dr. Kettner's evidence that the earlier intervention is provided, the better.

[359] In this connection, I consider the evidence of R's immature and inappropriate behaviour, lack of friends, the teasing and bullying to which he has been subjected, and his difficulties in engaging in many of the activities of daily living. The demeaning nature of some of R's age-inappropriate behaviour is likely to, and has, led to cruel taunts from some of his age peers. J applied for services for R, on the recommendation of his School Support Worker, as R was about to go to junior high school, where she was concerned that his difficulties interacting with his age peers would only worsen. A youth worker would have worked one on one with R in areas such as appropriate social interactions and functioning independently in the community. The absence of that assistance has likely led to ongoing damage to R's feelings, dignity, and self-respect.

[360] Neither party provided any authorities in support of their submissions on the quantum of compensation for injury to dignity. I agree with the respondents that the highest damage awards to date have been in employment cases, where the respondent's behaviour was egregious, and the consequences for the complainant correspondingly severe. There is no reason in law, however, that the highest awards should be reserved for the employment area. Each case must be assessed on its own facts, and in light of the purposes of the *Code*.

[361] There is some guidance to be found in earlier decisions of the Tribunal dealing with complaints of discrimination in the provision of services, especially services to disabled persons. In *Hutchinson v. B.C. (Min. of Health)*, 2004 BCHRT 58 (upheld *HMTQ v. Hutchinson et al*, 2005 BCSC 1421) the Tribunal awarded the complainant, who had been prohibited from hiring her father as a caregiver \$8,500, in compensation for injury to dignity. In *Moore v. B.C. (Ministry of Education) and School District No. 44*, 2005 BCHRT 580, (rev'd, but not on this point, on judicial review in *Moore, supra*) the Tribunal awarded the learning disabled child on whose behalf the complaint was filed \$10,000 in compensation for injury to dignity, feelings and self-respect. In both those cases, as in this, there was no suggestion that the respondents had acted outrageously or in bad faith; rather, the focus was on the impact on the complainants of not receiving services they required to assist them with the consequences of their respective disabilities. I also note *Radek v. Henderson Development (Canada) and Securiguard Services (No. 3)*,

2005 BCHRT 302, which, while factually distinct, is a services case in which \$15,000 was awarded for injury to dignity.

[362] *Moore, Hutchinson and Radek* were decided in 2004 and 2005. Since that time, there has been an increase in the quantum of awards for compensation for injury to dignity in other areas, especially employment: see, for example, *Senyk v. WFG Agency Network (No. 2)*, 2008 BCHRT 376, in which \$35,000 was awarded, the highest award to date.

[363] Taking into account R's age, the nature of his disabilities and his resulting profound vulnerability, and the probably irreparable impact on R of not receiving the services of a youth worker at the time they were applied for, I consider an award of \$20,000 in compensation for injury to dignity, feelings and self-respect appropriate. The respondents are to pay this amount to J on R's behalf within 60 days of the date of this decision.

XII CONCLUSION

[364] I have found the complaint on behalf of R justified as against Her Majesty the Queen in right of the Province of British Columbia as represented by the Ministry of Children and Family Development (Community Living British Columbia).

Lindsay M. Lyster, Tribunal Member