Court of Queen's Bench of Alberta

Citation: JH v Alberta Health Services, 2019 ABQB 540

Date:
Docket: 1501 03347
Registry: Calgary

Between:

J.H.

Applicant

- and -

Alberta Health Services

Respondent

- and -

The Minister of Justice and Solicitor General of Alberta and Calgary Legal Guidance

Interveners

Restriction on Publication

Identification Ban – See the *Public Health Act,* section 53(1).

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NOTE: This judgment is intended to comply with the ban so that it may be published.

Reasons for Judgment
of the
Honourable Madam Justice K.M. Eidsvik

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Introduction

[1] JH, a 49-year-old construction worker, was detained against his will at the Foothills Medical Centre ("Foothills") pursuant to the ***Mental Health Act***, 2000 RSA c M-13 ("***MHA***") on September 25, 2014. He was unsuccessful in having his renewal certificates cancelled at an automatic six-month hearing before the Review Panel on March 17, 2015. He filed an Originating Application and Notice of Appeal of the Review Panel decision challenging his certification,

claiming that his section 7, 9 and 10 rights under the ***Charter of Rights and Freedoms*** ("***Charter***") had been breached and asking for a declaration that the review and detention procedures in the ***MHA*** infringed sections 7, 9 and 10 of the ***Charter***.

[2] After a two-day hearing, on May 15, 2015, I cancelled JH's certificates because Alberta Health Services did not meet its onus to show that JH met any of the criteria in the ***MHA***. My brief oral reasons can be found at **2015 ABQB 316** (for simplicity sake, and completeness, I will outline the facts in more detail later in this decision despite the fact that there may be some repetition from my 2015 decision).

[3] On the Minister of Justice and Solicitor General of Alberta's ("Alberta") application before the hearing commenced, I adjourned the ***Charter*** issues for a subsequent hearing to allow Alberta time to reply to the brief filed by JH on the ***Charter*** issues. After the hearing I then heard a series of applications The first was from Calgary Legal Guidance ("CLG") who wanted to intervene in the ***Charter*** challenge, which I allowed. CLG has 45 years of experience in promoting and protecting individual rights and liberties and provides services to individuals involved in Alberta's mental health system. Another application was by Alberta to have the ***Charter*** challenge dismissed on the basis that it was moot, which I did not allow (my oral reasons are at **2017 ABQB 477**). Finally, there was an application to better define the terms of the constitutional issues.

[4] By Order dated July 27, 2017, I stated that the constitutional issues are the following:

1. Whether the review and detention provisions under the ***MHA***, in general, and ss. 2, 4(1), 4(2), 7(1), 8(1), 8(3), 38 (1) and 41(1) in particular, infringe sections 7, 9 or 10 of the ***Charter***, and
2. Whether Alberta Health Services, through the Foothills Medical Centre, has breached JH's rights under sections 7, 9 and 10 of the ***Charter.***

[5] It was also agreed at this last application that there would be no claim sought and no remedy granted in this action with respect to whether or not AHS or any AHS affiliates committed battery of the person of JH. A declaration of rights is what is being sought. However, this did not preclude JH from starting a separate action (which I do not believe was commenced).

[6] I also allowed the parties and Alberta (as intervener) to file further evidence by affidavit with respect to these constitutional questions by certain deadlines and the right to call further *viva voce* evidence if they desired. I received further affidavit evidence from JH in the form of three affidavits which included statistical information, several Mental Health Advocate Annual Reports and a review of the procedural steps taken in this action. Alberta also filed further statistical evidence and several annual reports from the Review Panels from three different zones in Alberta. AHS chose not to file any evidence. No further *viva voce* evidence was led from any party.

[7] Alberta filed a further brief and JH and CLG filed replies. I heard two days of argument on September 6 and 7, 2018 and adjourned to October 11, 2018 to hear the rest of the submissions. JH provided a "Cross Country Summary of Mental Health Legislation – Review of Key Provisions" for the October 11, 2018 hearing. AHS also filed a summary of its argument before it was heard on October 11, 2018.

[8] Further, Alberta provided the Court with the "*Standing Committee on Families and Communities - Review of the Mental Health Amendment Act 2007*" dated July 2016. This committee was statutorily required to review the legislation pursuant to s 54 of the ***MHA*** after 5 years from when the amendments came into force (royal assent of the amendments occurred on December 7, 2007 and various sections came into force between September 2009 and January 1, 2010). I also reviewed the "*Report of the Alberta Mental Health Review Committee*" commissioned by the Alberta government dated December 2015 and the follow up report prepared by Alberta Health "*Valuing Mental Health Next Steps*" dated June 2017 (the "Reports").

[9] The following are my reasons with respect to the constitutional issues that remain to be determined in this action. I plan to review the questions in reverse order i.e. whether JH's ***Charter*** rights were breached in his specific case, and secondly, whether the ***MHA*** is ***Charter*** compliant with respect to its detention and review provisions in situations as presented in the evidence – i.e. persons certified, detained and treated longer-term under the ***MHA*** based on the self-harm and deterioration of physical health criteria – such as JH. There are many other questions that could be reviewed in terms of the intersection of the ***MHA*** and the ***Charter*** but the evidentiary base of the case does not allow it here.

1. Were JH's *Charter* rights under ss. 7, 9 and 10 breached?

Background

[10] JH was 49 years old at the time of these events. He is a member of a First Nation in British Columbia. He was working in the logging industry in B.C. until the sawmill shut down. He moved to Calgary about seven years before the incident and was working full time with a stucco company as a stucco worker. He had been married, and his 28-year-old son was married and living in B.C. He was in daily contact with his mother who lived in Washington State, USA. JH had no history of mental illness.

[11] In 2014 he was the victim of a hit and run which caused injuries to his leg and back. He was hospitalised at the Peter Lougheed hospital for several months. Unfortunately, while he was in hospital he lost his apartment and so was homeless upon his release. He had trouble accessing social assistance because he also lost his ID and he wound up at the Alpha House for a period of time.

[12] JH was brought into the Foothills Medical Centre, run by Alberta Health Services, on September 5, 2014 by a DOAP team (Downtown Outreach Addictions Partnership team associated with Alpha House). It had noticed a 1-2 month cognitive decline according to a consultation report prepared sometime later. JH needed treatment for complications from his injuries which included an infection and sepsis. He was also suffering from hepatic encephalopathy (a liver condition) and delirium which resolved (which may have been caused by the sepsis). He had surgery on his septic right knee on September 7, 2014 (with his written informed consent) and tests done including a CT scan of his head and an EGD (camera test in his esophagus, stomach and small bowel done on September 18, again with informed written consent). He recovered to a certain extent over the next 20 days and he then wanted to be discharged.

[13] Instead of being discharged, he was certified on September 25, 2014 under the ***MHA.*** More specifically, a Form 1 admission certificate was issued by Dr. Maureen Young on September 25, 2014, on the basis that JH met the criteria since he was, based on what she observed: "disoriented, lacks insight into seriousness of his medical condition, states wants to leave hospital, unsteady gait" and based on what others had communicated to her: "multiple attempts to leave hospital, per neurology specialist – has multiple med conditions affecting cognition, hx etoh abuse, depression..."

[14] The next morning, on September 26, 2014, Dr. Workun issued a second Form 1 certificate indicating that he had personally examined JH (for 4 minutes) and based on the following facts observed by him, JH was "tangential, lacks insight into - illegible - needs" and on the following facts communicate to him by others: " ETOH cognitive impairment."

[15] Pursuant to s. 7(1) of the ***MHA*** these two certificates were "sufficient authority" to "care for observe, examine, assess, treat, detain and control the person ...for a period of one month." Further, pursuant to s. 14 of the ***MHA***, JH and his nearest relative were to be informed, in writing, by "the board" (which here would be the board of the Foothills) about the reason for the issuance of the admission certificates, the certificates themselves and his right to apply to a review panel, their function and the name of the chair. There is no evidence that verbal, let alone written notice was given to JH or his "nearest relative". Unfortunately, the record here is scant – only some of the treatment notes and medical records for this period were tendered and neither Dr. Young, Dr. Worken, or any of the nurses gave evidence.

[16] Further, there is no evidence that JH was advised by anyone of his right to obtain legal counsel who could help him challenge his certificates, nor that he was aware one way or another at this time that he could seek help from a Patient Advocate by telephone.

[17] There is no evidence about whether JH's competency was evaluated at this time. No Form 11 was completed declaring him incompetent however.

[18] In contrast to the contents of the certificates, JH's affidavit evidence and testimony indicated that "between September 2014 to March 15, 2015 (the date of the last disclosure) the hospital has consistently indicated that I have been able to communicate my needs, my speech has been clear and I have been alert. They have consistently reported that I am independent and there was "no neurological" sensory deficit" observed or reported". He attached some nurses notes in that regard (ex E to his affidavit of March 30, 2015).

[19] The record closest in time to this first detention was one of September 11, 2014. Under the heading "neurological" JH's level of consciousness was noted as "oriented to person alert". Next to communication it was noted "speech clear, fluid and appropriate. Can communicate needs". Next to sensory deficit it was noted "none observed or reported". Further in the "Confusion Assessment Method" it was noted "yes" next to "Acute change from Baseline and Fluctuating Course", "no" to "Inattention", "yes" to "disorganised thinking" and "no" to "altered level of consciousness".

[20] A series of renewal certificates were issued which continued JH's involuntary detention over the next few months. These included renewal certificates by Drs. Quickfall and Workun on

October 24 and 26 respectively and by the same two doctors on November 21 and 22 and on December 19, 2014. The first sets of renewal certificates authorised detention for 1 month, and the certificates in December authorised detention for "6 additional months" (s. 8 of the ***MHA***).

[21] The October 24 certificate issued by Dr. Quickfall indicates that JH had an "unspecified neurocognitive disorder, flight risk (previous AWOL's) and lacks capacity for healthcare and accommodation". With respect to facts communicated to him by others included "awaiting supportive placement". Despite this assessment of "lacks capacity for healthcare" again no Form 11 was filled out declaring JH incompetent to make treatment decisions.

[22] The November 21 and 22, 2014 certificates states "Pt has impaired insight, memory" and that he was "seen trying to leave unit AWOL. Require ongoing medical care + 24 h supervised living environment." Also, that JH was "confused" and according to others, had "ETOH Brain Disease". In the December 19, 2014 certificates it repeats "Pt cognitively impaired, lacks capacity to make decisions around health care and accommodation. Wants to leave" "Requires security constant to ensure he stays on the unit". And again "wants to leave". No Form 11 was issued at this time either.

[23] The social worker who testified confirmed that as early as October she was attempting to find accommodation for JH and that she was attempting to get the public guardian to act as a guardian in his case. At the hearing in May 2015, she testified that she was still working on this. There is no indication that when the certificates were renewed that they were given to JH or his "nearest relative" or any indication of the status of trying to get him supportive accommodation, or any form of detention with less restrictions, outside of the acute care ward of the Foothills. Again, there is no evidence that JH was given any advice that he could obtain counsel or appeal his certificates to a review panel. Nor is there any indication that he was advised of potential assistance from a Patient Advocate at this time.

[24] JH received no leave of absence passes other than a couple of times when he was accompanied by the social worker later in his stay to try and sort out his identification issues and once for a walk.

[25] Dr. Quickfall testified that JH was detained on the grounds that his condition would "likely cause harm to himself" however in Dr. Quickfall's view the harm was "unintentional" in nature. He testified that he was worried that JH was at significant risk of relapse to alcohol and that this would worsen his underlying liver condition and precipitate his hepatic encephalopathy which may lead to cognitive impairment. He also opined that there was no psychiatric treatment that was helpful for JH and that he did not feel that a community treatment order would be useful since JH did not require any psychiatric treatment.

[26] He agreed that an acute care hospital was not the best setting for JH but he felt that there was no other place for him so as a result he continued to renew his certificates. He indicated that there were "dozens" of other patients in this same situation.

[27] In sum, JH was being detained to provide a form of residential care "because there is no other place for him".

[28] On January 23, 2015, there is an inpatient consult report that discusses the issues JH was facing at the time. It noted that he "lacked capacity" and was "awaiting placement". It continued: "he is reluctant to agree with need and has decided to challenge his certification. A handout with all the necessary information was given. Patient says he would like to talk to the people who could assist on his own. He states that he will follow up on this. He appears to have forgotten today."

[29] This January 23 note is the first indication on the record that JH was advised of his rights to appeal his certification. AHS did not lead evidence about "all the necessary information" that he was given.

[30] JH did not follow up on his desire to challenge his certificates until early March. I note that at the time JH was being treated with Seroquel. A note dated January 14, 2014 indicates that this medication was "initially started at bedtime" but that it was now at 12.5 mg p.o. b.i.d. JH testified that he did not like this medication. It made them feel tired and listless. At one point, he recalled being held down by security guards and injected against his will with this medication.

[31] Further, he was prescribed Haldol, and Ativan, both anti-psychotic medications as well as morphine for his accident related pain issues. Dr. Hussein, who prepared an assessment of JH on April 1, 2015, noted that "benzodiazepines have the potential to adversely affect his [JH] cognition and foster his addiction" She recommended at that time that both the Ativan and Seroquel orders be reviewed.

[32] All to say that the medications JH was being given certainly could have had an effect on JH's ability to follow through with his clear desire to have his certificates cancelled. Nor is there any evidence that besides being given some information in January 2015, that he was given any assistance at that time to actually fill out the Forms.

[33] Finally, on March 5, 2015, JH obtained the telephone assistance of a Patient Advocate who intervened on his behalf. The first note in this regard is dated March 5, 2015, wherein Bev, of the patient advocacy office, asked the attending nurse for JH's certification Forms to be sent to her. She followed up the next day and the nurse noted that JH had not been given his own copy of the Forms. The nurse noted that the Forms from September, October, November and December were all provided to JH on March 6. This nurse also made a note that a Form 11 (the incapacity Form) was incomplete and she also gave JH Form 12 – a Form that allowed him to make an application for a Review Panel Hearing – although it appears that she did not help him fill it out. He made a failed effort to fill out the appropriate application to have his competence reviewed by the Review Panel (he misspelled one letter in his middle name so it was not acted on).

[34] Dr. Soolsma made a note the same day (March 6, 2015) that "patient is frustrated by stay and asks with every visit why he has to stay. He has no carryover from visit to visit. Patient has been challenging his stay but has problems comprehending the steps involved." Dr. Soolsma filled out the first part of a Form 11 by stating that JH was not mentally competent to make treatment decisions because of "poor comprehension, poor judgement, and alcoholic encephalomalacic dementia".

[35] On March 9, 2015, a nurse noted that his attempt to appeal his "certs" failed because he had written his name wrong on the Form. However, she also noted that JH had been certified since

September 25, 2014 so his automatic 6-month review was approaching. With the consent of the unit manager she helped JH fill out a new Form 12 appealing his certificates and faxed the completed Forms to the Chair of the Review Panel.

[36] Meantime, on March 13, there were a series of calls between Bev of the Patient Advocate office and the nurse about the fact that Form 11 was not properly filled out so that treatment could not be given over JH's objection. The nurse decided to "hold all treatments" until further notification. Later that day (16:49) Dr. Soolsma called back about the issue and indicated: "as long (sic) as he is concerned patient has been certified since last year and psych has followed, patient is legally treated. If Bev calls again get her name & position and direct her to talk to him directly, and patient's discharge responsibility on her." The nurse then called the "site manager" who advised that the nurse "was still legally allowed to provide treatment to the patient under emergency circumstances" and that the Form 11 would be completed on March 17, 2015, the date that had been set for the Review Panel hearing. (In fact, the second part was filled out on March 19, 2015 by "Milagros Averion", a "representative of board of facility").

[37] Luckily, Legal Aid of Alberta allows funding for counsel for Review Panel hearings. Here, Ms. Janmohamed was called on March 16, about the March 17 hearing. She was advised of JH's name and unit number at the Foothills. She spoke to JH on March 16 and attended the hearing the next day. There was some confusion about the location of the hearing so when she arrived at the right place, the hearing had already started.

[38] Dr. Quickfall, a nurse, and JH testified. Counsel for JH made some representations. The hearing lasted 30 to 45 minutes. There is no record of the proceedings but based on the brief summary in the ultimate Review Panel decision, I can discern the following about the hearing. Dr. Quickfall testified that JH had improved since admission but had lots of cognitive impairments and no ability to make health care decisions. Further that without hospitalization there was a risk of decompensation and that his prognosis without the same was not good.

[39] The nurse testified that JH's cognition had improved. She believed that this was because he was in a supportive environment.

[40] JH testified that he wanted to leave the hospital and return to work. He said that there was nothing wrong with him and he wanted to head north.

[41] JH's counsel confirmed that JH wanted to leave and get back to work and argued that there was nothing wrong with him mentally. She pointed out that he had worked for the last 18 years and had family in B.C. She argued that there was no clinical diagnosis of a mental illness except that he was "unable to meet the ordinary demands of life". The hospital in that regard was not the right environment for him and he should be entitled to his liberty and live the way he wants to.

[42] The application was denied. The Panel "accepted the submissions of the Hospital that the Patient suffered from a mental disorder that was a substantial disorder of thought, mood, perception and memory that grossly impaired the patient's judgment and behavior, and ability to meet the ordinary demands of life." The Panel continued that "as to the second leg of the three-part test, the panel concluded that it was likely that the patient would suffer both substantial mental and physical deterioration if not in hospital." They continued: "Finally as to the third requirement

of the test for formal admission, the panel thought that the patient was not suitable for admission other than as a formal patient, as the patient in his own evidence indicated that he would not remain in hospital if not required to do so."

[43] Counsel met with JH after the hearing to obtain his consent to get his health records and appeal to the to the Court of Queen's Bench within the 14-day timeline. She also spoke with Dr. Soolsma and the social worker while she was there. She (nor JH) did not have his medical records, which consisted of a stack about a foot deep, before the hearing. Nor does it appear that she applied for an adjournment of the hearing in order to obtain and review the records beforehand.

[44] Subsequent to the hearing, Dr. Quickfall requested a second opinion as "his physician-patient therapeutic alliance had deteriorated. Mr. [J]H perceives he is maintained in hospital as Drs. Soolsma and Q[uickfall] have it "out for" him due to his being "native"." (additions in parenthesis mine).

[45] As mentioned previously, Dr. Hussein performed the second opinion assessment on April 1, 2015. Dr. Hussein did a mental status examination at that time. She found that under "general behavior" JH "engaged well; maintained eye contact; appropriate laughter. Respectful and behavior settled." She also found that he had no psychomotor agitation or slowing in his motor activity, his mood was fine, his affect was "eurhythmic, stable, congruent", his thoughts were "generally goal directed and linear", he wanted to go back to work and live on his own, he had no suicidal ideation, he had no overt perceptual disturbances. He performed a memory test that scored 20+1/30 and noted his good effort in doing the test. She found that he had partial insight into his liver medications such as lactulose however it wasn't clear whether he had received recent medication teaching, and that his judgment was adequate with respect to acute safety in hospital.

[46] Dr. Hussein questioned the need for benzodiazepines being prescribed and wanted to clarify why Seroquel was being prescribed. She also wanted to check to see whether a second physician opinion had been obtained for the Form 11 and whether the client was appealing Form 11. She questioned whether or why a surrogate decision-maker had not been approached and/or the public guardian. She noted that "treatment decisions may be made on behalf of a formal patient when the patient is not mentally competent by his nearest relative, or as a last resort the public guardian, as he does not currently have a personal directive or appointed guardian."

[47] She also suggested that there should be an occupational therapy assessment. She finally recommended a formal assessment of his decision-making capacity to "guide discharge disposition and further assessment as to whether he continues to meet criteria for certification and Form 11 under the Mental Health Act."

[48] As a result of this assessment, Dr. Quickfall testified that he: "discussed with Dr. Workun that consent should be attempted to be obtained from his closest relatives. So Dr. Workun phoned his mother who lives in the United States. She declined to continue using Seroquel which had already been held, I believe, and so at that point I discussed with Dr. Workun that it was not in the best interest to force the Seroquel or to continue to try to force the Seroquel on Mr. [J]H and it has remained suspended."

[49] In short, despite the fact that JH's treating physicians were of the opinion that he was not competent to make treatment decision, they treated him without the appropriate Form (11) filled out as required under s. 27 of the ***MHA***. Further, when it was completed on March 19, 2015 it was not forwarded to the nearest relative pursuant to s. 27(3) and it is unclear if it was ever sent. Nor is there any evidence that "written notice that the patient has the right to have the physician's opinion about competence reviewed by a Review Panel" pursuant to s. 27 (3) was ever given to JH or his nearest relative.

[50] To their credit however, a call was finally made to JH's mother sometime after April 1 and her wishes were then apparently complied with in terms of the administration of Seroquel (as necessary pursuant to s. 28(1)). I note however that the Haldol and Ativan were standing orders up to the time of the appeal (May 13 and 14, 2015) and may well have been administered *the days of the appeal* according to the nurses' notes. There is no evidence that JH's mother was consulted about this treatment nor why this treatment was at all necessary.

[51] Dr. Bailey was retained to do an independent assessment for the purposes of the Court of Queen's Bench appeal and he testified during the hearing. Dr. Bailey is both a psychologist and lawyer and works extensively in the forensic field. Dr. Bailey's opinion was that JH had a "mild cognitive disorder" and that he did not meet the threshold for involuntary hospitalization. He also opined about the practical functioning of the ***MHA*** in Alberta but I will address this portion of his testimony later in my decision.

[52] As noted, I cancelled JH's certificates on May 15, 2015. He remained in hospital for some time thereafter to allow time for the social worker to finalise planning for his release. We were advised that the social worker could not help JH once he was released, which raises serious questions, as is pointed out in the Reports, about continuity of care of those certified as formal patients in Alberta.

Analysis

[53] I will analyse the issue of whether JH's rights pursuant to the ***MHA*** and the ***Charter*** were breached by firstly reviewing the general positions of the parties, secondly dealing with some preliminary procedural issues raised by AHS, and then reviewing the potential breaches raised by JH in categories dealing with his certificates, notice provisions, treatment issues and finally procedures undertaken in his case before the Review Panel.

Parties' Positions

[54] JH's counsel argued that JH's liberty and security were improperly infringed for a number of reasons where even the basic and incomplete provisions of the ***MHA*** were not followed in terms of the steps to be taken when certified, the treatment that was given involuntarily and without authority, and the procedural problems with the information given and the review process. More detail about their issues will be discussed below.

[55] AHS' views were that this was an appeal process and that in such processes AHS does not call fact witnesses to defend or explain its actions throughout the admission of the patient. It also points out that physicians are not employees of AHS. Rather they are independent contractors.

This is not an action for battery but a limited summary process as such the Court should be careful in its assessment of breaches that may have occurred.

[56] Alberta pointed out that it is intervening mainly on the issue of whether the ***MHA*** is ***Charter*** compliant and submits that it is a procedurally fair code in all respects. To the extent that there were compliance issues with the ***MHA*** or the ***Charter*** in JH's case, this is an issue for AHS, not Alberta. Indeed, for instance it conceded that there were issues in JH's case that could be considered to be problematic, but that this should not lead to a finding of invalidity of the ***MHA*** itself.

[57] CLG's submissions referred mainly to the ***MHA***'s lack of compliance with the ***Charter***. Its position, on behalf of the many low income and marginalised persons it represents, is that there are deep structural issues with the ***MHA***. JH's ***Charter*** rights were breached on multiple levels and these are examples of how the ***MHA*** is overbroad and does not have the appropriate procedural safeguards in place.

Preliminary Procedural Issues

[58] Firstly, with respect to the procedural issues raised by AHS, does the nature of this process limit this Court's jurisdiction to find that there was a ***Charter*** breach either with respect to JH in particular or the ***MHA*** in general?

[59] JH brought not only an appeal to this Court but also issued an Originating Notice claiming amongst other things that his ***Charter*** rights had been breached. He also sought a declaration that certain provisions of the ***MHA*** should be declared unconstitutional on notice to the Attorney General of both Alberta and Canada. In May 2015 we proceeded with the first part of this action, as set out in the Oral hearing, Order of Justice Erb dated May 1, 2015 (as amended on May 11, 2015) and the constitutional issues were adjourned. The scope of these issues was the subject of discussion multiple times and culminated in the Order of July 27, 2017 which set out the constitutional issues.

[60] As mentioned above, all parties had the opportunity to file further material or ask for further *viva voce* evidence to be heard on the constitutional issues. Both JH and Alberta took advantage of this opportunity. AHS could have done so as well but chose not to. I understand that the doctors who issued the certificates may well be independent contractors (no evidence was led in this regard but I have no reason not to accept this submission), however, this does not mean that their evidence could not be heard. Indeed Dr. Quickfall testified at the hearing in May 2015.

[61] I note that the Government of Alberta chose to delegate the power of detention and certain responsibilities into the hands of the boards of designated facilities. Foothills is such a designated facility run by AHS. Further, that "staff members" of such a facility are required to sign one of two admission and renewal certificates and, in this regard, Dr. Quickfall's C.V. indicates that he is "Clinical Staff" at the Foothills. As such, the Foothill's board had responsibilities to ensure that the board's obligations under the ***MHA*** were complied with.

[62] A similar issue about a hospital's responsibility in a mental health setting in Ontario came up in the case ***R v Webers***, [1994] OJ No 2767 (Ct J(Gen Div)) where Justice O'Connor said the following at para 23:

> The hospital operates the psychiatric facility. The attending physician enjoys privileges at the hospital. Although not an employee of the hospital, he is subject to its direction, in the persons of the chief of staff, the chief of his discipline and the "officer in charge". [...] The hospital must maintain overall responsibility for the activities of its employees, including its doctors with privileges. The officer in charge should institute and oversee procedures to ensure compliance with the *Act*.

[63] The Ontario mental health legislation is not the same as Alberta's ***MHA***, but the spirit regarding the responsibility of the hospital as delegated by the government is similarly applicable to Alberta's regime.

[64] Having said this, I am cognisant that the doctors are not parties to this action directly. Further, as noted, no damages are being sought against them or AHS. In any event, there is a fairly extensive record about JH's certification and stay at the Foothills and more than enough to make certain determinations about whether the ***MHA*** provisions were followed in his case and whether the procedures therein are ***Charter*** compliant.

General Detention Issues

[65] In JH's case, the general detention issues that arise deal with the state's desire to keep its population safe from self-harm in cases where mental disorder interferes with an individual's care decisions. The ***MHA*** in Alberta sets out the basic framework for detaining an individual for the purposes of treatment. It, of course, has to work within the rights set out for individuals in the ***Charter***. The sections at play in this regard in the ***Charter*** are ss. 7, 9 and 10. I shall analyse each as they become pertinent to the discussion, however the overarching section in question in this decision is s. 7.

[66] Section 7 of the ***Charter*** reads as follows:

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

[67] All parties agree that the Supreme Court of Canada case ***Re Charkaoui***, 2007 SCC 9 properly sets out the test that JH must meet to show an infringement of his s. 7 rights. The Court said at paragraph 12:

> This requires a claimant to prove two matters: first, that there has been or could be a deprivation of the right to life, liberty and security of the person, and second, that the deprivation was not or would not be in accordance with the principles of fundamental justice. If the claimant succeeds, the government bears the burden of justifying the deprivation under s. 1, which provides that the rights guaranteed by the *Charter* are subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

[68] The parties all acknowledge that JH's liberty interests were engaged by his detention and the detention provisions of the ***MHA***. Further, JH's security interests clearly were engaged by the competency assessment and treatment provisions of the ***MHA*** that led (much too late in his detention) to a finding of incompetency, and involuntary treatment of JH (even before the legal authority to do so had not been formalised before doing so). Therefore, the issue to be analyzed is whether the deprivation JH's liberty and security interests were infringed in accordance with the principles of fundamental justice.

[69] My analysis of whether there were breaches of the ***Charter*** provisions in question will start with a review of how detention was initially allowed under the ***MHA*** for JH through the criteria determination and certificate process. I will then review the notice JH was given of his reasons for detention and right to legal counsel. I will follow by reviewing the treatment and competency issues that arose in his case, and I will conclude by reviewing the procedural issues he faced in front of the Review Panel.

Criteria under the *MHA*

[70] The test to analyse the "principles of fundamental justice" requirement in s.7 is set out in ***Suresh v Canada (Minister of Citizenship and Immigration)***, 2002 SCC 1 at para 20: "Section 7 of the ***Charter*** requires not a particular type of process, but a fair process having regard to the nature of the proceedings and the interests at stake." The first step in the ***MHA*** to detain a person against his will for the purpose of treatment is a determination of whether the individual fulfills the criteria set out in the legislation to intervene.

[71] The criteria under the ***MHA*** to detain and individual, after the initial detention, is found in s. 8. It provides that in order to detain an individual, two physicians, after separate examination by each of them, have to be of the opinion that the patient is:

(a) Suffering from mental disorder

(b) Likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and

(c) Unsuitable to continue at a facility other than as a formal patient.

[72] "Mental disorder" is defined as: "a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs (i) judgment (ii) behaviour, (iii) capacity to recognize reality, or (iv) ability to meet the ordinary demands of life (s. 1(g)). "Harm" is not defined.

[73] As discussed above, JH was detained on all three criteria for the whole of his detention period. More particularly, with respect to the second criteria, that if released, he would likely cause harm to himself or suffer substantial mental or physical deterioration or serious physical impairment. There was never any concern that JH may cause harm to others. In other words, there was no public safety issue here with respect to JH.

[74] As discussed in my initial decision, in May 2015, I found that, at that time, JH did not meet the criteria for mental disorder at the time as he did not have a "substantial" disorder of thought or mind that was "grossly impairing" his judgement or ability to "meet the ordinary demands of life". Further, that any harm he may cause to himself, i.e. the risk that he may decompensate in weeks

or months, was not sufficient to detain under the ***MHA***. And finally, that I believed that JH would stay voluntarily in the hospital in any event for a period so that his transition back in to the community could be arranged. Thus, he did not meet the third criteria. I subsequently learned that this indeed happened.

[75] The parties did not really focus on whether JH's rights pursuant to s. 7 of the ***Charter*** were breached because he was detained under the criteria in question throughout his stay. Some evidence was led about his condition during his stay, but most of the evidence focussed on two things:1. The fact that the certificates were so poorly filled out it was hard to determine one way or another whether he met the criteria in question and 2. That JH did not fit the criteria in May 2015, at the time of the appeal of the Review Panel findings.

[76] Further, the focus of the parties' arguments was made on the constitutional validity of the criteria in the MHA – which I will deal with in the next part of this decision.

[77] Accordingly, I will not comment here on whether JH's rights under s. 7 were breached because of the use of the criteria in his case during his stay. I will instead turn to the other procedural safeguards under the legislation, such as the certificates filled out in his case, and whether they met the constitutional standards of fundamental justice required by the ***Charter***. I will discuss the constitutional validity of the criteria itself when answering the second question before me.

Certificates

[78] In the ***MHA,*** physicians need to fill out certificates to detain individuals. A properly filled out certificate is part of the "fair process" required pursuant to s. 7 of the ***Charter*** to detain individuals under the ***MHA***. It must, be strictly adhered to in terms of its completeness considering the serious liberty rights at stake here.

[79] Ss. 6 and 9 of the ***MHA*** outline the provisions required in an admission or renewal certificate. Section 6 reads:

> 6. A renewal certificate shall show
>
> (a) the name of the person in respect of whom the certificate is issued,
>
> (b) the name and address of the physician issuing it,
>
> (c) the date on which the personal examination was conducted,
>
> (d) the facts on which the physician formed the physician's opinion that the person is
>
> (i) suffering from mental disorder,
>
> (ii) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and
>
> (iii) unsuitable to continue at a facility other than as a formal patient,
>
> distinguishing the facts observed by the physician from the facts communicated to the physician by others,

(e) the name of the facility where the person was examined or, if the person is not in a facility, the name and address of the facility to which the person is to be conveyed, and

(f) the date and time of issue.

[80] Section 9 is similar to s. 6 except for subsection (e) where the facility where the examination took place is to be inserted.

[81] There is a helpful discussion in regards to the effect of certificates in the civil mental health setting in ***Abbass v The Western Health Care Corp.***, 2017 NLCA 24. That case dealt with whether Mr. Abbass had the right to bring a *habeas corpus* application, or not, and in discussing his rights in that regard, the Court noted the scant certificates that were filed out in his case, which were similar or better than the ones here, and noted at para 38 that:

> The certificate is not merely a piece of paper that evidences a decision that has been made. It is *the* authority in itself to intrude upon the liberty and privacy of an individual. Without the existence of the piece of paper, properly completed, the authority does not exist. [emphasis in original).

[82] The Court in ***Abbass*** criticized the failure of the certificates in that case to identify the mental disorder in question, and did not properly set out the "facts" within the physician's knowledge upon which the physician formed the said opinion. It criticized the "generalised references to personal and public safety" and to the "need for further observation" without more to show that by virtue of their significance and nature they related to and met the criteria of harm or to make an informed decision about treatment (see para 37). The Court held that it was certainly arguable that "as a matter of facial validity alone, the admission and detention certificates of Mr. Abbass in the hospital was not lawfully authorised.": para 39.

[83] In JH's situation, the original certificates, and those that followed, were filled out correctly except for the part in subsection (d) which requires "the facts on which the physician formed the physician's opinion". In that regard, the "facts" were very general and vague. Like in ***Abbass***, the certificates here failed to set out a proper diagnosis and the facts upon which the diagnosis was held. Further, the brief notes in the certificates did not talk about a degree of severity of any issue but just bald statements such as "lacked capacity" or "disoriented" without the facts that led to such an opinion. Further, I note, that the other evidence led, such as the nurses' notes from two weeks before he was first detained, was somewhat contradictory. The notes indicated that JH at that time was oriented to person, alert, had clear speech and could communicate his needs. Accordingly, it is hard to analyse based on these certificates whether in fact JH fulfilled the ***MHA*** criteria or not.

[84] Some months later, Dr. Bailey gave his opinion with respect to the following :1. That opinions about whether a patient fits the definition is very wide and subjective so that here in JH's case there were several doctors who over the months he was detained felt that he did fit this ***MHA*** criteria whereas in his view he clearly did not (nor it appears in Dr. Hussein's opinion) and 2. JH suffered from a medical condition to his liver which left untreated may eventually worsen the mild cognitive impairment he was suffering from. It was only on the stand some 9 months later that Dr. Quickfall also agreed that JH did *not suffer from any psychiatric condition whatsoever*, and was not being treated with any psychiatric measures (barring the medication which appeared to be for

agitation issues due to the fact he was detained against his will). None of this was set out or documented in any of the certificates.

[85] JH, CLG, and even Alberta, agreed that the certificates in this case were imprecise and lacking in the appropriate detail to make them valid.

[86] In sum, in JH's case, I find that the certificates were vague and incomplete and as such, they did not satisfy the provisions of the ***MHA***, nor the section 7 level of procedural fairness that was required to detain JH. Regarding the nature of the proceedings, and liberty and security interests at stake, a properly filled out certificate is the "fair process" that needs to be strictly adhered to in terms of its completeness to comply with s. 7. Therefore, AHS breached JH's rights under the ***MHA*** and s. 7. In other words, AHS denied JH's liberty and security of the person and it was not done in accordance with the principles of fundamental justice.

[87] As noted above, even though AHS may not employ the physicians who improperly completed these certificates, AHS is nonetheless responsible to ensure that they are properly filled out. Absent properly completed certificates AHS had no lawful authority to detain JH, and others in similar situations. See ***Webers*** at para 23.

[88] Further, this failure in terms of improperly filled out certificates implicates JH's rights pursuant to s. 9 of the ***Charter.*** Section 9 reads: "Everyone has the right not to be arbitrarily detained or imprisoned." Since the certificates fail, the detention became "arbitrary"; a detention without some legal basis or authority is necessarily arbitrary. As noted in ***AH v Fraser Health Authority***, 2019 BCSC 227 at para 143: "A detention not authorized by law is arbitrary and violates s. 9: *R. v. Grant* 2009 SCC 32(S.C.C.) at para. 54." In this regard, JH's s. 9 rights were also breached and he was unlawfully detained by AHS.

Notice

[89] One of the main principles of fundamental justice is the need for proper notice of the reasons for detention and the right to be advised about what steps an individual can take to challenge such detention. These notice provisions are recognised in the ***Charter***, generally in s. 7, and more specifically in s. 10 (a) and (b). The main notice provisions in the ***MHA*** are found in s. 14. As I will discuss, in JH's case, his rights to proper notice were breached on many fronts.

[90] Section 14 of the ***MHA*** provides:

14. (1) When 2 admission certificates or 2 renewal certificates are issued with respect to a patient,

(a) the board shall inform the formal patient and make a reasonable effort to inform the patient's guardian, if any, and, unless a patient objects, the patient's nearest relative of

(i) the reason, in simple language, for the issuance of the admission certificates or renewal certificates, and

(ii) the patient's right to apply to the review panel for cancellation of the admission certificates or renewal certificates,

and

(b) the board shall give the formal patient, the patient's guardian, if any, one person designated by the patient and, unless a patient objects, the patient's nearest relative a **written statement** of

(i) the reason, in simple language, for the issuance of the admission certificates or renewal certificates,

(ii) the authority for the patient's detention and the period of it, including copies of the admission certificates or renewal certificates,

(iii) the function of review panels,

(iv) the name and address of the chair of the review panel for the facility, and

(v) the right to apply to the review panel for cancellation of the admission certificates or renewal certificates. [emphasis added]

[91] Here, JH's "nearest relative" pursuant to the definition in s. 1(1)(i) would have been his son in B.C. or his mother in Washington. His relationship with his son is unknown, but JH testified that he was in close communication with his mother and used to call her everyday. He testified that she tried to send him a camera at one point and they took it away. Also, we know that at least Dr. Workun was aware of his mother and her telephone number since he phoned her about the Seroquel treatment later in April.

[92] From the evidence before me it appears that the notice requirements under s. 14 of the ***MHA***, were never met. JH may have been told that he was detained under the ***MHA***, but there is no evidence that they advised his nearest relative at any time, nor that he was given any written information, including his certificates, until some time much later into his detention.

[93] For instance, there is some indication that in January 2015, well after 8 certificates had been issued, some written information was given to JH. The nurses' notes indicate that on January 2, 2015 "all the necessary information was given" so that JH could appeal his certificates. No evidence was led about what this information was, but I would like to assume that it included at least a Form 12 application and address of the Chair of the Panel. However, I also emphasize that according to the nurses' notes in March 2015, the information provided in January could not have included his certificates – those were only given to him on March 6 after the Patient Advocate intervened.

[94] In addition to the notice rights in s. 14, as mentioned above, s. 10 of the ***Charter*** also applies here. It provides that:

10. Everyone has the right on arrest or detention

(a) To be informed promptly of the reasons therefor;

(b) To retain and instruct counsel without delay and to be informed of that right; and

(c) To have the validity of the detention determined by way of *habeas corpus* and to be released if the detention is not lawful.

[95] JH's rights under s. 10(a) were breached as it appears that he was not "informed promptly" of the reasons for his detention. In addition, there is no evidence that he was *ever* informed of his s.10(b) right to counsel. The nurses' notes in January suggest that he was given "the necessary information" but there is no evidence that this included any information about the right to counsel or Legal Aid's telephone number. We know that in early March JH spoke with a Patient Advocate, but this person is not legal counsel and it is unknown if she advised him of the right to counsel or Legal Aid's number. It appears that in this case, Legal Aid appointed counsel directly when JH did finally manage to apply to have his certificates reviewed. That process appears to have been triggered by the chair of the Review Panel's office. In any event, it was months later and obviously not done "without delay".

[96] It has long been established that s.10 (b) rights include not only the right to be informed of the right to counsel but also to be advised on how to exercise those rights: see ***R v Manninen***, [1987] 1 SCR 1233 at 1242-1243. Further, in light of the Supreme Court decision in ***R v Brydges***, [1990] 1 SCR 190 at 215, the s.10(b) right expands to the right to legal counsel free of charge depending on the financial criteria set up in the provincial legal aid program. This right is to be allowed "promptly" and "without delay" – not months later. On the record before me, none of these rights were respected in JH's case.

[97] I find support in my decision on these points, and the general law on rights of detainees applying in civil commitment settings, in ***Webers*** and ***Fraser Health Authority*** in which patients were similarly not told of their reasons for detention or their right to counsel, as a result of which, multiple ***Charter*** breaches were found.

[98] More specifically, in ***Webers***, Justice O'Connor discussed the purpose of s.10 and the notice provision in the Ontario ***MHA*** at para 29 when quoting from a review board decision (***K.S.*** (March 6, 1991, Toronto West Review Board at p. 21)). He repeated:

> The purpose of Section 10 of the Charter and Section 30a. (now s. 38(4)) of the *Mental Health Act* is to ensure that individuals faced with the overwhelming confusion and helplessness which seem to inevitably follow detention have brought to their attention their basic civil rights. The existence of these rights is often hollow without this extra procedural step.

[99] In ***Fraser Health Authority***, Justice Warren held that written reasons for detention were necessary to satisfy s. 7 and 10(a) ***Charter*** rights. Verbal explanations were not enough: see paras 148-149. The facts in this case are chillingly similar to JH's situation. Justice Warren said the following at para 150:

> I have no difficulty concluding that written reasons were required here. The detention decision deprived A.H. of her liberty, the most fundamental of her rights. The consequences could scarcely have been more serious. It is apparent that A.H. did not understand the basis for her detention or the reasons for it. She expressed, multiple times during the course of the detention, confusion about her ongoing detention, repeatedly asking why she could not go home. [...]

[100] Similarly, as noted above, JH also was constantly asking why he was being detained and the reasons for it. The failure to provide him with his certificates and the written reasons for his detention as required under s. 14 is egregious.

[101] ***Webers*** also confirmed that detention under its *Mental Health Act* constituted "detention" within the meaning of the ***Charter*** and consequently s. 10(b) would apply (see paras 29 and 31). Similarly, in ***Fraser Health Authority***, at para 143 Justice Warren accepted that detention under the ***Adult Guardianship Act***, RSBC 1996, c 6 was a detention that engendered s 10(b) rights.

[102] Counsel for JH brought to my attention the case of ***Evans v Mattice***, 2018 ABQB 27 where it appears that the Calgary Police Service is of the view that they do not need to advise patients detained under the ***MHA*** of their rights to counsel. The police have apparently been relying on the provincial court case of ***R v Whittman***, 2007 ABPC 89 in that regard, where that Court, citing no authority, found at para 10 that:

> So long as the police are acting lawfully within the provisions of Section 12 of the Mental Health Act, the accused's Charter rights are suspended. This suspension would only end if the purpose of police involvement changed from the purposes set out in Section 12 of the Mental Health Act to other purposes involving a criminal investigation.

[103] With respect, ***Whittman*** was wrongly decided on this point. The detention under our ***MHA*** is a "detention" under the ***Charter*** and triggers the need for compliance with the s.10 (b) right to retain and instruct counsel without delay, to be informed of that right, and how to exercise that right. And that in this case, it was not complied with by the AHS, so that JH's rights were breached in this regard.

Treatment and Competency

[104] JH argues that his s. 7 rights to security were breached while he was detained and treated against his will and without his consent.

[105] It appears from the evidence before me that JH consented to certain medical treatments during his stay at the Foothills. In particular, even before he was certified, his written consent was sought, and obtained, for his knee surgical procedure on September 7, 2014 and for the invasive diagnostic treatment he obtained on September 18, 2014. He was also aware, and consented, to the morphine that he was prescribed for his pain issues arising from his accident injuries and the lactulose which he understood was to help his liver issues.

[106] JH did not consent however to the Seroquel that he was prescribed sometime in January 2015, nor to the Haldol and Ativan that was prescribed in November 2014. In fact, it is unclear whether or not JH even knew that he was being treated with Haldol and Ativan at all. Indeed, as noted, JH testified that at one point he was held down by security and shot with what he believed to be Seroquel. No evidence was led from AHS about how this happened or why this was necessary. As noted in ***Fleming v Reid*** **(1991), 82 DLR 4th 298 at 312 (ON CA)**: "few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs [...]."

[107] The Supreme Court of Canada has recently reiterated the general law about an individual's right to determine their own medical treatment in ***Carter v Canada (Attorney General)***, 2015 SCC 5 at para 67:

> The law has long protected patient autonomy in medical decision-making. In ***Manitoba (Director of Child & Family Services)*** v. C. (A.), 2009 SCC 30, [2009] 2 S.C.R. 181 (S.C.C.), a majority of this Court, per Abella J. (the dissent not disagreeing on this point), endorsed the "tenacious relevance in our legal system of the principle that **competent individuals** are — and should be — free to make decisions about their bodily integrity" (para. 39). This right to "decide one's own fate" entitles adults to direct the course of their own medical care (para. 40): it is this principle that underlies the concept of "informed consent" and is protected by s. 7's guarantee of liberty and security of the person (para. 100; see also ***R. v. Parker*** (2000), 49 O.R. (3d) 481 (Ont. C.A.)). As noted in ***Fleming v. Reid*** (1991), 4 O.R. (3d) 74 (Ont. C.A.), the right of medical self-determination is not vitiated by the fact that serious risks or consequences, including death, may flow from the patient's decision. It is this same principle that is at work in the cases dealing with the right to refuse consent to medical treatment, or to demand that treatment be withdrawn or discontinued: see, e.g., ***Ciarlariello v. Schacter***, [1993] 2 S.C.R. 119 (S.C.C.); ***Malette v. Shulman*** (1990), 72 O.R. (2d) 417 (Ont. C.A.); and ***B. (N.) c. Hôtel-Dieu de Québec*** (1992), 86 D.L.R. (4th) 385 (C.S. Que.). [emphasis added]

[108] By common law, a person is deemed to be mentally competent unless otherwise determined. This presumption is not changed upon certification under the ***MHA***. However, once detained under the ***MHA***, there are many provisions that apply to treat someone without their consent: firstly, there is a provision about determining a patient's competency, as defined (s. 26 and 27), secondly, there are processes for substitute decision making, (s. 28) and how to deal with objections to treatment (s. 29). The MHA ultimately allows treatment without consent of the patient, or their substitute decision maker, which has serious constitutional problems (as will be discussed in the next section).

[109] In JH's case, unfortunately, most of the provisions about how to legally treat someone without consent under the ***MHA*** were ignored. His competency was not properly addressed and certified until well into his stay (in March 2015), notice to any substitute decision maker was not made until April 2015, notice was not given about his right to appeal his competency finding until March of 2015, and despite this, he was treated without his consent. Accordingly, not only were his rights under the ***MHA*** breached, his right to security of the person pursuant to s. 7 were also breached. The detail about these issues is as follows.

[110] According to section 27(1) of the ***MHA***:

> A physician who is of the opinion that a formal patient is not mentally competent to make treatment decisions shall complete and file with the board a certificate in the prescribed form.

[111] "Mentally competent" is a defined term under s 26 and reads: "For the purposes of this Part, a person is mentally competent to make treatment decisions if the person is able to understand

the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions."

[112] As noted above, no such Form (11) was properly completed and filed for JH until March 19, 2015, and as such, JH was legally competent and his treatment decisions should have been respected between the time he was first certified and that date (and appropriate procedures followed thereafter as I will discuss).

[113] It appears from the notes, certificates and Dr. Hussein's report, that Dr. Soolsma and others, including Dr. Workun, were of the opinion that JH did not have "capacity" to make decisions about his treatment. Indeed Dr. Workun apparently filled out a document on January 14, 2015 stating that JH lacked decision making capacity "in areas i-vii" and a referral was made to OPG (Office of the Public Guardian) for guardianship and trusteeship to be considered.

[114] Although a referral to obtain a guardian and trustee for JH was possibly a helpful step, and as I will discuss later, possibly the much more appropriate route for JH considering various care providers' views, this was not the right process under the ***MHA*** for JH to be treated without his consent. Instead, a Form 11 should have been properly completed pursuant to s. 27 and, once again, notice should have been given to both JH and his nearest relative (if he did not object), by giving them a copy of the Form 11 certificate and written notice that he was entitled to have the physician's opinion reviewed by a Review Panel. If such an application was made, then pursuant to s. 27(4) the physician or board was not to act on the opinion of incompetence pending the outcome of the application (save for emergencies or need to control a patient pursuant to s. 30).

[115] Further, even if the Form 11 is not objected to, pursuant to s. 28, treatment decisions are to be made by an agent, guardian, nearest relative or public guardian. Further, if a patient objects, like JH did with respect to the Seroquel medication, even if a surrogate decision maker had consented, the treatment was not to be administered until a 2nd physician was also of the opinion that the patient is not mentally competent to make decisions (s. 28(5)).

[116] As noted, a Form 11 was only properly completed in March once the Patient Advocate intervened. It was never forwarded to JH's nearest relative and consent to treatment was never solicited from either JH, his relative, or the Public Guardian as required, until the call from Dr. Workun to JH's mother in April sometime.

[117] Worse yet, JH tried to appeal his Form 11 in March but because of a spelling error in his second name, the Form was never sent to the Review Panel. S. 14 (3) mandates that the board shall do any other things the board considers expedient to facilitate the submission of an application. This did not happen either. As such, the finding of incompetence, in the Form 11, or as presumed "incapacity" without legal authority by those caring for JH, was never brought to the Review Panel's consideration – and was not subject to the appeal before this Court.

[118] All to say, it appears that the medical treatment that JH received without his consent – and with questionable need in light of Dr. Quickfall's evidence that he did not need "psychiatric treatment"- and without notice to his nearest relative, was a serious breach of both his s. 7 rights and the provisions of the ***MHA*** by AHS.

Procedure before the Review Panel

[119] As mentioned above, JH submits that the process he faced before the Review Panel did not meet the fundamental justice criteria in s. 7 of the ***Charter*** mainly because he did not know the case before him and he was therefore not able to properly answer it. AHS, on the other hand, defended the process that faced JH in that it complied with the provisions in the ***MHA*** and the ***Health Information Act***, RSA 2000, c H-5.

[120] As stated in ***Charkaoui*** at paras 28 - 29:

> The overarching principle of fundamental justice that applies here is this: before the state can detain people for significant periods of time, it must accord them a fair judicial process: *New Brunswick (Minister of Health & Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46 [...]
>
> This basic principle has a number of facets. It comprises the right to a *hearing*. It requires that the hearing be *before an independent and impartial magistrate*. It demands a decision *by the magistrate on the facts and the law*. And it entails the *right to know the case put against one*, and the *right to answer that case*. Precisely how these requirements are met will vary with the context. But for s. 7 to be satisfied, each of them must be met in substance. [emphasis in original]

[121] In JH's case many procedural laws applied with respect to what was the appropriate procedure of the Review Panel hearing that was held on his behalf on March 17, 2015. Firstly, although JH had expressed the continuous desire to leave the Foothills from the time of his detention in September 2014, it was only when the "deeming" provision of a review was imminent under s 39 of the ***MHA*** that a nurse finally helped JH apply for a hearing.

[122] Once the application was sent in to the Review Panel chair, Ms. Marilyn Smith, on March 9, 2015, the wheels started turning. A hearing date was set for March 17 and a Legal Aid counsel was appointed on March 16. JH also indicated on the application Form that he did not object to his nearest relative being informed of the hearing. There is no evidence that this was done. Certainly, his mother, who was most connected to JH, and to whom we know that at least Dr. Worken was aware of, considering that he called her a couple weeks later about treatment issues, was not at the hearing. Further the Form 11 itself references as "nearest relatives" an aunt and a sister with "no address" noted, instead of his mother with an address and telephone number, which is particularly baffling.

[123] Section 34 of the ***MHA*** requires the Minister to appoint a roster of review panel members who are, amongst other things independent of the patient. This apparently occurred here and there was no complaint in this regard.

[124] As noted above, s. 7 of the ***Charter*** requires that a patient has "the right to know the case put against one." Here, according to the evidence before me, JH had only recently been given copies of his certificates thanks to the Patient Advocate's intervention – i.e. on March 6. Further, he did not have his complete medical records before the hearing – nor did his counsel.

[125] Counsel for AHS argued that all counsel needed to do was to order these records and that they would be provided, with JH's consent, pursuant to the ***Health Information Act***. Alberta argued that if there was an issue in this regard, an adjournment could have been sought, under s. 40(5), the ***MHA*** allows that this can be granted for a period of up to 21 days.

[126] In reply, counsel for JH, pointed out that the practice is that the records are only available on the day of the hearing. An AHS form was produced entitled "Mental Health Review Panel Hearing" where after the patient name, RHRN # and date and time of the hearing is requested, it then states: "A copy of the chart will be available with Access and Disclosure, Health Information Management (room G-01) on the day of the panel. Our business hours are 0800-1615 Monday to Friday."

[127] Further, if one requests records through the normal process, there is a fee involved and their production ($1 a page at the time), according to the form that was entered into evidence, and it "may take up to 30 days to process".

[128] In my view, in JH's case, he did not "know the case" that was to be put before the review panel hearing. His record was extensive since he had been in hospital for over 6 months (initially on a voluntary basis). The record was kept in several different places according to Dr. Quickfall's evidence, and it is not clear that the whole of the record was even made available to JH after the hearing. Counsel for JH described it as being almost a foot thick, completely disorganised, and not possible to deal with in such a short time line.

[129] The record being unavailable until the day of the hearing was compounded with the fact that, as noted above, the detention certificates in this case were woefully inadequate for counsel or the Review Panel members to properly assess whether the criteria had been met. Referring to the Certificates under review in March, 2015, the December Certificates in particular, Dr. Workun noted: "I have formed my opinion (a) on the following facts observed by me:" in handwriting: "Wants to leave hospital AMA. No insight into medical care needs. Poor memory & judgement." And it was blank under "(b) on the following facts communicated to me by others."

[130] The questions that arise are: is it really unreasonable to want to leave the hospital? What are the medical care needs? What level of insight is JH missing in terms of his medical needs? What does "poor" memory and judgement mean? What testing or assessment was done in this regard? What treatment plan is he on? What level of security does he need? What are the plans for his reintegration into the community?

[131] Dr. Quickfall's December 19 Certificate is no better. It states "Pt cognitively imparied (sic), lack of capacity to make decisions around health care and accommodation. Wants to leave. Requires security to ensure that he stays on the unit."

[132] The questions Dr. Workun's and Dr. Quickfall's notes leave unanswered are crucial and include: what and why is there cognitive impairment and to what degree? What health care decisions was he having trouble with to the point that he "lacked capacity"? If he "lacked capacity", which I assume also refers to his lack of competence to make treatment decisions, where is the Form 11? Has a substitute decision maker been involved? If it is psychotropic drugs like Seroquel that he is refusing – in a situation where he has no psychiatric condition – is this not

reasonable? What efforts are in place for him to get accommodations? Can social work not help him get some ID, AISH and structured living accommodation outside the acute care ward of the Foothills?

[133] As far as I can tell from the evidence put before this Court, there was no formal written assessment done of JH's condition beyond the cursory certificates provided at the Review Panel hearing. A more complete assessment, i.e. the one done by Dr. Hussein *after* the hearing, was tendered to this Court, and only after an adjournment of the appeal proceeding before me because, again, complete medical records (including this assessment) had not been provided to counsel before hand.

[134] In other words, in my view, JH could not properly prepare for his hearing with so little information about his reasons for detention, what his treatment was, and why, what plans were for his continued detention, and what was in the works to allow him to be discharged from the acute care ward of the Foothills.

[135] Since JH did not know the case that was to be put before him, in breach of his rights, he obviously also was not able to properly "answer" his case either. The problems in this regard started when the Review Panel commenced the hearing without his counsel. As noted earlier, there was some miscommunication about the location of the hearing in the Foothills, and despite the Panel knowing that counsel had likely been appointed, they started anyway. It's not clear what, if anything the counsel missed. The hearing, in total, lasted no more than 45 minutes.

[136] It appears in the brief reasons provided by the Review Panel that JH's counsel made a valiant effort to represent JH despite not having time to prepare properly, and it was only when she appeared at the appeal that she had the ability to truly answer and cross-examine on the issues that should have been canvassed by the Review Panel.

[137] As described above, Dr. Quickfall appears to have given very general information to the Panel (based on its brief reasons since there is no transcript). He talked in generalities such as that JH had "improved" since admission but had "lots" of cognitive impairments and "no" ability to make health care decisions. Further that without hospitalization there was "a risk" of decompensation and that his prognosis without the same was not good.

[138] Only upon cross-examination in May in Court, after proper preparation and disclosure, was the evidence elicited that in fact JH had *no* psychiatric condition that could be treated, he did not really belong in an acute ward of the Foothills but that so far, no other place had been found for him (although Dr. Quickfall added that this was not his personal responsibility). Further, that the impairment was described as a "mild deficit" caused by a liver condition which caused a mild brain injury condition (hepatic encephalopathy) that could worsen if JH stopped taking his liver medication and if he started drinking alcohol again. This would happen over a matter of months *if this happened at all.*

[139] In sum, JH's right to a fair judicial process was denied at the Review Panel hearing. These issues were remedied to a certain extent, by the time he made it to his appeal some two months later. However, he was still not given his complete record before the hearing (as noted Dr. Hussein's report was not provided until the day of his appeal) and frankly, he did not know much

more about Dr. Quickfall's opinion until he learned of it under cross-examination. Further, I note that possibly an adjournment may have helped to remedy some of these issues at the Panel hearing however, I expect that after 6 months of waiting JH was likely anxious to proceed. It is not known whether this was canvassed one way or another.

Summary with respect to ss. 7, 9 and 10 breaches in JH's case

[140] In sum, in my view, JH suffered many breaches of his section 7, 9 and 10 (a) and (b) ***Charter*** rights and certain provisions of the ***MHA*** as follows:

1. His admission and renewal certificates were inadequate in that they were vague and incomplete and therefore did not provide the proper authority to detain him under the ***MHA*** in breach of ss. 7 and 9 of the ***Charter*** and ss 6 and 9 of the ***MHA***.
2. He was not promptly or properly advised of his reasons for detention (by failing to provide him and his nearest relative with his certificates or written information about the reasons for his detention) in a reasonable time in breach of s. 10(a) of the ***Charter*** and s. 14 of the ***MHA***.
3. Despite being detained pursuant to the ***MHA***, on the evidence before me, it appears that he was not advised of his right to counsel without delay, nor given prompt assistance on how to exercise those rights, in breach of his s. 10(b) rights.
4. He was treated without his consent in breach of s. 7 of the ***Charter*** and ss. 27, 28, and 29 of the ***MHA***.
5. He failed to have a procedurally fair hearing before the Review Panel in that he did not know the case he had to meet (by the failure to provide him with properly completed certificates, his medical records before the hearing, or any written assessment) and he was therefore not able to properly answer his case, in breach of his s. 7 ***Charter*** rights.

2. Do the review and detention provisions in general and ss. 2, 4(1), 4(2), 8(1), 8(3), 38(1) and 41(1) of the MHA breach ss. 7, 9 or 10 of the Charter?

[141] Having found that JH's individual rights were breached pursuant to the applicable provisions of the ***MHA*** and in violation of ss. 7, 9 and 10 of the ***Charter***, I now turn to analyse whether the review and detention provisions in the ***MHA*** breach these ***Charter*** sections.

[142] The impugned sections 2, 4 and 8 of the ***MHA*** deal with the issuance of certificates which provide the authority under the ***MHA*** to detain and, ultimately treat, an individual. Sections 38 and 41 deal with the application for a hearing by a Review Panel and the decision powers of the Panel. I have attached all of these impugned sections as **Appendix A** to this decision. The constitutional question also requires that I examine the review and detention provisions in general, accordingly, other sections of the ***MHA*** also become important, as already discussed. I deal with each of them as they come up in the analysis.

[143] I start this portion of the analysis with the premise stated in ***Carter*** at paras 71-72:

> Section 7 does not promise that the state will never interfere with a person's life, liberty or security of the person — laws do this all the time — but rather that the state will not do so in a way that violates the principles of fundamental justice.
>
> Section 7 does not catalogue the principles of fundamental justice to which it refers. Over the course of 32 years of *Charter* adjudication, this Court has worked to define the minimum constitutional requirements that a law that trenches on life, liberty, or security of the person must meet (***Bedford***, at para. 94). While the Court has recognized a number of principles of fundamental justice, three have emerged as central in the recent s. 7 jurisprudence: laws that impinge on life, liberty or security of the person must not be arbitrary, overbroad, or have consequences that are grossly disproportionate to their object.

[144] With these general comments in mind, I turn to the parties' complaints of the ***MHA*** and Alberta and AHS's response.

Parties' Positions

[145] JH and CLG submit that the ***MHA*** in general, and the impugned section specifically, are not ***Charter*** compliant and breach ss. 7, 9 and 10 for the combination of the following reasons:

1. The criteria for detention are vague and overbroad to the ***MHA***'s purpose to detain and treat and therefore it casts too wide a net over persons who are potentially inflicting an undefined "harm" to themselves but require no psychiatric treatment.
2. The detention period allowed by limitless certificate renewals, and therefore indefinite detention, without better procedural safeguards unnecessarily breaches security and liberty interests.
3. The treatment provisions in the ***MHA*** are infirm since they allow for treatment over competent person's, or their substitute decision maker's, rights to object and make no provision for a person's prior competent choices. Further, they allow for indefinite incompetency findings with no automatic need to review.
4. The notice provisions of the detention are unsatisfactory since there are no provisions in the ***MHA*** that provides for need for prompt notice of the right to counsel or access to free counsel pursuant to s. 10(b). The Patient Advocate system does not satisfy this provision since it is a non-lawyer, complaint-based system only.
5. There is no administrative oversight (except with respect to Form 11 that needs to be filed) which makes the multiple rights and safeguards that are present in the ***MHA*** illusory.
6. The Review Panel procedure is flawed in that the person does not have proper disclosure so that they know the case that is to be put against them and they have limited opportunity to answer that case. Particularly problematic is the lack of access to medical records and written medical assessments prior to the hearings.
7. The Review Panel does not have the proper authority under the ***MHA*** to deal with any substantive concerns of the detention and make orders about security decisions,

facility placement, treatment decisions, and orders dealing with the re-integration of persons into the community.

[146] Alberta and the AHS replied that, in summary:

1. Many cases with similar detention criteria have found that this kind of legislative scheme is ***Charter*** compliant since the level of harm can be assessed by professionals and it is not vague, overbroad, arbitrary or disproportionate to the legislation's purpose.
2. Certificates have to be signed by 2 physicians, need periodic renewal, and are subject to review on request and automatic tribunal review every 6 months. These are sufficient procedural safeguards for indefinite detention.
3. The treatment provisions contain safeguards such as the rights to have the decisions reviewed by a tribunal.
4. There is no constitutional requirement that the s 10(b) right to be notified of the right to counsel be embedded in the ***MHA***.
5. Administrative oversight need not be legislated for ***Charter*** compliance. AHS has internal processes and checklists that satisfy this requirement. Further a Patient Advocate system provides oversight of complaints with documented success.
6. In terms of disclosure issues, a person has the right to their medical records pursuant to the ***Health Information Act***.
7. In terms of the Panels' decision-making powers, the ***MHA*** has provisions that allow a facility to review the level of security required, in and out privileges and leaves of absence. The Panel does not need this duplicative power, and in any event it is not appropriate for the Panel to have the power to step into the shoes of the patient's physician or treatment team.

Analysis

[147] In order to determine if the impugned detention provisions in the ***MHA*** (ss. 2, 4 (1) & (2), 7(1), and 8(1) & (3)) breach the ***Charter,*** I will analyse the criteria provisions found in these sections, the certificate content and renewal issues, treatment that is allowed because of the detention, the administrative oversight issues and notice provisions that arise.

[148] I will then turn to analyse the impugned review sections 38(1) and 41(1) by concentrating on the Review Panel's disclosure and decision power concerns.

Criteria

[149] As discussed above, the detention provisions under the ***MHA*** interferes with a person's rights to liberty and security under s. 7 of the ***Charter***. The question here is whether detention is done in accordance with the principles of fundamental justice. The criteria that are used to determine if a person can be detained under the ***MHA*** are vitally important as they are used by those making the decisions to detain and by those reviewing these decisions about whether the detention is lawful for the purposes of the ***MHA***.

[150] Here, the criteria particularly under review are the provisions that deal with the state's need to intervene for paternalistic (*parens patriae*) reasons to prevent someone from self-harm and to help them recover.

[151] As discussed earlier, pursuant to s. 8, in order to be detained under the ***MHA***, after the initial detention, two physicians have to be of the opinion that the patient is:

(a) Suffering from a mental disorder

(b) Likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and

(c) Unsuitable to continue at a facility other than as a formal patient.

[152] "Mental disorder" is defined as: "a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs (i) judgment (ii) behaviour, (iii) capacity to recognise reality, or (iv) ability to meet the ordinary demands of life (s. 1(g)). "Harm" is not defined.

[153] As discussed above, JH was detained on all three criteria for the whole of his detention period. More particularly, with respect to the second criteria, that if released, he would likely cause harm to himself or suffer substantial mental or physical deterioration or serious physical impairment. There was never any concern that JH may cause harm to others. In other words, there was no public safety issue here with respect to JH.

[154] The Applicant and CLG intervener, in summary, argue that the large and undefined criteria for detention in the ***MHA*** are vague, overbroad, arbitrary and grossly disproportionate. The Applicant and CLG argue that since the purpose and objective of the ***MHA*** is to detain and treat severely mentally ill persons, the criteria definition of "mental disorder" (including the lack of definition of the words "substantial" and "gross") combined with the lack of a standard for what constitutes "harm", combined with the lack of limiting criteria such as the need for treatment or a finding of incapacity, means that the ***MHA*** now is so broad that it improperly captures those, like JH, who were not intended to be captured. As such, the criteria are too broad and arbitrary in its application and breaches s.7.

[155] Alberta argues, in summary, that the criteria in the legislation are proportional to its purpose of detaining and providing treatment services to those individuals subject to the ***MHA***. The terms "substantial", "grossly" and "harm" are adequately precise for the experts and Courts to apply. To the extent that experts may disagree on their interpretation does not make them vague or overbroad. Further, its possible misapplication in this case does not mean that the legislation breaches section 7 – it points to an administration problem, not a legislative problem. Here, for instance, Alberta submitted that: "Dr. Quickfall's approach is not supported by the legislation. The legislation does not authorize involuntary detention simply because social supports are not lined up on release."

Analysis with respect to the Criteria

[156] Alberta submitted that ***R v Levkovic***, 2013 SCC 25 properly set out the test when the court is analysing whether a law is unconstitutionally vague at paras 47 and 48:

> A court can conclude that a law is unconstitutionally vague only after exhausting its interpretive function. The court "must first develop the full interpretive context surrounding an impugned provision". *Canadian Pacific*, at paras 47 and 79.
>
> To develop a provision's "full interpretive context", this Court has considered:(i) prior judicial interpretations; (ii) the legislative purpose; (iii) the subject matter and nature of the impugned provision; (iv) societal values; and (v) related legislative provisions: *Canadian Pacific* at paras 47 and 87.

[157] As I will come to, many of the decisions dealing with whether mental health criteria met the s. 7 need for fundamental justice used vagueness constitutional tests and found, using these tests, that the impugned criteria were not vague and therefore did not breach s. 7.

[158] However, since those cases were decided, the Supreme Court has expanded the test for constitutional validity under s. 7 by asking the question about whether the impugned legislative provision is arbitrary, overbroad, or grossly disproportionate to the object of the legislation.

[159] For instance, ***Carter*** overturned ***Rodriguez v British Columbia (AG)***, [1993] 3 SCR 519 in part because the test under s.7 had changed. The Court said at para 46:

> The argument before the trial judge involved a different legal conception of s. 7 than that prevailing when *Rodriguez* was decided. In particular, the law relating to the principles of overbreadth and gross disproportionality had **materially advanced** since *Rodriguez*. The majority of this Court in *Rodriguez* acknowledged the argument that the impugned laws were "over-inclusive" when discussing the principles of fundamental justice (see p. 590). However, **it did not apply the principle of overbreadth as it is currently understood**, but instead asked whether the prohibition was "arbitrary or unfair in that it is unrelated to the state's interest in protecting the vulnerable, and that it lacks a foundation in the legal tradition and societal beliefs which are said to be represented by the prohibition" (p. 595). By contrast, **the law on overbreadth, now explicitly recognized as a principle of fundamental justice, asks whether the law interferes with some conduct that has no connection to the law's objectives (*Bedford*, at para. 101). This different question may lead to a different answer**. The majority's consideration of overbreadth under s. 1 suffers from the same defect: see *Rodriguez*, at p. 614. Finally, the majority in *Rodriguez* did not consider whether the prohibition was grossly disproportionate. [emphasis added]

[160] The principle of "overbreadth" of legislation was discussed in ***R v Heywood***, [1994] 3 SCR 761. As stated at pages 792-793:

> Overbreadth analysis looks at the means chosen by the state in relation to its purpose. In considering whether a legislative provision is overbroad, a court must ask the question: are those means necessary to achieve the State objective? If the State, in pursuing a legitimate objective, uses means which are broader than is necessary to accomplish that objective, the principles of fundamental justice will be violated because the individual's rights will have been limited for no reason. The

> effect of overbreadth is that in some applications the law is arbitrary or disproportionate.

[161] The doctrine has been discussed in many Supreme Court of Canada cases since then, including ***Bedford v Canada (AG)***, 2013 SCC 72 and ***Carter v Canada (AG)***, 2015 SCC 5. For example, in ***Carter***, the Court referred to the restatement of the test in ***Bedford*** at para 85:

> The overbreadth analysis asks whether a law that takes away rights in a way that generally supports the object of the law, goes too far by denying the rights of some individuals in a way that bears no relation to the object: *Bedford* at paras101 and 112-13

and then continued:

> The question is not whether Parliament has chosen the least restrictive means, but whether the chosen means infringe life, liberty or security of the person **in a way that has no connection with the mischief contemplated by the legislature**. The focus is not on broad social impacts, but on the impact of the measure on the individuals whose life, liberty or security of the person is trammelled. [emphasis added]

[162] The Court applied the test in ***Carter***; at para 86:

> Applying this approach, we conclude that the prohibition on assisted dying is overbroad. The object of the law, as discussed, is to protect vulnerable persons from being induced to commit suicide at a moment of weakness. Canada conceded at trial that the law catches people outside this class [...] It follows that the limitation on their rights is in at least some cases not connected to the objective of protecting vulnerable persons. The blanket prohibition sweeps conduct into its ambit that is unrelated to the law's objective.

[163] A different question in ***Carter*** resulted in a different answer.

[164] The principle of gross disproportionality was also discussed in ***Carter***. At para 89 the Court described the principle as follows:

> This principle is infringed if the impact of the restriction on the individual's life, liberty or security of the person is grossly disproportionate to the object of the measure. As with overbreadth, the focus is not on the impact of the measure on society or the public, which are matters for s. 1, but on its impact on the rights of the claimant. The inquiry into gross disproportionality compares the law's purpose, "taken at face value", with its negative effects on the rights of the claimant, and asks if this impact is completely out of sync with the object of the law (*Bedford*, at para. 125). The standard is high: the law's object and its impact may be incommensurate without reaching the standard for gross disproportionality [...] [citations omitted]

[165] The Court in ***Carter*** found it unnecessary to decide whether the prohibition in the law violated the principle against gross disproportionality in light of its conclusion that the law was overbroad.

[166] In order to answer the questions about whether fundamental justice has been breached in the **MHA**'s criteria, and otherwise, I need to turn to the question of the ***MHA***'s purpose in Alberta.

Purpose

[167] Unfortunately, no specific "purpose" clause was legislated into the ***MHA***. Interestingly, as a result, Alberta submitted various ideas about what the purpose was behind the legislation. In its first brief it suggested that the purpose was "treatment and protection", it then suggested in its second brief, that it was "diagnostic and treatment services" pursuant to s. 19(1). However, in argument, Alberta indicated that the purpose of the ***MHA*** was for "detention and treatment".

[168] JH argued that the ***MHA***'s purpose was to deal with the detention and treatment of severely mentally ill persons. CLG agreed that the purpose was the detention and treatment of people and that the focus of the ***MHA*** is on the prevention of harm through treatment.

[169] The ***MHA*** has been the subject of much review by the Legislature over the last 30 years. Both the criteria and procedures to detain and treat have been studied and changed. Some review of this history is necessary to understand the present purpose and objective of the ***MHA***.

[170] With the advent of the ***Charter*** and greater insistence of patient rights and higher standards of treatment of care coupled with the move to care in the community for the mentally ill as opposed to the two large facilities in Alberta that treated them historically (Alberta Hospital Edmonton and Ponoka which were the only "facilities" who could detain and treat mentally ill patients up into the late 80s for instance), the government saw fit to create a Task Force to Review the ***Mental Health Act*** in January 1982.

[171] This Task Force, led by Richard Drewry, Q.C., recommended "a more restrictive approach to compulsory hospitalisation" (*Report of the Task Force to Review the Mental Health Act*, December 2, 1983 at p.iii – which I will subsequently refer to as the "*Task Force Report*").

[172] These recommendations, in large part, made their way into Bill 29 that was passed in 1988 (***Mental Health Act***, SA 1988, c M-13.1). More specifically, the criteria were tightened up to increase the threshold by which someone could be put into a mental health facility against their will. This was accomplished by changing the definition of "mental disorder" from "lack of reason or lack of control of behaviour" (***Mental Health Act***, RSA 1980, c M-13 ss.1 (h)), to the one that is found in today's legislation, and by keeping the two main criteria for involuntary admission i.e. : "1) suffering from a mental disorder and 2) in a condition presenting a danger to himself or others" plus adding a third criteria "unsuitable for admission to a facility other than as a formal patient".

[173] The Task Force specifically rejected recommending a change to the "danger to self or others" criteria to a wider "need of treatment" criteria. The Task Force noted at p. 57:

> **Substitution of Language of "Safety" and "Protection" for Dangerousness**
>
> The British Mental Health Act 1959 (7& 8 Eliz. 2, c. 72) does not make reference to "dangerousness". Instead, it speaks of a disorder or disability of the mind which

> warrants detention under observation in the interests of the person's own health and safety or with a view to the protection of others.
>
> The adoption of this language in substitution for the criterion of dangerousness is advocated in some submissions. Although the use of these words avoids the problem of the unpredictability of dangerousness, it expands the umbrella of authorized compulsory hospitalization. It emphasizes the welfare of the patient and leads towards "in need of treatment" as a criterion.
>
> We believe that a stronger justification must be made before intervention occurs.

[174] This recommendation was accepted at the time considering the criteria change made did not include a wider "welfare" or *parens patria* component. Indeed, when the Bill was introduced to the Legislature, The Hon. Minister M. Moore pointed out that "the major purpose of the MHA was for the detention and treatment of people who suffer mental illnesses and for their treatment and detention as involuntary patients." Further, that "this Act did not purport to cover all aspects of mental health" and that there was a "host of measures and treatments available" that were not covered by this legislation. (Alberta Hansard, Bill 29 (*Mental Health Act*) (Second Reading), May 30, 1988 at p. 1353).

[175] Retaining the ***MHA*** with admission criteria that combined mental disorder with "dangerousness" was also applauded by the opposition at that time. Mr. Sheldon Chumir, a lawyer and MLA said the following: "I believe that models based on a simple need for treatment and allowing commitment on that basis are not appropriate. There's too great a danger of committal and a desire to treat in light of the state of uncertainty in the realm of medical knowledge in this area." (p. 1357 Hansard).

[176] In other words, the purpose of the scope of the ***MHA*** at that time was to restrict, not enlarge, the group of people that could be detained under the ***Act*** – the change in criteria was described by Minister Moore as a "significant safeguard" in order to respect the rights and freedoms under the ***Charter*** of people who suffer mental illness and require involuntary detention (Hansard at p. 1353).

[177] Nonetheless, some members of the legislature at that time were concerned that the definition of mental disorder was too vague and highly subjective. In particular the words "substantial" disorder and "grossly" impairs – was so subjective that it may lead to abuse. Further, that the definition of "mental disorder" was so broad that "even the mentally handicapped or the mentally retarded could be included in that section" (p. 1359 Hansard). There was discussion therefore about specifically exempting those with this type of mental disability.

[178] Notably, some years later the "dangerousness criteria" was changed in Bill 31, The ***Mental Health Amendment Act***, 2007 to include more of a welfare model in response to concerns that earlier intervention was required so that mentally ill people "receive the treatment they need" before they reach the point of being a danger to themselves or others. (Alberta Hansard, 26th leg., 3rd Session, May 1, 2007 at p. 747 (Hon. T. Abbott)).

[179] Dr. Baillie testified about this amendment. He indicated that the Schizophrenia Society was very much involved in the discussions about the legislative changes, being in large part, the family members of individuals, adults, who have schizophrenia and were concerned about the "revolving

door" of their adult children being hospitalized, placed on medication, released back to the community, doing well until they stop their treatment and then wind up back in the hospital. They wanted an amendment away from "dangerousness" as a criterion to one of "deterioration" so that treatment could be instituted sooner. They also wanted the introduction of community treatment orders so that treatment could be administered outside of the hospital setting.

[180] As a result, the dangerousness criterion, found in s. 2(b) and others, was repealed and the following was substituted: "(b) likely to **cause harm** to the person or others or to suffer substantial mental or physical **deterioration** or serious physical impairment." This is the same criteria that is present today.

[181] At the same time, changes in the ***MHA*** were made so that community treatment orders could be ordered which would allow "revolving door" patients to be treated in the community in a lesser restricted manner. (Note that I do not review the constitutionality of these Orders as they do not arise in JH's factual matrix).

[182] I agree that the government's purpose of the ***MHA*** was to enact legislation that dealt with the detention and treatment of persons suffering from serious mental illness.

[183] More recently, in amending the ***MHA*** by removing the stricter "dangerousness" criterion the government wanted to affect the timing of the intervention to allow mentally ill patients to receive treatment sooner. Implicit in this change however, is that the legislation would cover patients who *could be* psychiatrically treated, and then released sooner (since by implication they would not have deteriorated to the point of "dangerousness"). Indeed, the Minister alluded to the fact that this amendment may be a cost saving one in this regard.

[184] In my view, the legislation was never intended to apply to detain mentally disordered patients who could not benefit from psychiatric treatment in a facility. The focus of the ***MHA*** is on harm reduction through treatment, not detention for the purpose of housing.

[185] I agree with Dr. Baillie who testified as follows with respect to this issue:

> "The spirit of the Act is typically aimed at individuals who are facing acute mental health concerns. So, an individual who is depressed to the point of expressing suicide ideation, an individual who is psychotic as a result of schizophrenia or some other psychotic disorder, an individual who may be disassociating as a result of post-traumatic stress disorder and therefore being unable to take care of himself or herself or engaging in behaviours during the disassociated episode that put himself or others – herself or others at risk. So, it's this notion typically of somebody who is in an acute mental state that with hospitalization and treatment is likely to improve to the point that the that risk of harm to self or others or substantial deterioration is effectively eliminated."

[186] I also echo Minister Moore's comments that the ***MHA*** was not meant to cover all aspects of care for those afflicted with mental disorders. Indeed, in Alberta there are many statutes in the provincial legislative scheme that have protection and harm prevention as one of its purposes and in interpreting the ***MHA*** one must keep in mind the coordination of this *Act* with others. These

other statutes include more specifically the ***Adult Guardianship and Trusteeship Act***, SA 2008 c. A-4.2 (the "***AGTA***") which was passed at about the same time.

[187] It is notable that in the ***AGTA***, it provides for guardianship and other forms of support in a fashion where capacity is determined on a continuum and that there are provisions for supported decision making, co-decision making and specific decision making in terms of living arrangements and treatment, amongst other personal matters. The ***AGTA*** sets out principles up front in the legislation on how to interpret and administer the Act (s. 2). Amongst other things it indicates that an adult is presumed to have the capacity to make decisions until the contrary is determined, the adult's autonomy must be preserved by ensuring the least restrictive and least intrusive form of assistant or substitute decision-making that is likely to be effective, in determining whether a decision is an adult's best interest consideration must be given to any wishes known to have been expressed by the adult while the adult had capacity and any values and beliefs known to have been held by the adult.

[188] The ***AGTA*** has provisions in it for emergency guardianship when necessary, as well as long term guardianship provisions keeping the above noted principles in mind.

[189] It is in comparing this legislation to the ***MHA*** which were enacted at around the same time that it becomes clear in my view that the ***MHA*** was not intended to provide detention provisions for mentally disordered persons on a long-term basis for their own protection from "harm" – the ***AGTA*** is more appropriately crafted legislation for those purposes. The purpose of the ***MHA*** was to temporarily detain acutely mentally ill persons for the purpose of treatment and release back into the community.

[190] The Court of Appeal of Ontario found the same purpose in its ***MHA*** as discussed in ***PS v Ontario***, 2014 ONCA 900 at para 195:

> These statistics [that 34% of patients involuntarily committed in Ontario stay less than a week, 80% for less than a month and 98% for less than 6 months] are consistent with what appears to be a dominant theme of modern mental health care policy – minimizing hospitalization and maximizing the rapid return to community living. The involuntary committal provisions of the MHA are tailored to deal with urgent situations where an individual requires immediate treatment to avoid harm to him or herself or harm to others. Certifications typically have a short life. The short periods of certification [...] form a statutory pattern that indicates **an expectation that the risk of harm can ordinarily be resolved by treatment** and that the patient can typically be returned to the community within days or weeks. [statistics referenced and emphasis added]

[191] Therefore, now I must analyse whether the government achieved their intended objective and purpose in the legislation that they enacted keeping in mind the principles of fundamental justice requirements of s. 7. In this regard, I also keep in mind that it is not for this Court to determine where along the policy spectrum between the "dangerousness" and "welfare" continuum the ***MHA*** criteria should fall – that is the role of the Legislature. The Court's role is merely to determine if the ***MHA*** breaches the ***Charter*** provisions in this regard.

[192] The criteria in the ***MHA*** has three substantive requirements for commitment in its criteria: 1. a mental disorder, 2. harm and 3. unsuitability for voluntary admission. It is also important to note the omissions in the ***MHA*** criteria, specifically, the lack of the need for psychiatric treatment, and the lack of incapacity to consent. I shall review each of these criterion in turn however, I note from the outset of this analysis that it is the combination of how the criteria works as a whole which must finally be assessed for Charter compliance.

Mental Disorder

[193] The words used in the definition of mental disorder in the ***MHA*** certainly connote a serious situation. To repeat, the definition is: "a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs (i) judgment (ii) behaviour, (iii) capacity to recognize reality, or (iv) ability to meet the ordinary demands of life (s. 1(g)).

[194] JH and CLG argue that the words "substantial" and "grossly" are subjective and subject to wide interpretation. Indeed, JH was found to fit this definition by various doctors including specifically Dr. Quickfall, when in fact he had only a "mild cognitive disorder" which other professionals such as Dr. Baillie disagreed fit the definition of "grossly impairs". Alberta responds that these words connote seriousness and it's a matter of education for this definition to be complied with. Alberta acknowledges for instance that it may have been misapplied in JH's case but that doesn't impugn the legislation itself.

[195] In my view, this definition of mental disorder is wide but limiting in the sense that it attempts to connote serious illness. This definition is widely used in other Canadian mental health pieces of legislation – and indeed some, like Ontario's is even more vague: "any disease or disability of the mind" (***Mental Health Act***, RSO 1990, c M-7).

[196] The problem is that this definition encompasses many mental disabilities that the purpose of the ***MHA*** is not intended to target. So, for instance, those with cognitive issues that are permanent and not susceptible to psychiatric treatment, or perhaps any treatment – such as seriously brain injured person, dementia patients, serious learning-disabled persons, serious learning developmental disorders or other serious cognitive permanent issues caused by a stroke for instance. A move towards a definition that involves perhaps a "serious psychiatric disorder as defined in the DSM V" for instance may be more limiting and tied to the purpose of the ***MHA*** to detain for treatment purposes.

[197] The statistics bear this out. According to the discharge database information provided by Alberta (unfortunately Alberta cannot advise of actual numbers of patients detained – only those discharged after a certain period), over 50 % of the patients discharged in 2015-16 had been committed for either developmental or **organic** disorders (153 patients of 326 discharged that year). "Organic disorder" was defined by Alberta as a "form of decreased cognitive function that is acquired rather than developmental and includes dementia, delirium and other cognitive disorders." "Developmental disorders" is defined as a "group of neurological conditions originating in childhood that involve serious impairment in different areas, and includes autism and ADHD."

[198] Also, other Canadian jurisdictions have put specific exclusions of these longer-term disorders into their definitions (such as in Manitoba, New Brunswick, PEI and the NWT). As noted above, in 1988 this restriction was debated in the Legislature but rejected.

[199] Without further limits to this definition, which I will come to, it is overbroad and captures individuals, such as JH, not intended to be captured by the provisions of the ***MHA***.

Harm

[200] The ***MHA*** criteria here, to repeat is: "Likely to cause harm to the person or others or to suffer **substantial** mental or physical deterioration or serious physical impairment." As noted, there is not a 'need for treatment' provision.

[201] JH and CLG's concern with this criterion is that "harm" is undefined and can be widely interpreted. Alberta argues on the other hand that this "harm" criterion has withstood ***Charter*** challenges in many cases, which should be followed here.

[202] As discussed above, Alberta moved away from the stricter "dangerousness" criteria in 2010. There are several decisions that looked at whether this move to "harm" based criteria would render the criteria unconstitutional but, in my view, because of the *combination* of this part of the criteria with other parts, such as the need for treatment, the legislation in Manitoba, British Columbia and Ontario survived the ***Charter*** challenges: see ***Bobbie v Health Sciences Centre***, [1989] 2 WWR 153 (Man QB); ***McCorkell v Riverview Hospital*** 1993CarswellBC 188 (BC SC); ***Thompson v Ontario (AG)***, 2013 ONSC 5392 aff'd 2016 ONCA 676.

[203] In my view, these cases are all distinguishable from the situation at hand for two reasons: 1. That they rely on an outdated "vagueness" test and 2. That the "harm" criterion is combined with a "need for treatment" criterion which contributed to saving the legislation.

[204] In the ***Bobbie*** and ***McCorkell*** cases, they relied on the now outdated "vagueness" test, and although they discussed the overbreadth test, in ***McCorkell***, the Court held that the overbreadth test held no independent existence in ***Charter*** law although it may serve as an "analytical tool" (at para 92 – referring to ***Canada v Pharmaceutical Society (Nova Scotia)***, [1992] 2 SCR 606). As discussed above, ***Carter*** has found that the law on overbreadth is now explicitly recognised as a principle of fundamental justice in determining s.7 compliance of legislation. A different question may lead to a different result, as it did in ***Carter*** compared to the older ***Rodriguez*** case.

[205] For instance, in ***McCorkell,*** one of the plaintiff's arguments was that the criteria in British Columbia was so vague and poorly defined that it allowed the doctor in charge of the Riverview facility to reduce involuntary patients from 90% of all patients in the facility to 60% by simply changing the status of the patients from involuntary to voluntary and discharging others. The Court held that the criteria was not vague because although there were examples of differences in interpretation in applying these criteria, it did not prove that "the words were incapable of guiding legal debate". The overbroad question was not asked i.e. whether the criteria caught people outside the class of those meant to be protected. Considering that 30% of the Riverview population was able to be released on a simple review of their status, one wonders if their criteria was not capturing

them improperly and therefore its criteria suffered from being overbroad. That question was not answered.

[206] More importantly perhaps, is the fact that all of these cases dealt with criteria that included the "need for treatment" as part of their criteria. In fact, in ***Thompson*** where the Box B criteria from Ontario's legislation was being analysed, the need for treatment criteria found in the Ontario *Mental Health Act* includes a determination that treatment for the mental disorder had been given previously and there had been shown clinical improvement – similar to the treatment requirements for community treatment orders in the ***MHA*** (see s. 9.1). As the Ontario Superior Court of Justice found at para 86:

> Having found that one of the two purposes was the improved treatment of the mentally ill, it becomes difficult i[f] not impossible for the applicants to show that the Box B and/or CTO provisions are broader than necessary to accomplish the treatment objective.

[207] Therefore, none of these cases stand for the proposition that "harm", by itself, is an appropriate criterion on its own to detain in cases where the purpose of the legislation, like here, is to detain and treat.

[208] I note that Alberta also suggests that ***B (C) v Sawadsky***, [2005] OJ No 3682, affd. 82 OR (3d) 661(CA) also stands for the proposition that our ***MHA*** criteria is constitutionally valid since the Ontario MHA Box A criteria (which does not have the need for treatment included in it) was found to withstand ***Charter*** scrutiny in that case. However, this case does not answer the question before me since firstly, the legislation in Ontario is quite different overall, and secondly the case dealt mainly on the factual issue about whether procedural rights (notice issues) had been breached. The procedural protections in the Ontario legislation (which are much broader as I will come to) were found to be constitutionally valid – which I have no quarrel with. There was no independent discussion about whether the harm criteria *without more* met s.7 requirements – which is the question before this Court.

[209] Here it could be argued that since the rest of the sub section deals with "*substantial* mental or physical deterioration" or "*serious* physical impairment" this would suggest that this is the way that "harm" should be interpreted. Yet that is not how the section is drafted. "Harm" stands alone. We also have concrete proof, in JH's case, that it was not interpreted this way by Dr. Quickfall.

[210] Alberta answers that Dr. Quickfall's approach that "harm" includes "potential harm" that may arise if JH was released in a non-supportive situation is an incorrect interpretation and "is not supported by the legislation". I agree that this not the way the legislation is supposed to work, or in other words, it is not the purpose of the ***MHA*** to detain persons who may suffer "potential" "harm" at some undetermined time in the future. However, without qualifying the word "harm" it is clear that it can be interpreted this way. In other words, once again, it is overbroad and captures persons not intended to be captured.

[211] I am supported in this view by a policy body connected with the Legislature. In a recent 2017 report by the Standing Committee on Families and Communities, at p. 9, its first recommendation was that the ***MHA*** be amended to provide a definition of the term "harm" given that the term is currently interpreted differently by various stakeholders. Also, the report noted that

there were differing views amongst the professionals about the criteria's application – especially between police and physicians which called out for clarifying legislation. Of note is that this Committee is statutorily required to review the ***MHA*** pursuant to s. 54.

[212] Since "harm" is not defined, even the legislature's committee has noted the problem that it can be interpreted widely. This lack of clarity can lead to individuals being included in the definition of "harm" and have their freedom restricted improperly.

Need for treatment

[213] The criteria in the ***MHA*** has no linked "need for treatment" criteria in it. I have already discussed the cases where the need for treatment – which is linked to the need for a finding of a serious level of potential harm, has been found to be ***Charter*** compliant: see ***Bobbie***, ***McCorkell*** and ***Thompson***.

[214] I also note that in other Canadian provincial jurisdictions which have preambles or purposes clauses in their mental health legislation, the key purpose in all of these statutes is the provision of treatment of persons with mental disorders: see s. 3(1) of the *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1., the preamble in the *Mental Health Act*, RSY 2002, c 150, s. 1.1 of the *Mental Health Act*, RSNB 1973, c M-10 and s. 2 of the *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42.

[215] Connected with this purpose in *all* of these pieces of legislation is a "need for treatment" in their criteria. As an example, in Ontario, s. 20 of its *Mental Health Act*, RSO 1990, c M.7 states, in part, as follows:

> 20 (1) The attending physician, after observing and examining a person who is the subject of an application for assessment under section 15 or who is the subject of an order under section 32,
>
> > (a) shall release the person from the psychiatric facility if the attending physician is of the opinion that the person is not in **need of the treatment provided in the psychiatric facility**; [emphasis added]

[216] The lack of this connected and limiting criteria in the ***MHA*** also leads to individuals being captured outside the purpose of the ***MHA***. As the criteria presently stands without this limiting qualification, those, such as JH, can be detained even though they do not need psychiatric treatment or care.

Unsuitability for voluntary admission

[217] None of the parties had a specific complaint about this criterion. It is certainly a helpful criterion to ensure that the least liberty restrictions are used to treat someone with a mental disorder – if they will stay voluntarily then there should be no need to detain them. It is a reasonable measure to try and ensure that detention is not forced on those who will stay voluntarily.

Capacity

[218] CLG submitted that the emphasis on harm prevention should be coupled with the need in the criteria that persons must lack capacity to make treatment decisions for themselves. Notably many Canadian jurisdictions have made treatment incapacity a requirement for involuntary admission (Nova Scotia, Newfoundland and Labrador, Saskatchewan and Ontario).

[219] CLG relies on the ***Carter*** and ***Fleming*** cases in this regard. These cases stand for the proposition that competent adults have a constitutional right to make their own treatment decision. Further, in ***Fleming***, the Court held that a competent person's wishes about treatment had to be complied with by a substitute decision-maker even once a patient may become incompetent. ***Carter*** held that medical self-determination includes the right to make poor decisions, and of course can include (what may be a good decision), to die and seek assistance in doing so. The issue is that there is no justification detaining someone for treatment of their mental disorder if they are competent to refuse treatment and do so. And further, that it is discriminatory to detain competent mental health patients when other competent patients with physical health issues are not so detained when they make treatment choices that are potentially harmful to themselves.

[220] The ***MHA*** does not deal with capacity to make treatment decisions up front in its committal criteria. Instead it deals with the definition of competence to make treatment decisions, and the ability for the facility to override those decisions, even when competent, or even when a person's substitute decision-maker objects, in ss. 26 to 30.

[221] Considering that the purpose of the ***MHA*** is to detain and treat, and in light of more recent jurisprudence dealing with the interplay of s. 7 and the ability to self-determine one's treatment decisions, a review of the treatment links to detention needs to be undertaken in my view so that the ***MHA*** is ***Charter*** compliant.

[222] Presently, the ***MHA***'s authority to override competent patient's wishes and those of a substitute decision-maker (who should be bound by a patient's wishes when they are competent) are non-compliant with s. 7 in light of ***Carter*** and ***Fleming***.

[223] One consideration would be to put the lack of capacity (or competency) right in the initial admitting criteria – but another might be to insert it later in a more robust treatment section, such as it is now, with the rights described properly addressed. Further, it may be worthwhile adding that such competence review should be done at the outset of detention. Certainly, that would have been helpful in JH's case. Instead he was treated without consent and over his objections in clear violation of his s. 7 rights.

[224] The debate is a thorny one since it is recognised that mentally ill patients may be competent to accept or refuse treatment. If they are competent and refuse – then the purpose of the ***MHA*** to treat is undermined. The solution, with respect to those who may pose a risk to themselves, is that they should be released. Perhaps that is the result. However, there may be procedural protections that may be put into place so that the ***MHA*** stays ***Charter*** compliant. Certainly, for instance, this occurred in ***Thompson***, where the Box B criteria that forced treatment on persons, but outside the hospital setting and with other strict criteria was found to be ***Charter*** compliant.

[225] For present purposes, I do not accept the bold proposition of CLG that the criteria must have a lack of capacity to consent to treatment factor added, although it is an idea worth considering. The issue is complex and indeed s. 15 of the ***Charter*** equality rights need to be considered to properly review the issue. That is, why should competent mentally ill individuals be treated differently than physically ill ones? This was raised by this intervener but not argued by the other parties so I will not deal with this issue – I just raise it to highlight the complexity of this issue. I have opined on my views with respect to certain treatment provisions in the ***MHA*** that breach s. 7, but it is not the role of this Court to opine whether the CLG solution is the best way to deal with this thorny issue. This I leave to the Legislature to determine how best to amend the treatment provisions in the ***MHA*** so that they are ***Charter*** compliant.

Summary with respect to the Criteria

[226] As discussed above, in order to determine if the criteria breaches s. 7 it is important to look at the criteria a whole and to look at its effect. As stated by Cromwell J in ***R v Moriarty***, 2015 SCC 55 at para 24: "at the outset of an overbreadth analysis, it is critically important to identify the law's purpose and effects because overbreadth is concerned with whether there is a disconnect between the two."

[227] With respect to the effect of the criteria change and where we are now, I heard evidence from Dr. Quickfall that there are "dozens" of patients who are like JH and basically housed in the Foothills hospital. Dr. Baillie gave examples of patients who were in the Foothills and the Peter Lougheed acute care wards for 2 and 3 years. He was of the opinion that the ***MHA*** is being "used to address the shortfall in other appropriate resources in the community by keeping people in designated facilities because the Act says that once the Forms have been completed, the individual is then in a designated facility and it's very difficult to find placements for those long-term issues when, in my mind, the original spirit of the act was to address these more acute mental health issues."

[228] Further, I am also concerned with the statistics led in this case that show that since the criteria were changed in 2010, the number of involuntary detentions has skyrocketed. For instance, in 2008-09 year there were 4805 patients certified, whereas in 2015 – 16 there were 7816. Worse, the number within this total shows that certified patients with the reason for detention being "organic disorder" (like JH) rose from 333 patients to 596 in the same period – a 100% increase. Further, as noted above, that with respect to those who stayed 6 months or more – *half* of that population consisted of patients with organic disorders.

[229] Unfortunately, AHS was not able to give an accurate count of how many patients have been under a certificate for more than 6 months – they simply do not keep those statistics. They could say however that in the 08-09 year there were 148 discharges of patients held for over 6 months and in 15-16 there were 326 – again an increase of over 100%.

[230] As I have discussed, I have serious concerns about aspects of the criteria that the Legislature has decided upon and in particular, the definition of mental disorder that captures those who may not be improved by psychiatric treatment, the lack of limiting adjectives to the word "harm" which leaves it open to a wide area of discretion amongst professionals trying to use the

legislation, and most importantly, the lack of a criteria that ties detention with treatment, which is the purpose that I have found that the government intended with this legislation.

[231] In my view, JH has met his onus to show that the criteria in the ***MHA*** is overbroad in that it denies the rights of many individuals who are being detained under the auspices of the ***MHA*** when they cannot benefit from treatment. As discussed in ***Canada (Public Safety and Emergency Preparedness) v Chhina***, 2019 SCC 29 at 135 detention may become arbitrary when it becomes unhinged to the legislation's purpose. Although the Court at that point of the decision was discussing s. 9, in my view this view applies equally to s. 7.

[232] I also note in this regard, as briefly discussed above, that there are other pieces of Alberta legislation which may be more suited to capture the population of mentally disordered persons who may not need psychiatric treatment but may require varying levels of help, protection and oversight. In particular, the ***AGTA*** has more nuanced powers to deal with those who may need help but not necessarily on an all or nothing approach as is seen in the ***MHA***. The provisions potentially allow for orders where patients can exercise different levels of control over their lives. The purpose of that legislation deals more with the protection of vulnerable adults, and not necessarily acute care short term detention on hospital wards which is the aim of the ***MHA***.

[233] In JH's case, this route was being investigated but for some reason it was taking months to deal with: that does not show, however, that they could not have been used. There are emergency provisions in the ***AGTA*** which could have allowed for a guardian to be appointed if necessary. Another option would have been to get his mother involved in some level of decision-making that is available under that Act. Unlike the ***MHA***, the capacity and consent issues are dealt with in a much more nuanced fashion in the ***AGTA***.

[234] In any event, by the time May 2015 rolled around, JH did not need a guardian at all but just help with transitioning him out of the hospital into the community. The government has recognised that there are issues in this regard. In 2015 it commissioned a committee to review mental health issues in the province. In December this Committee reported on the issues: *Report of the Alberta Mental Health Review Committee 2015*. One of the key recommendations that it made was that "Alberta Health and AHS must establish a process to harmonise their respective roles and goals in order to effectively develop an integrated service delivery system for addiction and mental health." This was made in light of the evidence they found of poor coordination and integration of services. We saw this first hand with JH where the social worker who was trying to help him in the hospital had no jurisdiction to continue to help him once he left the hospital steps.

[235] A follow up report was provided by Alberta Health in 2017: *Valuing Mental Health Next Steps*. Interestingly, amongst the recommendations in this Report (no 17) was that there be an "update to the ***MHA***". Considering my opinion that the criteria in the ***MHA*** as it stands now does not comply with s. 7 of the ***Charter***, this is good suggestion.

[236] Ultimately, it is not for this Court to determine how to make the ***MHA Charter*** compliant. And to be clear, I am not necessarily advocating a return to the stricter "dangerousness" criteria. My comments merely point out that the way the current criteria are presently drafted result in the detention of people outside the class of persons contemplated to be detained by the ***MHA***. Alberta, in pursuing a legitimate objective of detaining and treating acutely mentally disordered people,

have used means (here the criteria for detention) that are broader than is necessary to accomplish that objective and as such, has violated the principles of fundamental justice by limiting certain individual's rights in a way that bears no relation to the object of the ***MHA***.

[237] Further, the impact of ***MHA***'s overbroad criteria has the potential to restrict an individual's life, liberty and security by unwanted detention and inability to determine what to do with their bodies and how they are to be treated. When an individual is not suffering from an acute psychiatric ailment that can be treated in a psychiatric setting, but is still detained because of an untreatable organic disorder which may at some future point cause potential harm to themself, then arguably the impact of the legislation is "out of sync" with its object – so that it is grossly disproportionate in its effect. In light of my finding however that the criteria are overbroad, like in ***Carter***, I find it unnecessary to determine if the criteria also violate the principle of gross disproportionality.

Other Rights and Procedural Safeguards

Certificates' Procedural Issues and Unlimited Renewal

[238] JH did not raise concerns about the provisions in the ***MHA*** about what the contents of the admission certificate should be included – but rather what little they contained in his case, as discussed above. In addition, JH and CLG's raised concerns that the indefinite renewal of certificates allowed under s. 8(3) of the ***MHA***, without the appropriate procedural safeguards, was not ***Charter*** compliant in particular with respect to sections 7 and 9. Alberta submitted, on the other hand, that the procedural safeguards are sufficient in that the certificates can only be renewed on the opinion of two physicians and there is not only a right to appeal them, but an automatic right to review every 6 months.

[239] Ss. 6 and 9 of the ***MHA*** outline the provisions required in an admission or renewal certificate (to repeat, in brief: name, date, facts upon which the criteria is satisfied, and facility).

[240] As noted above, these certificates form the legal authority to detain a patient in the hospital. These certificates also need to be given to the patient and others, as I will come to, so they most often form the most important part of the written reasons for a patient's detention and information for the patient to decide whether to submit to the detention order and the means to meaningfully exercise their right to counsel.

[241] In ***Fraser Health Authority*** at paragraph 146 Justice Warren discussed the need for written reasons when one is detained (which in that situation dealt with detention under the BC *Adult Guardianship Act*). She said:

> Section 7 of the *Charter* guarantees the right not to be deprived of liberty except in accordance with the principles of fundamental justice, which have been interpreted to include compliance with common law requirements of procedural fairness such as the provision of reasons and, when the consequences are serious, the provision of written reasons: *Suresh v. Canada (Minister of Citizenship and Immigration)*, 2002 SCC 1 (S.C.C.)

[242] Later she added about the content of the reasons at para 152:

> At minimum, those reasons ought to have clearly set out the specific facts underlying the decision, explained how those facts related to and met the criteria for emergency assistance under the *AGA* and advised of the nature and anticipated timing of a section 54 application.

[243] Here, sections 6 and 9 of the ***MHA*** clearly outline all of these factors except for the right to apply to the Review Panel for the cancellation of the certificate in question. In this regard, the ***MHA*** has a separate provision to satisfy these requirements, section 14. To repeat, it states:

> 14 (1) When two admission certificates or 2 renewal certificates are issued with respect to a patient,
>
> (a) the board shall inform the formal patient and make a reasonable effort to inform the patient's guardian, if any, and, unless a patient objects, the patient's nearest relative of
>
> (i) the reason, in simple language, for the issuance of admission certificates or renewal certificates, and
>
> (ii) the patient's right to apply to the review panel for cancellation of the admission certificates or renewal certificates,
>
> and
>
> (b) the board shall give the formal patient, the patient's guardian, if any, one person designated by the patient and, unless a patient objects, the patient's nearest relative a written statement of
>
> (i) the reason in simple language, for the issuance of the admission certificates or renewal certificates,
>
> (ii) the authority for the patient's detention of the period of it, including copies of the admission certificates or renewal certificates,
>
> (iii) the function of review panels,
>
> (iv) the name and address of the chair of the review panel for the facility, and
>
> (v) the right to apply to the review panel for cancellation of the admission certificates or renewal certificates.

[244] In my view, on the face of it, these provisions in the ***MHA***, for the most part, satisfy the principles of fundamental justice and procedural fairness required under section 7 of the ***Charter***. Having said that, the Patient Advocate reported in its Annual reports that many breaches of the rights to proper notice were expressed to this office over the years. This is a common form of complaint it appears and indeed I noted that the failure to provide JH with proper reasons by failing to provide him his certificates, let alone further written reasons as required by s. 14, raises serious administration concerns.

[245] Further, I note that the certificate Form (no. 1 and 2) set out by regulation is only one page, i.e. very short and therefore promotes brief unsubstantiated comments done in a very generalised format as seen in JH's case. As noted in ***AH***, when commenting on ***Charlie v British Columbia (AG)***, 2016 BCSC 2292, at para 151 "in the context of a detention, it is not enough for the reasons

to reflect "generalised information", but the individual must be told the "who, what, where, and when" of the alleged facts leading to the decision (referring to para 34 of the ***Charlie*** decision). Certainly, if there were emergent circumstances, a short version would be acceptable, however, there is no such excuse on renewals. This is perhaps a symptom of the ***MHA*** being mainly focussed on short term detentions and treatment versus dealing with those who get trapped by the overbroad criteria and wind up detained for a long time (like JH).

[246] I also note that in terms of the "written information" that is required by s. 14, unlike the many Forms that are provided for other procedural steps (for certificates, incompetency findings etc.), the Government has not made available a Form to make sure that this s. 14 information is easily provided.

[247] Finally, with respect to the concern raised by JH and CLG about unlimited renewal of certificates, and suggestion that they be limited to 6 months, Alberta's position was that it would be unsafe to disallow further certificates in certain warranted circumstances.

[248] Recall that what is paramount here is procedural fairness requirements mandated by the principles of fundamental justice. ***PS*** reviews the principles that emerged from cases dealing with long term detention issues which are raised with this complaint. In this regard ***PS*** emphasised that the s.7 ***Charter*** guarantee of fundamental justice "requires that there be a fair procedure to ensure, on a regular and ongoing basis, that: 1. the risk to public safety continues; and 2. the individual's liberty is being restricted no more than is necessary to deal with that risk. It is also implicit that protection of the liberty interest requires appropriate steps to be taken to facilitate, to the extent possible, the individual's eventual re-integration into the community" (see paras 112 and 113).

[249] Ultimately in ***PS***, the restricted powers of the Ontario review board (the CCB) were under review. The Court held at para 127:

> I agree with and adopt the submissions in the factum of the intervenor, the Mental Health Legal Committee, that the CCB's inability to tailor conditions of detention to meet the individualized circumstances of long-term patients "constitutes a **statutory gap**" that "can lead to overly restrictive, prolonged and indefinite detentions thereby rendering the impugned scheme **overbroad**" in relation to long-term patients (at para. 20). By limiting the power of the CCB to confirm, rescind or transfer, the MHA fails "to ensure that the conditions of a person's long-term detention are tailored to reflect the person's actual level of risk, moving towards their ultimate integration" (at para 31). As articulated at para 13 of the Canadian Civil Liberties Association's factum, the CCB lacks the required authority to "make orders regarding security, privileges, therapy and treatment, or access to and discharge into the community", including basic questions as to where and how a person is detained and how they are discharged into the community. While the MHA enables physicians to issue and renew community treatment orders (s.33.1) and provides for review of such orders by the CCB (s.39.1) the MHA does not give the CCB the power to issue a community treatment order as an alternative to detention for an individual certified as an involuntary patient. [emphasis added]

[250] The Ontario Court of Appeal therefore concluded at para 129 that "the MHA lacks the procedural safeguards required by s.7 to ensure adequate protection of a long-term patient's liberty interest". By way of remedy for the gap of powers that rendered the involuntary committal procedures constitutionally infirm with respect to long term detainees, the Court limited the maximum duration of ***MHA*** committals to approximately 6 months: see para 202. The Ontario government proceeded to amend its legislation allowing the CCB more powers to tailor detention conditions (transfers, leaves of absence, security levels) and release conditions to include the provision of rehabilitation and vocational services (see s. 41.1 (2) of *Mental Health Statute Law Amendment Act, 2015, SO 2015, c 36*).

[251] The concerns raised in ***PS*** are somewhat different than here in that there they were dealing with a long-term patient who was a possible safety risk to the public – whereas here we are discussing patients who are a potential risk to themselves – not the public. In my view, the same procedural concerns in this context arise – indeed, in light of ***Carter***, and the right to self-determination that was recognised therein, arguably the procedural safeguards need to be stricter.

[252] Returning to the issue at hand, whether an indeterminate certificate power is reasonable, in my view one must analyse what it represents in the process. JH and CLG are concerned about the fact that some patients can be detained for years under this system. Alberta however points to the safeguards that are in place in terms of notice at each set of certificate renewals including the 6-month set, and the rights the facility has to determine and review security conditions (under s 19(2), grant leaves of absence (s. 20) and transfer to another facility (s 22).

[253] I also note the positive obligation found in s. 19(1) that

> 19(1) On the admission of a patient to a facility, the board of the facility shall provide the diagnostic and treatment services that the patient is in need of and that the staff of the facility is capable of providing and able to provide.

[254] The problem I see is that if the facility is not providing any psychiatric treatment or care, so that detention in that type of facility is not required to mitigate potential harm to a patient, as was the case with JH, the certificates nonetheless could be continually renewed without any plan necessarily to tailor a program that would lead to the patient's release or less restrictive conditions. Certainly, there is no obligation in the ***MHA*** for this to happen, and in this regard, there is a "statutory gap" and the overall commitment process is overbroad as it does not fit with the overall purpose of the ***MHA*** as discussed of the need to detain **and** treat.

[255] The answer by Alberta that the *facility* has the ability to grant leaves of absence or transfers to less restrictive facilities possibly is not a solution since the Review Panel itself cannot make these recommendations. Indeed, a similar argument made by the government of Ontario in ***PS*** was rejected. The Court stated at para 115:

> By failing to confer upon the CCB the necessary authority, the MHA fails to ensure, as required by *Winko* and *Penetanguishene,* that "at every step of the process consideration of the liberty interest of the [detained individual] is built **into the statutory framework**." Specifically, the CCB lacks the jurisdiction to supervise the security level, privileges, therapy and treatment of long-term detainees and to

> craft orders that would ensure an appropriate balance between public protection and the protection of detainees' liberty interests. [emphasis added]

[256] In sum, I agree with JH and CLG that the indefinite renewal of certificates without more procedural safeguards to ensure that the focus remains on the liberty interests of long-term patients so that their liberty is restricted no more than necessary, is a gap in the ***MHA*** statutory scheme. On this point, the ***MHA*** does not provide the minimal procedural safeguards that are necessary pursuant to s. 7 of the ***Charter*** and therefore it breaches this section.

Treatment Provisions

[257] A mentioned above, JH and CLG take issue with the ***Charter*** compliance of the treatment provisions in the ***MHA***. Alberta defends the process as ***Charter*** compliant.

[258] The ***MHA*** has a distinct part that deals with "Treatment and Control" (Part 3). In it, is outlines the definition of "competency" (s. 26), processes for determining if a patient is not competent, including rights of appeal (s. 27), substitute decision making (s 28), and how to deal with objections to treatment (s 29).

[259] As discussed above, in my view, JH's treatment rights were breached under the ***MHA*** and under ss.7 of the ***Charter*** since he was treated without his consent. The steps that could have been taken to treat him legally under the ***MHA*** were never completed. A Form 11 declaring him incompetent was filled out very late in his stay (after the Patient Advocate intervened) but it was never provided to JH's nearest relative as required. Nor is there any evidence that it was filed with the Board of the facility.

[260] The ***MHA***'s treatment provisions have many aspects that are ***Charter*** compliant in that they set out a procedure for determining competency, along with appeal rights, and empower substitute decision maker's authority. However, as discussed above, the ***MHA*** is outdated since the decisions of ***Fleming*** and ***Carter*** which have recognized the individual's rights to self determination in medical treatment decisions. In particular, s. 29 ultimately allows a competent patient's treatment decisions (and even their substitute decision maker's decision if incompetent) to be overridden by a Review Panel if the treatment was found to be in a patient's best interest. Most Canadian jurisdictions require consent for treatment by either a competent patient or his or her substitute decision maker.

[261] Notably, the ***Criminal Code*** s 672.55(1) also requires that an NCR patient not be subjected to psychiatric treatment unless they consent *and* the Review Board "considers the condition to be reasonable and necessary in the interests of the accuse."

[262] Having said this, I note that the constitutional questions that were set out at the outset of JH's case focussed on the review and detention portions of the ***MHA***. As a result, there is little evidentiary foundation in this case to rule on this issue, except for the breach issues specific to JH with respect to the treatment he received without consent, and the issues with respect to including treatment in the criteria for detention, which I have already discussed above. Accordingly, I will leave this issue to another day, having set out some preliminary concerns about how the ***MHA*** is presently structured.

Lack of Administrative Oversight

[263] JH and CLG submitted that the various procedural safeguards in the ***MHA*** are illusory since there are no control mechanisms in the ***MHA*** to ensure compliance, therefore the is a lack of compliance with fundamental justice under s. 7 of the ***Charter***.

[264] More specifically, JH and CLG noted that all other Canadian jurisdictions have control mechanisms embedded in their legislation to ensure that mental health rights are monitored on the ground. They also submitted that it is notable that only one certificate – the one dealing with incompetence (Form 11), needs to be filed with the Board. However, they point out that in the Patient Advocate reports, people on the ground do not know who the "Board" is and Dr. Quickfall. confirmed that there is no administrator that reviews certificates and that certificates are not provided to anyone to review or assess.

[265] Alberta argued that it is up to the facility to put procedures in place and that it understood that checklists and such have been put into place. Neither Alberta nor the AHS provided the Court with any such checklists or other evidence of how they ensure compliance.

[266] Needless, to say, legislation can have many procedural safeguards, but to the extent that they are not followed, it will not necessarily render the legislation infirm, but rather it highlights the need for better compliance.

[267] Here in JH's case for instance, there was no overview, based on the evidence before me, to ensure that his certificates were properly filled out, that they had been provided at all, that he was advised of his right to counsel, right to appeal his certificates, or that his competency had been formally assessed and certified one way or another.

[268] The Mental Health Review Task Force reviewed this issue in 1984. It recommended that a Patient Advocate, with legal training (best being a lawyer), be put into place to review the legal situation with an individual who had been detained, at the time of detention or shortly later if necessary. This level of oversight is in place in Ontario, and in part, this level of procedural oversight has saved its mental health legislation from ***Charter*** infirmity (see ***Thompson)***.

[269] Instead, the legislature put in a Patient Advocate system that is reactive to complaints as opposed to proactive, coupled with no provisions for certificates to be reviewed internally except for by a Review Panel on appeal, raising further procedural safeguard concerns in light of individual's s. 7 ***Charter*** rights.

Notice

[270] Further in terms of procedural safeguards, and fundamental justice concerns pursuant to s. 7, as noted above, JH and CLG also raised serious concerns surrounding the notice provisions under the ***MHA***. I have dealt with these to a certain extent in terms of reviewing the notice provisions in s. 14, which Alberta argues is more than satisfactory from a constitutional perspective. Alberta also argues that legislation does not need to have this s. 10(b) right spelled out in it. Certainly, the right to counsel is not embedded in the ***Criminal Code*** it argues.

[271] I have already mentioned that s. 14 does have extensive notice provisions. However, I have also noted that the Patient Advocate has also complained that these are not regularly followed. This complaint is not surprising in light of the ***Evans*** case, discussed above, where the Calgary Police have taken the position that a detention under the ***MHA*** is not a detention under the ***Charter***. As I have discussed, this is not a correct interpretation of a ***MHA*** detention, which does in fact trigger the procedural rights under the ***Charter***: ***Webers***.

[272] Further, I note that there is no Form that complies with s. 14 notice provisions which would help with implementation. I also note that there are such forms in other jurisdictions – and indeed in Ontario the provision of the written form (Form 42) has been found to satisfy the constitutional requirements in ***Sawadsky***. Further, notably, the lack of service of a Form 42 was found to breach the individual's ***Charter*** rights (s. 7, 9 and 10) in ***Webers*** (and cases noted therein).

[273] Of most concern, is that s 14 does not have any notice requirements embedded in the legislation about the right to legal counsel – and the right to be provided this counsel for free – as required under s. 10(b): see ***Manninen*** and ***Brydges*** – and as discussed above. The Patient Advocate reported in its 2014-15 annual report that this lack of notice embedded in the legislation is a problem and that the Government should consider adding it in.

[274] JH and the CLG provided the Court with a review of all other Canadian jurisdictions' mental health legislation on this point and determined that *all of them* had a specific legislated duty to provide notice (most in writing) of the right to counsel. Alberta's legislation stood out in the absence of this right embedded in the legislation.

[275] In terms of Alberta's argument that the 10(b) ***Charter*** right to notice of the right legal counsel need not be embedded in the legislation, I note that the Court of Appeal of Ontario dealt with a similar argument in ***PS*** – where similarly powers to order more flexible rights to detention were found not to be embedded in the Ontario legislation. The Court pointed out at para 84 that the new amendment under the ***Criminal Code*** that set out further procedural rights for NCR individuals survived s. 7 ***Charter*** challenge "*only because at every step of the process, consideration of the liberty interest of the NCR accused was built into the statutory framework*" [emphasis in ***PS***]). In other words, there are times where ***Charter*** rights *do* need to be spelled out specifically in legislation.

[276] Alberta relied on the cases of ***Alberta (Director of Child Welfare) v KB***, 2000 ABPC 113; overturned for other reasons at 2000 ABQB 976, to support its argument that there is no requirement to necessarily incorporate ***Charter*** protections into legislation. I note that this passage (found in para 99) had no authority set out for that proposition, but in any event, with respect, I disagree that this proposition applies here.

[277] Here, the ***MHA*** is supposed to be dealing with people who fit the definition of having a "mental disorder" – i.e. those who have a "substantial disorder of thought, mood, perception, orientation or memory that grossly impairs their judgement, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life."

[278] As a consequence, when assessing the context of what procedural fairness demands in this situation, the right to counsel, and notice of the availability of free services if necessary through

Legal Aid (along with its telephone number), must be given in written form to the patient, along with information about the other rights to appeal to a Review Panel. Further, such rights need to be included in the legislation. This goes beyond what is required under s. 10(b) perhaps which requires only verbal notice, however, in these circumstances, this is a necessary safeguard. A vulnerable population losing their liberty in circumstances where their security of the person is at stake, must be protected through meaningful procedural safeguards to ensure fundamental justice. The failure to do so through the terms of the legislation, or in its application, demonstrates the ***MHA***'s inconsistency with the requirements of fundamental justice.

Procedures before the Review Panel

[279] As discussed earlier, the legislation setting up the procedures under the Review Panel entails the right to know the case put against one, and the right to answer that case: ***Charkaoui*** Both of these rights were breached in JH's case and unfortunately there are legislative gaps in the ***MHA*** that led to these problems.

[280] Part 5 of the ***MHA*** sets out the sections that deal with the Review Panels. As noted above, these sections allow for the appointment of an independent panel and certain procedures for an application and notice of the hearing, authority under the ***Public Inquiries Act***, RSA 2000, c. P-39 and certain decision abilities (which is basically to cancel or refuse to cancel certificates, direct or refuse to direct treatment that has been objected to, and to provide a decision regarding the detention certificate appeals within 24 hours – with reasons if they are not cancelled: s. 41).

[281] JH and CLG had two main concerns about the lack of procedural safeguards in the ***MHA*** Review Panel hearing provisions: 1. The lack of timely disclosure and 2. The lack of authority to deal with detention concerns beyond upholding or canceling certificates.

1. Disclosure

[282] JH led the affidavit evidence in this regard of Mr. Darren Hamilton, duty counsel who started acting for patients in 2011 and had assisted between 75 to 100 patients in this role. He indicated that normally he had one or two days' notice of a hearing, and then later in 2017 sometimes up to a week notice. He would do between 1 to 4 back to back hearings in a day and most of them lasted 30 minutes.

[283] Mr. Hamilton would request a "disclosure package" from the Chair of the Panel since there is no right to request access directly through the ***MHA***. He would normally get disclosure the morning of the hearing. The size of this package would be between 250 and 750 pages.

[284] His experience tracks, in part the experience JH encountered: his counsel had 1-day notice of the hearing. JH, however, had only been provided with his inadequate certificates days before that (6 months into his stay) and the rest of his medical records the day of his hearing.

[285] As mentioned earlier, this failure of adequate disclosure breached JH's s. 7 rights to fundamental justice because he did not know the case against him. On the evidence before me it appears that most patients do not know the case before the Panel before they attend.

[286] The lack of provision in the ***MHA*** to ensure a patient sees his medical record in time to prepare for his hearing is problematic. The ***Health Information Act*** has procedures so that *theoretically* a patient can obtain their record in due course, but the cost and delay (up to 30 days) does not ensure access to them for the hearing and, consequently, procedural fairness at that hearing. Section 17 of the ***MHA*** deals with the confidentiality of records and some procedures surrounding its being produced and stored – but it does not allow the patient any rights to see it in time for a hearing. Further, the practice of allowing access to the records the day of the hearing is not satisfactory and does not meet constitutional requirements.

[287] As noted in ***Charkaoui*** how this disclosure right is met will vary with the context in question – but in any event it must be met in substance. Here, there is a balance of wanting to have an early and quick hearing with the delay of obtaining and making available a sometimes extensive medical record package. In this digital age, electronic access will make this whole process more efficient. In any event, as it stands, the gap in the ***MHA*** legislation makes the review panel procedures in violation of s. 7.

[288] With respect to the right to "answer the case", in my view, on the face of it, the ***MHA*** provides for many procedural rights during the hearing that satisfy s. 7 requirements. These include the right to be present, provide testimony, cross examine, etc. Further, there is a reference to powers under the ***Public Inquiries Act*** being conferred, which in theory would allow Review Panels to seek expert evidence (s. 37(1)). Also, Legal Aid Alberta allows counsel to be appointed for the patient so they have legal representation.

[289] However, as discussed above in analysing JH's case, many of these rights cannot be properly exercised because certificates are short and often do not give a complete review of the situation, medical records are disclosed at the last minute, the facility is under no obligation to set out a long-term plan of treatment and re-integration into the community and independent experts are not in practice retained. Further, counsel is appointed with very short notice (although in 2017 that seems to be improving a bit). Accordingly, the substantive right to properly answer the case is limited.

[290] I note that the ***MHA*** does allow for up to 21 days adjournment of the hearing - or more if the patient requests in s. 40 (5). Although this would help in terms of preparation, it still does not address the need to provide disclosure without cost to the patient, which should be the case. Further, without an expedited process set out in the ***MHA***, the delays for provision of medical records (up to 30 days) is not reasonable.

[291] Interestingly, the 1984 Task Force had made recommendations that dealt with some of these concerns. It recommended at p. 104 of its Report that several documents should be before the Panel including "a summary of the patient's medical records prepared by a member of the staff of the facility", "a report prepared by the physician responsible for treatment of the patient of the facility summarizing the current medical condition of the patient, his present treatment and treatment plan, and reasons why the physician thinks that the patient still satisfies the criteria for compulsory hospitalization" and "a home circumstances report". Further, it recommended that patients "should have access to all documentation and other evidence before the review panel." Sadly, these recommendations did not make it into the legislation in 1988.

[292] The Court of Appeal in ***PS*** made an interesting observation in this regard at paras 193-195 of its decision (as I also noted above):

> The review procedures and the jurisdiction conferred upon the CCB in relation to involuntary committals appear to me to be tailored to meet the exigencies of short-term committals. I agree with the following statement from Ontario's factum, at para. 47;
>
> > The CCB's mandate is to make actual point in time determinations about whether the criteria in the *Mental Health Act* or other legislation are satisfied and to make decisions about such things as involuntary status, capacity to make treatment decisions, and so on. Unlike the ORB, *the CCB has never been mandated to provide oversight over involuntary patients for the indefinite future*.[Emphasis added]
>
> As I explained earlier in these reasons, the most recent provincial statistics on involuntary detention under the MHA indicated that 34% of patients involuntarily committed under the MHA were in hospital for less than a week, 80% for less than a month and 98% for less than 6 months.
>
> These statistics are consistent with what appears to be a dominant theme of modern mental health care policy – minimizing hospitalization and maximizing rapid return to community living. The involuntary committal provisions of the MHA are tailored to deal with urgent situations where an individual requires immediate treatment to avoid harm to him or herself or harm to others. [...]

[293] The statistics in this case are similar. For instance, in the 2015-2016 year 96% of the 7800 patients certified that year were discharged before 6 months. However, the average length of stay of those patients was 15 months. Further, of the 346 patients with certificates lasting more than 6 months who had automatic hearings under s 39 of the ***MHA***, only 9 had their certificates cancelled (2%), JH would have been one of those patients (i.e. one of the 98%) who did not have his certificate cancelled.

[294] I share the concerns of the Court in ***PS*** that the Review Panel procedures are geared towards short term certified individuals where it may not be as important to worry about a short time to review few medical records or be better prepared to answer one's case. However, for the small percent who have had a lengthier stay, procedural requirements, in that context, may require more stringent procedural protections. As the situation presently stands, the rights of patients, such as JH are not met under the present ***MHA*** scheme for review as it is not possible to "answer" the case without proper and timely disclosure, better prepared counsel, and proper planning about re-integration into the community.

[295] It is no surprise that only 2% of certificates of long-term patients are cancelled at hearings in light of the present situation.

2. Power and Authority

[296] As discussed earlier with respect to the issue of limitless renewal of certificates, JH and the CLG submit that the Review Panels only have the power to uphold or cancel certificates and not to tailor conditions for a patient's release. The failure to have these powers was found to be a constitutional legislative gap in the ***PS*** case. The Court of Appeal stated at para 114 "... the MHA fails to provide the CCB with the tools necessary to ensure that the liberty interests of long-term involuntary patients are restricted no more that is necessary to deal with the risk they pose and that appropriate steps are being taken towards their eventual reintegration into the community."

[297] The steps discussed in that case were that the Ontario review boards lacked jurisdiction to supervise the security level, privileges, therapy and treatment of long-term detainees and to craft orders that would ensure an appropriate balance between public protection and the protection of the detainee's liberty interests.

[298] Alberta pointed out that in our ***MHA*** there are provisions that allow for facilities to determine security levels, privileges, therapy, and treatment of all patients. Nonetheless, the Review Panel, similarly to the situation in Ontario at the time of ***PS*** (which has since been revised as noted above), has no jurisdiction to override any of these decisions. The only power the Review Panel has (at issue in this case) is to revoke the certificates in place. Similar to the Ontario situation, our ***MHA*** has a legislative gap that fails to meet the constitutional standard of fundamental justice in this regard.

[299] It is notable that in JH's case it appears at the hearing that there was no discussion about his security levels privileges, therapy, treatment or any discussion about appropriate steps for his eventual reintegration into the community. The evidence from the social worker suggests that she was looking for him to be transferred to another facility but there was a debate about what type of facility was even appropriate for JH. Further, as noted in the recent government reports, transitioning to appropriate community supports is problematic and needs to be worked on.

[300] As discussed, the fact that the Review Panel is tailored to meet the needs of short-term urgent care patients means that long-term patient's rights are not sufficiently protected in my view.

[301] In sum, I agree with JH that there are not appropriate safeguards in the ***MHA*** that deal with long-term patients in the Review Panel's ability to order a less restrictive situation if appropriate. This legislative gap renders this portion of the ***MHA*** in breach of section 7.

Conclusion regarding ss. 7, 9 and 10 of the *Charter* and the *MHA*

[302] In conclusion, in my view, the ***MHA*** lacks the procedural safeguards required by ss. 7 and 10 of the ***Charter*** with respect to individual's rights to liberty and self-determination and their right to not be deprived thereof except with the relevant principles of fundamental justice. The ***MHA*** breaches the principles of fundamental justice in several respects:

1. The criteria for detention are overbroad since they capture individuals who may not be improved by psychiatric treatment, the term "harm" is not qualified and can therefore

be interpreted in an overinclusive way, and there is no link between detention and the need for psychiatric treatment in a facility which is the purpose of the ***MHA***. Accordingly, the criteria are overbroad and in breach of s. 7

2. The unlimited renewal of certificates without appropriate procedural safeguards to ensure that the focus remains on the liberty interests of long-term patients and that they are not restricted more than necessary, is inappropriate and a gap in the MHA statutory scheme that breaches s. 7
3. There are no appropriate administrative safeguards to ensure that the many rights in the ***MHA*** are complied with i.e. there is a lack of oversight of patient's rights except on a complaint basis, in breach of s. 7
4. The notice provisions are inadequate in that they do not provide for written notice of the right to counsel and the meaningful opportunity to access counsel, including free counsel, without delay, in breach of s. 10(b)
5. The procedure before the Review Panel fails to allow the individual's right to know the case against them and the right to properly answer that case by failing to provide timely and free medical records disclosure in breach of s. 7 and,
6. The Review Panel powers are overly restricted with respect to the rights of long-term patients and should include the ability to make orders to tailor solutions that are the least restrictive to these patients' liberty and promote their re-integration into the community. This legislative gap breaches s. 7.

Section 1 of the *Charter*

[303] No serious argument was made by Alberta that any breach of ss. 7, 9 or 10 could be justified as a reasonable limit pursuant to s. 1 of the ***Charter*** and I agree that it would not be so saved. The Court in ***PS*** summarized the law succinctly on this point at para 130:

> [130] The Supreme Court stated in *Suresh*, at para 78, quoting from *Reference re s.94(2) of the Motor Vehicle Act (British Columbia)*, [1985] 2 SCR 486, at p. 518, that s. 7 violations will be saved by. 1 only in "exceptional conditions" such as natural disasters, the outbreak of war, epidemics and the like". The court added in *Charkaoui*, at para 66, that "violations of the principles of fundamental justice, specifically the right to a fair hearing, are difficult to justify under s. 1." There appears to be no case where the Supreme Court has held that a violation of s. 7 was justified under s.1: Hamish Stewart, *Fundamental Justice: Section 7 of the Canadian Charter of Rights and Freedoms* (Toronto: Irwin Law, 2012), at p.289.

Remedy

[304] JH seeks a declaration that his rights under the ***MHA*** and the ***Charter*** were unjustifiably infringed and as discussed at the outset, he does not seek any financial compensation. In addition, pursuant to s. 52 of the ***Charter***, that the detention and review scheme of the ***MHA*** be struck down and found to be of no force and effect. More specifically, that s. 8(3)(c) should be amended so that the third renewal certificate should only permit a three-month additional detention and the reference to "and in each subsequent case" is deleted in its entirety.

[305] Further, JH seeks a reading into s. 41 of the ***MHA*** powers for a Review Panel to be able to order a full assessment of a patient's needs medically and with respect to housing placement when appropriate and finally, more specifically, that sections 2, 4(1), 4(2), 7(1), 8(1), 8(3), 38(1) and 41(1) of the ***MHA*** be struck down in their entirety.

[306] JH concedes that a time limited suspension of the declaration of invalidity may be warranted but for no longer than 6 months given the seriousness of the ***Charter*** breaches.

[307] Alberta submits that s. 8(3)(c) wording can already include a renewal of only 3 months and that there is no evidence to support a total of 6 months as the final determination of detention. With respect to a tailored plan, Alberta suggests that this is already being done and in any event the Review Panel is already able to engage the service of experts to help them with their inquiry under the legislation now (s. 37(10) of the ***MHA*** and s. 3(1)(b) of the ***Public Inquiries Act***). Alberta also notes that the ***MHA*** is not administered in isolation to other social benefits and that a social worker is embedded at the Foothills for instance. Reading-in such a provision should be sparingly used.

[308] Finally, with respect to striking down the impugned provisions, Alberta asks that if these sections are found to be unconstitutional, that any declaration of invalidity be suspended for 18 months to allow a legislative response.

Analysis

[309] Section 52(1) of the *Constitution Act, 1982* provides:

> The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.

[310] In my view, the ***MHA*** as a whole is outdated and review at several levels is necessary to now make it ***Charter*** compliant as discussed. It would be inappropriate to sever a portion here, and read in a portion there, in an attempt to fix the several areas of concern. Ultimately this is the role of the Legislature to determine and correct this legislation to ensure a scheme of detention and treatment that complies with its purpose, is not overbroad, and properly respects the rights and liberty of detained individuals who need treatment in a facility.

[311] I also repeat that this need to update the ***MHA*** has been recognised already by Alberta in Alberta Health's 2017 report *Valuing Mental Health Next Steps*. As well, I repeat that I am cognisant that the needs of individuals like JH are not only ameliorated by ***Charter*** compliant legislation but also other steps by government agencies such as I noted where the Report of the Alberta Mental Health Review Committee 2015 recognised and recommended that the Alberta Health and AHS "establish a process to harmonise their respective roles and goals in order to effectively develop an integrated service delivery system for addiction and mental health." It is to be remembered that at the end of the day, it was Dr. Quickfall's reluctance to release JH into the community without proper support that kept him institutionalised for 9 months against his will.

[312] With respect to this ***Charter*** challenge here, I declare that the following impugned detention provisions of the ***MHA***'s infringe s. 7 and 9 of the ***Charter***: ss. 2, 4(1), 4(2), 7(1), 8(1), and 8(3) and I therefore strike them down. These all deal with the criteria and timelines for

certifying patients under the ***MHA***. Without constitutionally valid criteria and procedures that comply with the principles of fundamental justice, these detention provisions cannot stand.

[313] With respect to the impugned review procedures, ss. 38(1) and 41(1), they are not in and of themselves in breach of the ***Charter*** – they set out the right to apply to have certificates cancelled and the Review Panel's limited rights to cancel or refuse to cancel them. The problem with these sections is that they are incomplete as discussed above. Accordingly, there is no point striking them down. Like in ***PS*** where the Ontario Court of Appeal similarly found that the Ontario review panel did not have appropriate jurisdiction with respect to long-term patients, the remedy there was to suspend the certification rights beyond 6 months so that once the procedure was remedied to comply with fundamental justice concerns, the certification rights could be reinstated.

[314] I note that in ***PS*** the criteria itself was not at issue - like it is here - so limiting the striking down of merely the certification section beyond 6 months in this case would not be enough. Here the criteria are overbroad and breaches the ***Charter*** from the first certificate onwards – hence the striking down of all of these impugned detention provisions.

[315] I am cognisant that an immediate declaration of invalidity of the certifying (detention) sections, as discussed at para 206 of ***PS***, would pose a potential risk to certain individuals and the safety of the public. Accordingly, it is appropriate to suspend this declaration for a period of twelve months from the date of these reasons to afford the Legislature the opportunity and time to consider the necessary amendments required to ensure compliance with the ***Charter***.

Summary and Conclusion

[316] In sum, I declare that JH suffered multiple breaches of his fundamental rights to life liberty and security protected by s. 7 of the ***Charter,*** was arbitrarily detained in breach of s.9, and was not given appropriate notice of the reason for his detention or his right to legal counsel in breach of s. 10 (a) and (b). AHS is responsible for these breaches. More particularly:

1. JH's admission and renewal certificates were incomplete and inadequate so that they did not form the legal authority to detain him. His ss. 7 and 9 rights were breached.
2. JH (or his nearest relative) was not provided with written reasons for his detention by the provision of his certificates or other written information in a reasonable time in breach of s. 10(a).
3. JH was not advised of his right to counsel or right to free legal advice in a reasonable time in breach of s. 10(b).
4. JH was treated with psychiatric medications which were not medically required without his consent in breach of s. 7.
5. JH failed to have a procedurally fair hearing because he did not know the case he had to meet as a result of the lack of information provided to him, including his reasons for detention, and his medical records, and therefore he was not able to properly answer his case in breach of s. 7.

6. As a result, he was detained against his will for a period well beyond what was appropriate in breach of ss. 7 and 9.

[317] Further, I declare that the detention provisions ss. 2, 4(1), 4(2), 7(1), 8(1), and 8(3) of the ***MHA*** are of no force or effect as they infringe s. 7, 9 and 10 (a) and (b) of the ***Charter***. This declaration will be suspended for 12 months so that the Legislature can take the appropriate steps to bring the ***MHA***'s detention and review procedures into compliance with the ***Charter.*** These steps may include:

1. Revising the detention criteria to refine the definition of "harm" (as also suggested by the Standing Committee on Families and Communities in its 2017 Report to the Legislature mandated by s. 54 of the ***MHA***).
2. Coupling the detention criteria with the need for treatment in a psychiatric facility, and the ability to be improved with psychiatric treatment in a facility, so that it aligns with the purpose of the ***MHA***
3. Adding administrative oversight safeguards so that the oversight of patient's rights is pro-active and not only reactive. This could include requiring the Patient Advocate to meet with each patient upon detention (or so soon thereafter if the patient is unwell at detention) to advise them of their rights and provide the written information required
4. Including the need to provide notice of the right to counsel and free legal advice in s. 14 of the ***MHA*** (as recommended by the Patient Advocate) or elsewhere in the ***MHA***
5. Requiring the free provision of disclosure (including medical records and assessments) on a timely basis to patients who appeal their detention to the Review Panel and the Court of Queen's Bench
6. Enhancing the Review Panel's powers to ensure that they have the power to order conditions that provide the least restrictions on a detained patient depending on their circumstances which could include: leave of absences, transfers to a lesser restrictive housing, different security level, and direction to the facility to provide vocational, interpretive or rehabilitative services

[318] In addition, while the review of the ***MHA*** is being undertaken, I recommend that the treatment provisions for competent and non-competent detained individuals be reviewed and revised so that it becomes compliant with the ***Charter.***

[319] Finally, although I have stayed the striking down of the detention provisions for 12 months, this does not preclude AHS from immediately attempting to implement further procedural safeguards, as discussed, to ameliorate the present situation that detained individuals under the ***MHA*** face.

Heard on the 6th and 7th days of September, and 11th day of October, 2018.
Dated at Calgary Alberta this 17th day of July, 2019.

K.M. Eidsvik
J.C.Q.B.A.

Appearances:

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APPENDIX A

IMPUGNED SECTIONS OF THE *MENTAL HEALTH ACT* RSA 2000 cM-13

Admission certificate

2 When a physician examines a person and is of the opinion that the person is

(a) suffering from mental disorder,

(b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and

(c) unsuitable for admission to a facility other than as a formal patient,

the physician may, not later than 24 hours after the examination, issue an admission certificate in the prescribed form with respect to the person.

Effect of one admission certificate

4(1) One admission certificate is sufficient authority

(a) to apprehend the person named in the certificate and convey the person to a facility and for any person to care for, observe, assess, detain and control the person named in the certificate during the person's apprehension and conveyance to a facility, and

(b) to care for, observe, examine, assess, treat, detain and control the person named in the certificate for a period of 24 hours from the time when the person arrives at the facility.

(2) The authority to apprehend a person and convey the person to a facility under subsection (1)(a) expires at the end of 72 hours from the time when the certificate is issued.

Renewal certificates

8(1) The period of detention of a formal patient may be extended when 2 physicians, after a separate examination by each of them, are of the opinion that the formal patient is

(a) suffering from mental disorder,

(b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and

(c) unsuitable to continue at a facility other than as a formal patient,

and each issues a renewal certificate in the prescribed form within 24 hours after the examination.

(2) At least one of the physicians who issue renewal certificates under this section shall be a member of the staff of the facility at which the formal patient is detained and at least one of the certificates shall be issued by a psychiatrist.

(3) Two renewal certificates are sufficient authority to care for, observe, examine, assess, treat, detain and control the person named in them,

(a) in the first case where 2 renewal certificates are issued, for a period of not more than one additional month,

(b) in the 2nd case where 2 renewal certificates are issued, for a period of not more than one additional month,

(c) in the 3rd case and in each subsequent case where 2 renewal certificates are issued, for a period of not more than 6 additional months

Application for hearing

38(1) A formal patient, the patient's agent, the patient's guardian or a person on the patient's behalf may apply to a review panel for cancellation of

(a) admission certificates, or

(b) renewal certificates,

by sending a notice of application to the chair of the appropriate review panel in the prescribed form.

Decision of review panel

41(1) A review panel may

(a) with respect to an application for the cancellation of admission certificates or renewal certificates,

(i) cancel the admission certificates or renewal certificates, as the case may be, that are in effect at the time of the hearing, or

(ii) refuse to cancel the admission certificates or renewal certificates;