In the Court of Appeal of Alberta

Citation: JH v Alberta (Minister of Justice and Solicitor General), 2020 ABCA 317

Date: 20200911
Docket: 1901-0249-AC
Registry: Calgary

Between:

J. H.

Respondent

- and -

Alberta Health Services

Respondent

- and -

Minister of Justice and Solicitor General of Alberta

Appellant

- and -

Calgary Legal Guidance

Intervener

- and -

Legal Aid Society of Alberta

Intervener

Restriction on Publication

Identification Ban – By Court Order, the identity of JH must not be disclosed in the course of these proceedings.

NOTE: This judgment is intended to comply with the identification ban.

The Court:

The Honourable Madam Justice Sheila Greckol
The Honourable Madam Justice Elizabeth Hughes
The Honourable Madam Justice Jolaine Antonio

Reasons for Judgment Reserved of
The Honourable Madam Justice Antonio

Concurred in by The Honourable Madam Justice Greckol and
The Honourable Madam Justice Hughes

Appeal from the Judgment by
The Honourable Madam Justice K M. Eidsvik
Dated the 17th day of July, 2019
Filed on the 12th day of November, 2020
(2019 ABQB 540, Docket: 1501 03347)

Reasons for Judgment Reserved of
The Honourable Madam Justice Jolaine Antonio

I. Introduction

[1] The respondent JH sought help at the Foothills Medical Centre for complications related to his infected knee. He ended up being involuntarily admitted as a psychiatric patient pursuant to the *Mental Health Act*, RSA 2000, c M-13, (the *Act*) and detained for over nine months despite not having any treatable psychiatric illness. The court below found that the *Act* violates sections 7, 9 and 10(a) and 10(b) of the *Charter*. The appellant Minister of Justice and Solicitor General of Alberta and the respondent Alberta Health Services ask this court to set aside the trial judge's declarations of invalidity.

[2] For the reasons that follow, the appeal is dismissed.

II. Background facts

[3] JH is a member of a First Nation in British Columbia and was employed in the logging industry there. In 2007, he moved to Calgary and worked for a stucco company. He had been married and has an adult son. He was in frequent contact with his mother, who lives in Washington state.

[4] JH was 49 years old with no history of mental illness when he was hit by a car in a parking lot and suffered significant injuries to his leg and back. He spent five months in hospital, during which time he lost his rented apartment and his identification. When discharged, he was homeless and unable to obtain social assistance without identification. He sought shelter at Alpha House.

[5] On September 5, 2014, an addictions team associated with Alpha House brought JH to the Foothills Medical Centre, run by the respondent Alberta Health Services. He was feverish, delirious and in pain because of sepsis in his injured knee. He also was suffering a liver condition as a result of previous alcohol consumption. He consented to knee surgery and various medical tests.

[6] After 20 days in the hospital, JH sought discharge. Instead, he was certified under the *Mental Health Act* and involuntarily detained in lockdown. In more than nine months of detention, he left the hospital unit only twice, accompanied by a social worker, to obtain identification and for a walk.

[7] His psychiatric admission was initially authorized on a Form 1 admission certificate by a family doctor on September 25, 2014. Among her observations, she listed that JH was "disoriented, lacks insight into seriousness of his medical condition, states wants to leave hospital, unsteady gait". She learned from others that he had repeatedly tried to leave the hospital, and had a history of alcohol use and depression.

[8] The next day, a second Form 1 certificate was issued by a hospitalist, indicating he had examined JH for four minutes and observed that he was "tangential, lacks insight into [illegible] needs". Others had informed him that JH was cognitively impaired from alcohol use.

[9] There was no evidence that JH, his mother, his son, or any relative was informed orally or in writing about the reasons for the issuance of the admission certificates. There was no evidence that JH was advised of his right to obtain legal counsel to challenge the certificates, nor was he advised that he could seek help by contacting the Mental Health Patient Advocate.

[10] Form 1 admission certificates permit detention for one month. A series of renewal certificates in Form 2 were issued to continue JH's involuntary detention. There was no evidence that when the certificates were renewed, they were given to JH or a relative. There was no evidence that JH was advised he could obtain counsel to appeal his renewal certificates or that he could seek assistance from the Patient Advocate.

[11] The certifying psychiatrist testified that JH was assessed as having a neurocognitive disorder, specifically, an "ongoing problem with his cognition, including his memory, his understanding of information, his ability to retain that information and use it appropriately to make choices that ensured his mental and physical well-being". JH was detained on the ground that he was likely to harm himself unintentionally, owing to his condition, and because he was at significant risk for relapse to alcohol, which would renew the cycle of liver damage and confusion. There was no psychiatric treatment that was helpful for JH and therefore a community treatment order would not be useful. In the psychiatrist's view, learning disabilities can be mental disorders.

[12] The psychiatrist agreed that an acute care hospital was not the best setting for JH but it provided more stability than homelessness. Finding more suitable accommodation for JH was difficult because his support needs were relatively minor. Ironically, he was not eligible for some housing options because he did not have a mental health disorder. As the trial judge concluded, JH was being detained to provide a form of residential care "because there is no other place for him".

[13] Despite the psychiatrist's opinion that JH did not require psychiatric treatment, JH was treated with anti-psychotic medications. JH testified he did not like Seroquel as it made him feel tired and lazy. He testified that twice he was held down and injected with the medication against his will. Most of JH's treatment occurred without his consent and without a Form 11, which is necessary to authorize treatment of incompetent patients in the absence of their consent.

[14] The earliest indication that JH was given information about challenging his certification was in a record from January 2015, four months into his detention. The information took the form of "a handout with all the necessary information". A note on the record indicated that JH said 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."

[15] A nurse's note dated March 5, 2015 indicated that someone from the Patient Advocate's office had asked for JH's certification forms. The certificates from September, October, November and December were first provided to JH on March 6. He was also given a blank Form 12 to apply for a Review Panel Hearing. A doctor's note from March 6 relates 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."

[16] JH completed the Form 12 but because he misspelled his middle name by one letter, the form was not acted on.

[17] On March 9, 2015, a nurse spotted the problem with the form. She helped JH to complete it properly and send it to the Chair of the Review Panel.

[18] The Review Panel heard JH's appeal on March 17, 2015. The Legal Aid Society of Alberta provided funding for counsel for JH but a lawyer was not retained until March 16. She spoke to JH then but had not yet seen his medical records.

[19] There is no record of the proceedings. It lasted no more than 45 minutes. Hospital staff stood by the opinions previously described. JH testified that there was nothing wrong with him, and he wanted to leave the hospital and return to work. His counsel argued that there was nothing wrong with him mentally. He had worked for the last 18 years and had family in British Columbia. There was no clinical diagnosis of a mental illness except that he was "unable to meet the ordinary demands of life". The hospital was not the right environment for him, and he should be entitled to his liberty and to live as he chooses.

[20] The Review Panel upheld the recertification of JH. 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 "it was likely that the patient would suffer both substantial mental and physical deterioration if not in hospital." Finally, and tautologically, the Panel "thought that the patient was not suitable for admission other than as a formal patient [meaning an involuntary in-patient], as the patient in his own evidence indicated that he would not remain in hospital if not required to do so."

[21] After the Review Panel hearing, the certifying psychiatrist requested a second opinion from another psychiatrist. She formed a more positive impression of JH's abilities. She questioned a number of past decisions in JH's case and recommended that his prescriptions be reviewed. As a result of her assessment, the first psychiatrist phoned JH's mother to seek her consent to JH's treatment. She did not consent to one of the medications; its use was suspended.

[22] JH's counsel appealed the Review Panel's decision to the Court of Queen's Bench. On May 15, 2015, in reasons reported at *JH v Alberta Health Services*, 2015 ABQB 316, the trial

judge held that Alberta Health Services had not met its onus to show that JH fit the detention criteria in the *Mental Health Act.* She ordered that the renewal certificates be cancelled.

[23] In his originating notice, JH also sought a declaration that Alberta Health Services, through the Foothills Hospital, had breached his rights under sections 7, 8, 9 and 10 of the *Charter*. Further, he alleged that the *Mental Health Act* itself is unconstitutional.

[24] The constitutional issues raised in the originating notice were adjourned. After the May 2015 decision, Alberta applied to have the constitutional matters dismissed on the basis that they were moot because JH was no longer detained. The trial judge held the issues were of public importance and their determination was in the public interest: *JH v Alberta Health Services*, 2017 ABQB 477.

III. The trial tudge's decision on the constitutional issues

[25] The constitutional issues before the trial judge were:

> i) whether Alberta Health Services, through the Foothills Hospital, has breached JH's rights under sections 7, 9 and 10 of the *Charter*; and
>
> ii) whether the review and detention provisions under the *Mental Health Act*, RSA 2000, c M-13, as amended, 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*.

[26] On the first issue, the trial judge concluded that JH had suffered many breaches of his section 7, 9, and 10(a) and (b) rights: *JH v Alberta Health Services*, 2019 ABQB 540 [Reasons] at para 140. These findings are not under appeal.

[27] On the second issue, the trial judge found the *Act* is overbroad and procedurally unfair and therefore violates the *Charter*.

[28] The trial judge found that the purpose of the *Act* is to "temporarily detain acutely mentally ill persons for the purpose of treatment and release back into the community": paras 182, 189.

[29] The trial judge's central conclusions on overbreadth relate to the criteria for detention in section 8 of the *Act* (at para 302):

> 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 section 7.

[30] On procedural fairness, the trial judge's main findings are listed at para 302:

> 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.

[31] No arguments were made that any of the breaches could be justified under section 1 of the *Charter*: 2019 ABQB 540 at para 303.

[32] The trial judge declared that sections 2, 4(1), 4(2), 7(1), 8(1) and 8(3) of the *Act* contained discrete *Charter* violations and were of no force or effect.

[33] The provisions allowing for review panel hearings were "not in and of themselves in breach of the *Charter*", but were "incomplete" as they did not provide adequate procedural safeguards. The trial judge did not strike the hearing provisions, but declared that the *Act*'s procedures were constitutionally deficient. She ordered Alberta to rectify the legislative gaps and suspended the operation of her declarations for 12 months to enable it to do so.

IV. Legislative provisions

[34] The *Mental Health Act* permits the state to intervene in the care of individuals who struggle with mental health issues. Treatment may take place in the community if the individual has previously been subject to the *Act* or has been in another custodial facility and if other conditions are met: s 9.1. Community treatment orders are not the subject of this appeal; involuntary in-patient admission, tantamount to detention, is.

[35] For present purposes, involuntary admissions are those effected by the state acting under the authority of the *Act*. By contrast, voluntary admissions are sought by the patient or a person who legally stands in his shoes, such as a guardian or power of attorney. On involuntary admission, a patient will be placed in a "facility". The *Mental Health Regulation*, AR 19/2004 designates twenty hospitals and psychiatric institutions as "facilities". Long-term living settings such as those caring for dementia patients are not "facilities" and are not authorized to accept involuntary admissions. The *Adult Guardianship and Trustee Act*, SA 2008, c A-4.2, provides for long-term or permanent care of the mentally disadvantaged by the state or a private individual.

[36] The *Mental Health Act* provides for involuntary admission using a certificate system. A physician may issue an admission certificate if, after examining the person, she forms the opinion that the person (a) suffers from a "mental disorder", (b) is likely to cause harm to the person or others or to suffer "substantial mental or physical deterioration or serious physical impairment" and (c) is "unsuitable" for admission to a facility other than as a formal patient: s 2. An admission certificate must show the facts grounding the opinion that the admission criteria have been met: s 9.

[37] "Mental disorder" is defined as a "substantial disorder of thought, mood, perception, orientation or memory that grossly impairs" judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life: s 1(g). "Formal patient" is defined as a patient detained in a facility pursuant to two admission certificates or two renewal certificates: s 1(e). "Facility" is defined in the regulations. "Substantial mental or physical deterioration or serious physical impairment" and "unsuitable" are not defined.

[38] One admission certificate is authority to apprehend the person and take him to a facility "to care for, observe, assess, detain and control" him for 24 hours: s 4. Unless a second admission certificate is issued within 24 hours, the person must be released: s 5. With two admission certificates, the person can be detained for one month from the date of the second admission certificate: s 7.

[39] Detention may be extended by two renewal certificates from two separate physicians, of whom one must be a psychiatrist. Both physicians must be satisfied after independent examinations that the person continues to meet the admission criteria: s 8. A renewal certificate, like an admission certificate, must state the facts on which the physician's opinion was formed.

[40] The board (defined as the board of an approved hospital or provincial health board) must "inform the formal patient and make a reasonable effort to inform the patient's guardian, if any, and, unless the patient objects, the patient's nearest relative" of the reason for the admission certificates or renewal certificates and the patient's right to apply to the review panel for

cancellation of the certificates.[1] The board must also provide copies of the certificates and a written statement containing the reasons for the certificates, the function of the review panel, the name and address of the chair of the review panel for the facility and the right to apply for cancellation of the certificates: s 14.

[41] A person is mentally competent to make treatment decisions if he is "able to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions": s 26. A physician who opines the patient is not mentally competent to make treatment decisions is required by section 27 to complete and file with the board a certificate (as prescribed in the regulations), and the board is required to give the patient and any surrogates a copy of the certificate and written notice that the patient is entitled to have the physician's opinion reviewed by the review panel.

[42] A patient may apply for cancellation of admission or renewal certificates by sending a notice of application to the chair of the review panel in a prescribed form: s 38. Where a patient has been subject to certificates for six continuous months, section 39 deems a review. The chair must give reasonable notice of the hearing to the patient and any surrogates: s 40. On an application to cancel admission or renewal certificates, the review panel may cancel or refuse to cancel them, and it must inform the patient and any surrogates: s 41. The review panel must also inform the patient and his guardian, if any, of the result. If the certificates are not cancelled, the panel shall provide reasons and a statement of the right to appeal to the Court of Queen's Bench: s 41.

V. Grounds of appeal and standard of review

[43] The appellant advances three grounds of appeal:

1. Whether this Court has jurisdiction to hear this appeal;
2. Whether the trial judge erred in concluding that provisions of the *Act* are overbroad; and
3. Whether the trial judge erred in concluding that provisions of the *Act* are procedurally unfair.

[44] Section 43(5) of the *Act* states that "An order of the Court [of Queen's Bench] under this section is not subject to appeal"; it thereby prohibits appeals of judgments from review panel orders. However, the parties agree that this Court has jurisdiction to hear an appeal of the trial judge's declarations of unconstitutionality. The trial judge decided two separate matters: the appeal of the Review Panel decision, and an originating notice seeking declarations that the *Act* violated JH's *Charter* rights and was unconstitutional. The latter process is not prohibited by section 43(5).

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[1] At points, the *Act* refers to various individuals who might support the patient, such as guardians and relatives. For simplicity, and where nothing turns on any distinction, I will refer to these individuals as "surrogates".

The dual proceedings approach, as described by the Supreme Court of Canada, permits appeals of rulings on constitutionality independent of an appeal on the substance of a matter: *R v Keegstra*, [1995] 2 SCR 381 at paras 14-18, 124 DLR (4th) 286, citing *R v Laba*, [1994] 3 SCR 965 at 977-984, 120 DLR (4th) 175.

[45] The live questions on appeal are legal ones, and therefore are reviewable on a standard of correctness: *Housen v Nikolaisen*, 2002 SCC 33, [2002] 2 SCR 235.

VI. Analysis

A. History of mental health detention in Canadian law

[46] In the early days of the English common law, mental disorder was sometimes portrayed as an all-or-nothing state of being: either entirely absent or fully debilitating. A person deemed a "fool natural", or some similarly dehumanizing label, was understood to "remain without discretion and the use of reason" for life. The law's response was equally all-or-nothing: it gave "the custody of [the mentally ill individual], and all that he has, to the King": *Beverley's Case* (1603), 4 Co Rep 123 b at pp 126 a, 126 b, 76 ER 1118, Sir Edward Coke at 1124, cited in *E v Eve* (1986), [1986] 2 SCR 388 at para 40, 31 DLR (4th) 1. Individuals so labelled were detained in lunatic asylums and thus were "subjected to a modified status of subcitizenship" under the "secure dominance of the medical profession in the therapeutic management of the asylum population": Clive Unsworth, "Law and Lunacy in Psychiatry's Golden Age" (1993) 13 Oxford J Leg Stud 481 at 481.

[47] Canada inherited the all-or-nothing view of mental illness alongside the related traditions of the English common law. See, for example, *The Mental Defectives Act*, RSA 1922, c 224, which provided for committal but not for discharge. The English courts' jurisdiction over "lunatics and their property and their estates" was, and is, vested in Canadian superior courts: for example, see the *Judicature Act*, RSA 1955, Chapter 164, s 33; *Judicature Act*, RSA 2000, c J-2, s 7; *Chancery Jurisdiction Transfer Act*, SPEI 1974, c 65, s 2; *Judicature Act*, SO 1881, 44 Vict, c 5; *Courts of Justice Act*, RSO 1990, c C43, s 11; *Law & Equity Act*, RSBC 1996, c 253, ss 1-3; see, also, J. E. Côté, "The Introduction of English Law into Alberta" (1964) 3 Alta L Rev 262-292.

[48] From Confederation until the 1960s, Canada employed a version of the asylum system. Some patients spent their lives institutionalized and isolated away from family. Mechanisms for case management or review were non-existent, and prospects for community reintegration were poor due to inadequate oversight, treatment options and programming: Jennifer Chandler, "Mental Health and Disability in Canadian Law: Evolving Concepts, Concerns and Responses" in Jennifer Chandler and Colleen Flood, eds, *Law and Mind: Mental Health Law and Policy in Canada*, (Toronto: LexisNexis, 2016) at 11.

[49] Over time, mental illness ceased to be viewed in all-or-nothing terms. It is now understood that "mental health problems are highly variable in symptoms and severity and can fluctuate over the life course": Chandler at 1-2. Similarly, there is a wider and more nuanced range of treatments than the binary choice of whether or not to commit a patient to an asylum.

[50] Notwithstanding scientific and social developments, "[t]he tendency to conflate mental illness with lack of capacity" persisted: *Starson v Swayze*, 2003 SCC 32 at para 77, [2003] 1 SCR 722, citing D. N. Weisstub, in his Enquiry on Mental Competency: Final Report (1990) at 116. With *Fleming v Reid* (1991), 4 OR (3d) 74, 82 DLR (4th) 298 at para 36, the Ontario Court of Appeal began to break the monolith of "insanity" into more realistic gradations, recognizing that not all mental illnesses result in a lack of decision-making competence:

> Until [involuntary patients] are found incompetent, they hold the same rights as any other competent patient in the facility. Indeed, they hold the same rights as competent persons elsewhere in the province whose consent must be obtained before they can be the subject of medical treatment. Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, than that of competent persons suffering from physical ailments.

[51] In the words of McLachlin CJC (as she then was), "Mental illness, without more, does not remove capacity and autonomy": *Starson* at para 10 (dissenting).

[52] As the all-or-nothing approach to mental health labelling began to crumble, so did the all-or-nothing approach to the state's response. Regimes that defaulted to involuntary detention, with no prospect of individualization, were held to violate several constitutional norms, including overbreadth, arbitrariness, and fundamental justice.

[53] For instance, under a former provision of the *Criminal Code*, when an accused was acquitted by reason of insanity an order of "strict custody" automatically followed. There was no opportunity for a hearing on the accused's current mental state, and no discretion as to the outcome. The provision therefore allowed for arbitrary detentions, in violation of s 9 of the *Charter*. It also failed to meet constitutional requirements of procedural fairness, and thereby violated section 7: *R v Swain*, [1991] 1 SCR 933, 5 CR (4th) 253. Parliament enacted the "not criminally responsible" (NCR) provisions of the *Code* in response to *Swain*. The new legislation was found constitutionally compliant because it was flexible enough to "tak[e] into account the specific circumstances of the individual ... on an ongoing basis": *Winko v British Columbia (Forensic Psychiatric Institute)*, [1999] 2 SCR 625 at para 59, 25 Crown (5th) 1. In particular, the legislation mandated that "the least onerous and least restrictive disposition of the accused must be selected", thereby ensuring

"that the NCR accused's liberty is impaired no more than is necessary to protect public safety": *R v Demers*, 2004 SCC 46 at para 40, [2004] 2 SCR 489.

[54] The concept of "the least restrictive disposition" was not exhausted with the either-or question of detention or release. It also engaged the conditions governing any detention or conditional discharge, since such conditions "can also have serious ramifications for [the individual's] liberty interest". In other words, the NCR regime survived "only because at every step of the process consideration of the liberty interest of the NCR accused was built into the statutory framework": *Penetanguishene Mental Health Centre v Ontario (Attorney General)*, 2004 SCC 20, [2004] 1 SCR 498 at paras 24, 53.

[55] Separate provisions of the *Criminal Code* establish procedures to be followed when an accused has been found unfit to stand trial. In *Demers*, the Supreme Court of Canada found at para 2 that the legislation "fail[ed] to deal fairly with the permanently unfit accused who are not a significant threat to public safety." The provisions allowed for indefinite restrictions on liberty, but did not empower the Review Board or the courts "to adapt a disposition to meet the permanently unfit accused's current circumstances": *Demers* at para 55. The provisions were overbroad "because the means chosen are not the least restrictive of the unfit person's liberty and are not necessary to achieve the State's objective": *Demers* at para 43.

[56] "The notion that someone who has been civilly committed has fewer liberty interests at stake than does someone in the forensic system simply because the former has not been charged with a crime cannot be justified": Isabel Grant and Peter J Carver, "*PS v Ontario*: Rethinking the Rose of the *Charter* in Civil Commitment" (2016) 53 Osgoode Hall LJ 999 at 1019. It follows that the all-or-nothing approach to remedying mental illness has also been rejected in the non-criminal context.

[57] In *PS v Ontario*, 2014 ONCA 900, 123 OR (3d) 651, the Ontario Court of Appeal drew on NCR jurisprudence in the context of civil commitment. Ontario's *Mental Health Act*, RSO 1990, c M.7, established a board to review involuntary treatment and detention cases, but did not endow it with the ability to tailor conditions of detention, or to make orders regarding patients' privileges, security levels, therapy, treatment, community access or conditional discharge. Since the review board could not fashion remedies to suit a long-term patient's individual circumstances or actual risk level, the legislation allowed for "overly restrictive, prolonged and indefinite detentions thereby rendering the impugned scheme overbroad" and in violation of section 7 of the *Charter*: *PS v Ontario* at para 127. In short, where legislation limits the liberty of an individual in pursuit of protection, "that limitation should not go beyond what is necessary to accomplish that goal": *R v Heywood*, [1994] 3 SCR 761 at 794, 34 Crown (4th).

B. Life, liberty and security of the person

[58] Issues of overbreadth and procedural fairness fall under section 7 of the *Charter*. Section 7 is engaged when a state action impacts on an individual's life, liberty or security of the person to a degree that warrants *Charter* protection: *Cunningham v Canada*, [1993] 2 SCR 143, [1993] SCJ No 47 at para 15.

[59] Alberta concedes that section 7 is engaged here as the *Act* enables restriction of an individual's liberty and ability to make inherently personal decisions. The framing of this concession appropriately recognizes that liberty is not an all-or-nothing proposition.

[60] For example, after an inmate has been sentenced to jail, significant denials of liberty can still result from "a substantial change in conditions amounting to a further deprivation of liberty, and a continuation of the deprivation of liberty": *Dumas v Leclerc Institute of Laval*, [1986] 2 SCR 459 at 464, 55 Cr (3d) 83. Examples of so-called "residual liberty" in this context include the availability of parole, disciplinary measures such as solitary confinement, and transfer to an institution with a higher security level: *Howard v Stony Mountain Institution*, [1984] 2 FC 642 at para 23, 4 DLR (4th) 147 (CA); *Cunningham v Canada*, [1993] 2 SCR 143, 20 CR (4th) 57; *May v Ferndale*, 2005 SCC 82, [2005] 3 SCR 809 at para 74. A change in duration is also a relevant restriction; bail provisions that had the effect of requiring certain offenders "to serve more time in prison than they would have otherwise" created a clear restriction of liberty: *R v Safarzadeh-Markhali*, 2016 SCC 14, [2016] 1 SCR 180 at para 20.

[61] Concepts of liberty and residual liberty extend beyond the criminal and correctional contexts: *Charkaoui v Canada (Citizenship and Immigration)*, 2007 SCC 9 at para 18, [2007] 1 SCR 350. Long-term detentions related to immigration and national security can be constitutional if assessed according to individualized factors, including the reasons for the detention, its connection to public safety, its potential duration, and the "availability, effectiveness and appropriateness of alternatives to detention such as outright release", release on conditions, or "detention in a form that could be less restrictive to the individual": *Charkaoui* at para 108, citing *Sahin v Canada (Minister of Citizenship & Immigration)* (1994), [1995] 1 FC 214, 24 CRR (2d) 276 (TD), *per* Rothstein J.

[62] In the mental health context, failure or inability to consider the conditions and duration of detention have been found to engage life, liberty and security of the person, as discussed above at paras 52-57. Under the *Mental Health Act*, admission as a formal patient is all-or-nothing: if the admission criteria are met, detention follows. A review panel revisits the all-or-nothing question of whether detention should be continued or terminated by applying the same criteria. The *Act* contains no mechanism, on admission or review, for considering the degree of intrusion on liberty, except as determined by doctors and facilities. Significantly, review panels have no ability to consider any conditions of detention, no ability to release a patient on a Community Treatment Order, and no ability to direct the duration of the continued detention or to mandate steps that

should be taken to render detention as brief as possible. Thus, as Alberta has conceded, the *Act* restricts the individual's liberty and ability to make inherently personal decisions.

C. The doctrine of overbreadth

[63] Since the *Act* restricts life, liberty and security of the person, this Court must determine whether restrictions are imposed in accordance with the principles of fundamental justice, beginning with the question of whether the trial judge erred in finding the *Act* overbroad.

[64] An overbroad law is one which uses broader means than necessary to accomplish a legislative objective. If it does, "the principles of fundamental justice will be violated because the individual's rights will have been limited for no reason": *Heywood* at 792-3.

[65] The Supreme Court of Canada summarized the rationale for, and the operation of, the overbreadth doctrine in *R v Appulonappa*, 2015 SCC 59 at paras 26-7, [2015] 3 SCR 754:

> A law is said to violate our basic values by being overbroad when "the law goes too far and interferes with some conduct that bears no connection to its objective": *Bedford v Canada (Attorney General)*, 2013 SCC 72, [2013] 3 SCR 1101 at para 101. As stated in *Bedford*, "[o]verbreadth allows courts to recognize that the law is rational in some cases, but that it overreaches in its effect in others": at para 113; see also *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 at para 85.
>
> The first step in the overbreadth inquiry is to determine the object of the impugned law. The second step is to determine whether the law deprives individuals of life, liberty or security of the person in cases that do not further that object. To the extent the law does this, it deprives people of s. 7 rights in a manner that infringes the principles of fundamental justice.

[66] "With respect to both purpose and effects, the focus is on the challenged provision . . . understood within the context of the legislative scheme of which it forms a part": *R v Moriarity*, 2015 SCC 55, [2015] 3 SCR 485 at para 24. As always, legislative purpose is found from "the words of the provision, the legislative context and other relevant factors": *Appulonappa* at para 33.

[67] In an overbreadth analysis, determining the purpose of an enactment is a sensitive exercise. An unduly narrow definition will increase the likelihood of finding that the effects overshoot the purpose. An unduly broad definition will have the opposite effect. In particular, since the overbreadth test compares an enactment's purpose to the means it uses to achieve them, care must be taken in using the means to determine the purpose. The means may "throw light on the objective", but if they are given undue weight "there will be nothing left to consider" when deciding whether the enactment's effects overreach its purpose: *Moriarity* at para 27.

[68] In the context of an overbreadth analysis, the purpose of an enactment should be defined as follows, according to *Safarzadeh-Markhali* at paras 26-28:

> First, the law's purpose is distinct from the means used to achieve that purpose: *Moriarity*, at para 27. A law's means may be helpful in determining its objective, but the two must be treated separately.
>
> Second, the law's purpose should be characterized at the appropriate level of generality, which "resides between the statement of an 'animating social value' — which is too general — and a narrow articulation" that amounts to a virtual repetition of the challenged provision, divorced from its context: *Moriarity*, at para 28.
>
> Third, the statement of purpose should be both precise and succinct: *Moriarity*, at para 29. Precision requires that courts focus on the purpose of the particular statutory provision subject to constitutional challenge: *ibid*; see also *RJR-Macdonald Inc. c Canada (Procureur général)*, [1995] 3 SCR 199, at para 144.

D. The purpose of the *Mental Health Act*

[69] At trial, constitutional questions were raised pertaining to "the review and detention provisions in general", and in particular those provisions dealing with admission and renewal criteria and renewal procedures. I will focus my analysis on the purpose of these parts of the *Mental Health Act*, as informed by the context of the *Act* as a whole.

[70] There is general agreement among the parties that the *Mental Health Act* targets the detention and treatment of people with serious mental disorders. But "[t]he devil, as is so often the case, lies in the details": *Penetanguishene* at para 52.

[71] The overarching theme of protecting the patient and others is not unique to Alberta's *Act*. Historically, legislation governing the involuntary detention and treatment of mental health patients was justified as being in the patient's best interests and grounded in the state's *parens patriae* authority: *E v Eve*; *Howlett v Karunaratne* (1988), 64 OR (2d) 418, [1988] OJ No 591 (QL) (Dist Ct); *Fleming v Reid*, (1990) 73 OR (2d) 169 (Dist Ct); *SMT v Abouelnasr* (2008), 171 CRR (2d) 344, 2008 CanLII 14550 (ONSC). A second rationale for state intervention emerged in the late 20th century: to protect the mentally ill and others from the consequences of disordered behaviour: Sophie Nunnelley, "Involuntary Hospitalization and Treatment: Themes and Controversies" in Chandler and Flood, eds, *Law and Mind: Mental Health Law and Policy in Canada* at 113, 116; *McCorkell v Director of Riverview Hospital* (1993), 104 DLR (4th) 391, 81 BCLR (2d) 273 (SC).

[72] Using "dangerousness" as the basis for committal has been criticized for leaving intervention too late and forcing discharge too early, and thereby failing to provide proactive health

care or public protection: *McCorkell* at paras 53-59. In 2007, the Alberta legislature amended the *Act* to allow for earlier intervention, before a patient puts himself or others in imminent danger: Reasons at para 178, Alberta Hansard, 26th leg, 3rd Session, May 1, 2007 at 747 (Hon T Abbott). (More detail on the legislative history can be found at paragraphs 169 to 183 of the trial reasons.)

[73] Though the *Mental Health Act* does not contain a statement of purpose, it is easy to conclude that its focus is on mental health. The title is the first indication. The language used in the *Act* is consistent with that focus: patients, psychiatrists, physicians, health boards, admission and discharge. A facility to which a patient is admitted "shall provide the diagnostic and treatment services" that the patient needs, insofar as the staff is capable: s 19(1). The *Act* contains repeated references to the *Health Professions Act*, *Health Disciplines Act*, *Health Information Act*, and *Hospitals Act*, as well as a few mentions of criminal statutes in the context of transferring patients from a correctional institution to detention in a health facility or supervision on a community treatment order: ss 3, 9.1, 13. The Minister responsible for the *Act* is the Minister of Health.

[74] Along with mental health treatment, the *Act* clearly provides for detention and control. The Minister is empowered to do "anything [she] considers advisable for preventing circumstances that may lead to mental disorder and distress and for promoting and restoring mental health and well-being", including to "establish and operate places for the observation, examination, care, treatment, control and detention of persons suffering from mental disorder": s 49(1). Two admission or renewal certificates provide authority to "care for, observe, examine, assess, treat, detain and control" the patient: ss 7(1), 8(3). Other provisions provide authority to "care for, observe, detain and control" or to "to care for, observe, assess, detain and control" the patient during apprehension, conveyance or transfer: ss 9.6(1)(c), 10(6), 12(2), 24(2). Under section 30, the authority to control a patient is defined as

> authority to control the person without the person's consent to the extent necessary to prevent serious bodily harm to the person or to another person by the minimal use of such force, mechanical means or medication as is reasonable, having regard to the physical and mental condition of the person.

[75] In addition to the pervasive theme of protection of the patient, provisions of the *Act* speak to protection of the public. Most significantly, the admission and renewal criteria allow for care, observation, examination, assessment, treatment, detention and control of patients who are, among other things, likely to harm themselves or others: s 2. Peace officers may apprehend persons who meet similar criteria, either under the authority of a warrant or on reasonable grounds: ss 10, 12. The choice to bestow these powers on peace officers further supports a link to public safety concerns.

[76] The trial judge found that "the focus of the [*Act*] is on harm reduction through treatment, not detention for the purpose of housing", and that its purpose is "was to temporarily detain acutely mentally ill persons for the purpose of treatment and release back into the community": Reasons at paras 184, 189. Alberta argues that this formulation of the *Act*'s purpose is erroneous.

[77] Alberta submits that the purpose of the involuntary admission provisions is "to provide for the involuntary detention and care or treatment of persons who suffer from serious mental disorders and who pose a risk of harm, either to themselves or others, or are likely to suffer substantial mental or physical deterioration or serious physical impairment". In other words, the purpose of these provisions is "[to] permit the state to restrict an individual's liberty where necessary to ensure proper treatment and protection (both of the mentally disordered individual and the public)". Further, "[i]f the purpose of the *Act* were only treatment in a mental health facility on a temporary basis, the small subset of dangerous individuals whose conditions cannot be effectively treated on a temporary basis, would be released into the community without the protection they (or the community) may require". In essence, Alberta submits that the purpose of the *Act* includes interventions beyond the short term and allows for detention without treatment.

[78] In defining the purpose in terms of "temporary" treatment, the trial judge seems to have meant "short-term" treatment: Reasons at paras 245, 294, 300. I agree that detention under the *Act* was intended to be temporary. The goal of eventual discharge is implicit in the requirements to treat patients and to hold regular reviews. However, I would not attempt to define the permissible duration of detention; that should depend solely on the patient's progress. A time limit defined in any other way would threaten the best interests of the patient and the safety of others, and does not form part of the purpose of the *Act*.

[79] Alberta contends that detention *without* treatment is among the purposes of the impugned enactment. In support of this position, it submits that the *Act* permits the detention of a person who is dangerous yet competent and refuses treatment. It is true that this can be an effect of a combination of the *Act*'s provisions. If a competent patient objects to treatment, a doctor can apply to a review panel for an order directing that treatment be administered. The panel must be satisfied that treatment is in the patient's best interest, including the likely effect of treatment or absence of treatment, whether the anticipated benefit outweighs the risk of harm to the patient, and whether the treatment is the least intrusive and restrictive means of meeting the patient's best interest: s 29. Thus, detention without treatment would only apply to the small subset of patients who are dangerous yet competent and who refused a treatment that a review panel has deemed contrary to their best interests. This would be a precarious basis on which to define the *Act*'s purpose. In any event, incorporating this one effect into the definition purpose would skew the analysis in the manner discouraged by *Moriarity*.

[80] In *Thompson v Ontario (Attorney General)*, 2016 ONCA 676, 352 OAC 336, in which Ontario's *Mental Health Act* was challenged, the court found at para 51 that the public safety aspect of the legislative purpose could not "be viewed in isolation. It must be seen as part and parcel of an integrated scheme that promotes both improved treatment and public safety. The legislation does not rest upon unproven stereotypes or assumptions about mental health and violence". The record disclosed "no evidence to support the proposition that those suffering from mental disorder pose a disproportionate threat to public safety": para 16.

[81] Similarly, nothing here suggests that the Alberta Legislature relied on the unwarranted stereotype that people who have mental disorders pose a greater public safety risk than people who do not. Nor is there any suggestion that the *Act* was intended to pre-emptively incarcerate those who might perpetrate crimes or other threats to safety, which would be the effect of lengthy detention without treatment. Incarceration in anticipation of crimes not yet committed would constitute a violation of section 7 of the *Charter*: *R v Lyons*, [1987] 2 SCR 309, 44 DLR (4th) 193. I am unable to conclude that the *Act* was intended to detain mental health patients (and only mental health patients) without treatment in the name of public safety.

[82] On appeal, Alberta suggests that "treatment" can include "the removal of external stimulus to stabilize symptoms". On a review of the appeal record, it appears that this position was not taken or developed at trial; therefore, it is not clear what constitutes "removal of stimulus" or how long such measures would last. If this is a legitimate form of medical treatment, then it would not constitute detention without treatment. It is implicit in the *Act* and the realities of mental illness that "treatment" does not necessarily mean "cure"; it includes measures to stabilize or ameliorate conditions for which no cure is known.

[83] The purposes of the *Act* do not include detention without treatment. At all points, the provisions of the *Act* are tied to mental health care. Nothing in the *Act* directly authorizes control unconnected to care or treatment. Even apprehension by a peace officer results in detention in a health care facility, not a correctional institution: ss 10(5)(b), 12(1).

[84] I accept that the "animating social value" behind the *Act* is protection of the patient and others, but this is not sufficiently precise to serve as a definition of purpose within the overbreadth analysis: *Safarzadeh-Markhali* at para 27. I conclude that the purpose of the *Act* is to permit the state to restrict the liberty of individuals with significant mental health disorders where necessary to provide protection through treatment.

E. The *Act*'s reach exceeds its purpose

[85] Having determined the purpose of the *Act*, the second step of the overbreadth analysis "is to determine whether the law deprives individuals of life, liberty or security of the person in cases that do not further [its] object": *Appulonappa* at para 27.

[86] Overbreadth can arise in many different ways. For example, in *Heywood*, the Supreme Court found an enactment prohibiting convicted sex offenders from attending certain places to be overbroad geographically (the restrictions applied to more locations than necessary) and temporally (the restrictions applied for the offender's lifetime with no process to determine whether they continued to be necessary). It was also overbroad in that it applied to too many people: all those convicted of designated offences whether or not the individual offender constituted a danger to children. The possibility that an offender might obtain a pardon to expunge his conviction was no answer, since the conditions for granting pardons are not

necessarily related to the individual's dangerousness, and unnecessary liberty restrictions would endure for offenders who were not dangerous but not yet eligible for a pardon.

[87] The purpose of the *Mental Health Act* is to permit the state to restrict the liberty of individuals with significant mental health disorders where necessary to provide protection through treatment. Its effect is to deprive patients of liberty beyond what is required to achieve that purpose. Therefore, the *Act* is overbroad and in violation of section 7.

[88] In certain respects, the *Act* preserves the all-or-nothing approach and therefore is overbroad. Unlike the legislation considered in *Thompson*, it does not provide for "a highly individualized assessment and consideration of the patient's specific condition and treatment needs": at para 46. On an application to cancel an admission or renewal certificate, s 41(1) empowers a review panel only to make an all-or-nothing decision: cancel it or renew it. This blunt instrument will foreseeably overshoot the *Act*'s protective goals in some cases. It cannot be said that the *Act* "tak[es] into account the specific circumstances of the individual ... on an ongoing basis": *Winko* at para 59. In other words, the *Act* is overbroad because it does not allow for tailoring the degree of restraint of liberty to the individual case.

[89] The trial judge found that the admission and renewal criteria were overbroad because they do not define or qualify "harm". I agree that this creates overbreadth. For a patient with no history of psychiatric detention, community treatment is not available. Therefore, where a patient meets the other criteria and is "likely to cause harm" to herself or others, the result is involuntary admission. JH's case provides a concrete example: his inability to tend to his own needs without support resulted in long-term detention instead of support.

[90] Owing to the admission and renewal criteria, the *Act* "captures people it was not intended to capture", and applies to more people than necessary to advance its purpose: *Safarzadeh-Markhali* at paras 52-53. The context of the *Act* indicates a focus on mental health issues that are susceptible to psychiatric treatment, but the admission and renewal criteria are not so limited. Therefore, the *Act* captures people with conditions such as learning or developmental disorders, brain injuries and cognitive impairment. JH was such a person, and he was not alone. A report compiled by Alberta Health Services shows that hundreds of patients with developmental and organic disorders are certified under the *Mental Health Act* each year. Of the patients who remained under involuntary admission for six months or more, half suffered from organic disorders: Reasons at para 228. Alberta Health Services defines developmental disorders as "a group of neurological conditions originating in childhood that involve serious impairment in different areas, and include autism and ADHD." It defines organic mental disorder as "a form of decreased cognitive function that is acquired rather than developmental and includes dementia, delirium and other cognitive disorders.": Alberta Health Services, *Performance Measurement, Provincial Addiction and Mental Health*, May 2016.

[91] The admission and renewal criteria require that an individual suffers from a substantial mental disorder and is likely to cause harm to himself or others or to suffer substantial mental or physical deterioration or serious physical impairment. These requirements are conjunctive, not causal. That is, there is no requirement that the risk of harm or deterioration *result from* the substantial mental disorder. Further, as noted, the magnitude of the likely harm to the patient or others is unqualified. To apply a reasonable hypothetical, the criteria would therefore allow for detention of a person who suffers from a substantial mental disorder and smokes cigarettes: *Appulonappa* at para 28. Such a detention would not advance the *Act*'s purpose of protection through treatment: if the potential harm is not connected to the mental disorder, then one cannot expect that treating the disorder will reduce the potential for harm.

[92] Finally, the structure of the *Act* means that detention can continue indefinitely. Indefinite detention overreaches the purpose of the *Act*. The *Act* identifies the time at which discharge should occur: when the patient no longer meets the admission or renewal criteria. At that point, the certificates "shall" be cancelled by a physician: s 31(2). Alternatively, they "may" be cancelled by a review panel after hearing an application by the patient: s 41(1). After the first two months, review hearings are held by default every six months, creating the risk that a patient may languish unnecessarily in the interim: s 8(3). Neither path to cancellation provides adequate procedural safeguards, as will be discussed below.

F. Procedural justice

[93] A patient or surrogate may apply to have an admission or renewal certificate cancelled: s 38(1). At the hearing, the onus is on the board of the facility to show that detention is required, and the patient meets the admission or renewal criteria: s 42(1). The review panel may cancel the certificate or leave it in place: s 41(1). The trial judge found that the review panel process is inadequate to meet the guarantee of fundamental justice. Alberta disputes that conclusion.

[94] The present issue is not whether the state has the power to deny liberty. The question is how. The more a state action intrudes on life, liberty and security of the person, "the greater the need for procedural protections to meet the common law duty of fairness and the requirements of fundamental justice": *Suresh v Canada (Minister of Citizenship & Immigration)*, 2002 SCC 1, [2002] 1 SCR 3 at para 118.

[95] In *Charkaoui*, the Supreme Court of Canada considered the prospect of long detentions in the national security context. It reiterated that "[b]efore the state can detain people for significant periods of time, it must accord them a fair judicial process": para 28, citing *New Brunswick (Minister of Health & Community Services) v G (J)*, [1999] 3 SCR 46, 177 DLR (4th) 124. The court set out the basic components of fundamental justice at para 29:

> 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*. [Emphasis in original.]

[96] Alberta accurately observes that the way in which these requirements must be met will vary with context. But regardless of the context, the process must be fair "having regard to the nature of the proceedings and the interests at stake"; each of the fundamental requirements "must be met in substance": *Charkaoui* at paras 20, 29. "If the context makes it impossible to adhere to the principles of fundamental justice in their usual form, adequate substitutes may be found. But the principles must be respected to pass the hurdle of s. 7. That is the bottom line": *Charkaoui* at para 23.

[97] Section 31(2) of the *Act* provides that "[w]hen a formal patient no longer meets the criteria for the issuance of admission certificates or renewal certificates, a physician shall cancel the admission certificates or renewal certificates, as the case may be." This section tailors the duration of detention by providing for immediate discharge once the criteria are no longer met. One hopes this is the typical path to discharge. But the unilateral exercise of a physician's discretion is not sufficient to satisfy section 7. It does not meet the *Charkaoui* requirements, in particular because there is no opportunity for the patient to be heard. Similarly, while boards and facilities can make decisions about conditions of the patients' detention and other aspects of their liberty, the procedures they follow are opaque and their decisions are not subject to review.

[98] Alberta has suggested that some oversight might lie in other agencies such as the Alberta Ombudsman. Requiring an involuntary patient to seek external remedies is "legally inadequate and practically unworkable. It would be prohibitively costly, very slow, seriously inconvenient and almost certainly ineffective": *PS* at para 119. I will therefore focus my procedural fairness analysis on the review panel process.

[99] The context in which review panel hearings take place is unique in two significant respects. First, that the parties ought not to be not truly adverse in interest: psychiatrists, physicians and other institutional participants should be acting on their view of the patient's best interests. That said, the section 7 analysis cannot rest on the discretion and judgment of state actors: *Appulonappa* at para 74.

[100] The second significant contextual factor is that the individuals whose interests are at stake are uniquely vulnerable. Patients seeking review of a certificate have been found by two medical professionals to suffer from a "substantial disorder" that "grossly impairs" their judgment, behaviour, capacity to recognize reality, or ability to meet the ordinary demands of life: s 1(g). Their vulnerability is exacerbated by their detention: it is not clear whether all patients have consistent access to telephones or informational resources such as the internet. Some patients might be subject to physical restraint within the facility. Some might be voluntarily or involuntarily taking medications that further impair their abilities.

[101] Some patients might feel powerless, as explained in *Abbass v The Western Health Care Corporation*, 2017 NLCA 24 at para 52, 409 DLR (4th) 670:

> The reality is that if you're involuntarily confined, you are viewed differently; you are seen as less credible. That is not how it should be but that is how it is. As well, there is an intimidation factor. If the police can take you away once and the physicians confine you, maybe they will do so again.

[102] Formal patients are subject to the control of the *Mental Health Act* precisely because the state has decided that their mental disorder renders them incapable of acting in their own best interest. In this context, fairness cannot depend on the patient's ability to make decisions in his own best interests, or to access resources, or to advocate for himself. Having imposed restrictions on the patient's liberty and triggered a hearing process, the state is "under an obligation to do whatever is required to ensure that the hearing be fair": *New Brunswick (Minister of Health & Community Services) v G (J)* at para 2.

[103] The *Act* falls short of ensuring a fair hearing in the following ways.

i. Initiating the review process

[104] Upon initial or continued detention, the board of the facility shall inform the patient of the reasons for the admission/renewal certificate and the patient's right to apply to a review panel for cancellation. The board must also provide a statement setting out the reason for the certificates and the period of detention, along with the authority for and period of the patient's detention; the function of review panels; the name and address of the panel's chair, and the right to apply to the review panel for cancellation of the certificate. In addition, the board must make a reasonable effort to provide the same information to the patient's guardian or other surrogate, if any, and, unless the patient objects, his nearest relative: s 14(1). The board "shall do any other things [it] considers expedient to facilitate the submission of an application": s 14(3).

[105] An application for review of an admission or renewal certificate may be brought by a patient or a surrogate at any time: s 38(1). Subsequent applications may be rejected without consideration if the chair of the review panel reasonably believes that they are frivolous, vexatious, not made in good faith, or if there has been no significant change in circumstances since the previous hearing: s 38(4). The procedure by which these latter findings are made is not clear.

[106] Certificates are automatically reviewed after six months of detention if there has been no application for review and if no application has been withdrawn or cancelled: s 39(1).

[107] The *Act* ensures a hearing every six months. More frequent hearings will only take place if the patient is capable of filing an application, or has a surrogate who can do so. The risk of detention for an unnecessary duration is obvious.

ii. Failure to ensure the patient knows the case she must meet

[108] "[A] fair hearing requires that the affected person be informed of the case against him or her". If the affected person does not know some or all of the information put against her, she "may not be in a position to contradict errors, identify omissions, challenge the credibility of [sources of information] or refute false allegations." This undermines the ability of the tribunal to make a fair and fully informed decision: *Charkaoui* at paras 53-54.

[109] The *Act* makes no specific provision for providing information to a patient in preparation for a hearing. Below, Alberta submitted that patients can always access their own medical records under the *Health Information Act*. The trial judge found that procedure was insufficient at paras 286-287:

> 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.
>
> 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. … [A]s it stands, the gap in the *MHA* legislation makes the review panel procedures in violation of s. 7.

[110] I agree. The *Act* falls sort of ensuring procedural fairness because it does not ensure that a patient or surrogate will know the case she must meet before the review panel. I would add that for the disclosure to be meaningful, it must be presented in a way that is comprehensible to the recipient.

[111] Alberta submits on appeal that the courts can direct the state to comply with *Charter* requirements even where the governing statute is silent. For example, Alberta submits, many procedural rights have been entrenched in criminal law by the courts' direction, not by provisions in the *Criminal Code*.

[112] Such an approach is not suitable in the current context.

[113] In most other contexts, a decision-maker can expect each party to protect its own interests, for example, by seeking initial, continuing or expanded disclosure. On rare occasions, criminal courts deal with individuals who cannot be expected to navigate the process unassisted. In such cases, courts have the jurisdiction to intervene and to ensure the individual's interests are protected, for example through disclosure orders or the appointment of counsel or amicus curiae.

[114] In the *Mental Health Act* context, one cannot rely on any patient's ability to initiate or to navigate the disclosure process, or to understand disclosure once it is received. It is therefore inadequate to leave disclosure to the case-by-case discretion of the presiding review panel. Further, since section 11 of the *Administrative Procedures and Jurisdiction Act*, RSA 2000, c A-3, purports to deny review panels *Charter* jurisdiction, there may be no recourse when failures of fairness rise to the level of *Charter* breaches. This concern, along with the absence of pre-hearing procedures to ensure *Charter* compliance, form the essence of what the trial judge called a lack of administrative oversight.

iii. Answering the case

[115] A fair hearing necessarily includes an opportunity for each party to present its case effectively. Some information that should be before a review panel may be available only to the patient. If that information cannot be effectively presented to the panel, the integrity of the result is threatened: *New Brunswick v G (J)* at para 73; *R v Walker*, 2019 ONCA 765 at para 62. Even a judge, equipped with *Charter* jurisdiction, cannot always compensate for "the lack of informed scrutiny, challenge and counter-evidence that a person familiar with the case could bring. Such scrutiny is the whole point of the principle that a person whose liberty is in jeopardy must know the case to meet" and must be able to present his own case in a meaningful way: *Charkaoui* at para 64.

[116] In a variety of contexts, courts have recognized that a fair trial is sometimes not possible absent representation. As a *Charter* remedy, courts may order the provision of counsel or amicus curiae if the circumstances require. Relevant circumstances include the seriousness of the interests at stake, the complexity of the proceedings, and the capacities of the affected participant: *New Brunswick v G (J)* at paras 37, 74-75.

[117] In *New Brunswick v G (J)* at paras 80, 83, the Supreme Court concluded that a parent required representation at a hearing that would determine whether the state would retain custody of her children:

> In proceedings as serious and complex as these, an unrepresented parent will ordinarily need to possess superior intelligence or education, communication skills, composure, and familiarity with the legal system in order to effectively present his or her case. ...
>
> ...

> ... Competence is a necessary but not sufficient condition for determining whether an unrepresented parent will receive a fair custody hearing. Although competent, the parent must be able to participate meaningfully at the hearing, which goes beyond mere ability to understand the case and communicate.

[118] In the child welfare context, the seriousness and complexity of the hearing and the capacity of the parent will vary from case to case; therefore, any decision to appoint counsel must be made on a case-by-case basis: *New Brunswick v G (J)* at paras 86, 88.

[119] As discussed above, at a review panel hearing, the liberty stakes are high, and the patient's capacities are "grossly impaired" by definition. To exacerbate matters, presenting his case to a review panel is likely to place the patient in "a foreign environment, and under significant emotional strain": *New Brunswick v G (J)* at para 79. It is foreseeable that a patient will not be able to present his case effectively.

[120] In litigation, complexity often arises from courtroom procedures such as adducing evidence, cross-examining witnesses, making objections and presenting defences: *New Brunswick v G (J)* at para 79. Procedures before a review panel are likely to be somewhat more straightforward, but added complexity is likely to arise from the specialized medical content.

[121] The *Act* provides a right to representation, but it does not ensure representation. The difference is significant. In this context, the obligation to ensure a fair hearing includes the obligation to ensure that someone is present to advocate for the patient. Because the review proceedings are not likely to be legally complex, the advocate need not be a lawyer, though that could be one solution. Other solutions might include a suitably equipped guardian or other surrogate, or a person with sufficient expertise to make sense of the specialized subject matter and terminology. If the patient cannot make decisions in her own best interests, it may be necessary for an advocate to be present over her objections: *Walker* at para 63.

[122] Alberta suggests that the *Act* already provides for someone to advocate for the patient: the Patient Advocate, as established by s 45(1) of the *Act* and the *Mental Health Patient Advocate Regulation*, AR 148/2004. Ironically, the Patient Advocate lacks the power to advocate for the patient at a review panel hearing. The Patient Advocate has some systemic investigative and reporting powers. In individual cases, the Patient Advocate is empowered to investigate and to provide information about rights and procedures – but only upon receipt of a complaint. As explained above, reliance on an involuntary patient's self-help is insufficient as a guarantee of procedural justice.

[123] In summary, the state is required to ensure that patients can have their cases reviewed in accordance with the principles of fundamental justice. In context, this means that the state must ensure that the patient's case can be fairly made even when the patient lacks the capacity to make it, or to take steps to know the case against him, or to initiate a review on his own. The state must take responsibility for ensuring: that the patient, or a surrogate or advocate, is informed of review

procedures and rights on review; that disclosure reaches the patient, or a surrogate or advocate, in a form that can be adequately understood; and that the patient's case can be adequately presented, whether by the patient, a surrogate or an advocate. Absent these assurances, the *Mental Health Act* permits denial of liberty without fundamental justice and thereby violates section 7.

G. Section 10 rights

[124] The trial judge found that the *Act* violates sections 10(a) and (b) of the *Charter*.

[125] Section 10(a) provides the right, arising on arrest or detention, "to be informed promptly of the reasons therefor". The trial judge explained how section10(a) was breached in JH's case, but she did not explain how she reached the same conclusion regarding the *Act* itself.

[126] Alberta submits that the legislated procedures comply with section 10(a). Upon initial detention, the board must make a reasonable effort to inform the patient or a surrogate "in simple language" of the reasons the admission certificate was issued, and must give the patient or surrogate a written statement of the reasons, again "in simple language": s 14(l). I agree that these provisions meet the requirements of section 10(a); the trial judge erred in finding otherwise.

[127] Section 10(b) of the *Charter* provides the right on arrest or detention "to retain and instruct counsel without delay and to be informed of that right". The *Act* makes no provision for the implementation of section 10(b). The state is bound to ensure that a detainee is afforded these rights, the importance of which is heightened if there is no other guarantee of representation or advocacy. In the present context, it is especially important that the information reach the patient or surrogate in a form capable of being understood.

[128] The trial judge concluded that the *Act* violates section 10(b) by failing to provide for implementation of the right. Alberta disputes this conclusion. It agrees that the state must implement the section 10(b) right but submits that legislating its implementation is unnecessary. It argues from analogy to criminal procedures: police are obligated to implement section 10(b) rights when a person is detained in the criminal context, but those obligations arise directly from the *Charter* and are not found in the *Criminal Code.*

[129] Alberta's analogy is accurate in itself: the state's obligations under s 10(b) arise from the *Charter* and exist independently of legislation. However, the analogy is insufficient here for the reasons given above regarding procedural fairness. I find no error in the trial judge's conclusion that, in this unique context, implementation of the section 10(b) right must be legislated.

[130] I agree with Alberta that this Court should go no further in prescribing the manner of implementation, which was not the focus of evidence or argument below. As the Legal Aid Society of Alberta points out, there may be sound reasons why implementation of section 10(b) rights in the mental health context needs to differ from other, more prevalent contexts.

H. Arbitrary detention

[131] Based on the factors discussed in her section 7 analysis, the trial judge found that the *Act* violates section 9 of the *Charter*.

[132] In *Swain* at 1012, detention was found to be arbitrary where it was automatic and all-or-nothing:

> The detention order is automatic, without any rational standard for determining which individual insanity acquittees should be detained and which should be released. . . . The duty of the trial judge to detain is unqualified by any standards whatsoever. I cannot imagine a detention being ordered on a more arbitrary basis. As La Forest J. stated in *R v Lyons*, *supra*, at p. 348, adopting the submission of the Crown in finding that the Crown's discretion with respect to dangerous offender applications was not "arbitrary" and did not infringe s. 9:
>
> > ... it is the absence of discretion which would, in many cases, render arbitrary the law's application.

[133] In *Swain*, some initial criteria needed to be met before the impugned provision could operate, but the mandatory detention order was arbitrary in the way that it operated. The automatic detention provision mandated detention "based on no criteria or standards" and without consideration of the acquittee's present condition or needs. Therefore, it violated both sections 7 and 9 of the *Charter*.

[134] For reasons given above, the *Act*'s provisions enabling detention create the potential for arbitrary detention. The trial judge was correct in so finding.

I. Remedy

[135] Alberta argues that a declaration of invalidity is not an appropriate or necessary remedy because requirements can be imposed on state actors through decisions of the courts and need not be spelled out in legislation. I have explained above why this approach is inadequate in these unique circumstances, where the state intrudes heavily on the liberty of individuals with grossly impaired functioning.

[136] Reading in operational requirements would not be appropriate here. There is more than one means of meeting constitutional minimum standards; the choice of means is for the Legislature, not the courts: *Shachter v Canada*, [1992] 2 SCR 679, [1992] SCJ No 68 (QL) at paras 56, 74; *Demers* at paras 57-58. A declaration of invalidity is the appropriate remedy to ensure that the rights of involuntary patients are protected while leaving the government with the flexibility to fashion a response: *Mahe v Alberta*, [1990] 1 SCR 342 at 394, 68 DLR (4th) 69, [1990] SCJ No 19 (QL) at para 96.

VII. Result

[137] The appeal is dismissed, and the declarations of invalidity are upheld.

[138] At present, the effect of the declarations of invalidity is suspended until September 30, 2020. I understand that an application to extend the period of suspension has been provisionally scheduled and will be heard in due course.

Appeal heard on February 27, 2020

Reasons filed at Calgary, Alberta
this 11th day of September, 2020

Antonio, J.A.

I concur:

Authorized to sign for: Greckol, J.A.

I concur:

Authorized to sign for: Hughes, J.A.

REGISTRAR
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