September 18, 2017

Is Alberta's *Mental Health Act* Sufficiently Protecting Patients?

By: Lorian Hardcastle

Case Commented On: *JH v Alberta Health Services*, 2017 ABQB 477 (CanLII)

At first blush, *JH v Alberta Health Services* does not seem to warrant much attention. It is an oral judgement relating to a procedural matter—whether a plaintiff can proceed with a moot claim. However, this case highlights several important issues in mental health law and its resolution could result in significant reforms to Alberta's *Mental Health Act*, RSA 2000, c-13. The plaintiff, who was involuntarily detained and treated at Foothills Hospital for nine months, disputed his detention and challenged the constitutionality of several provisions of the *Mental Health Act*. He was diagnosed with a neuro-cognitive disorder and had also struggled with alcoholism and the physical injuries resulting from a car accident.

The first decision in this case, *JH v Alberta Health Services*, 2015 ABQB 316 (CanLII), addressed JH's detention. The *Mental Health Act* has several requirements for involuntary admission, including the presence of a "mental disorder", which is defined as a "substantial disorder of thought, mood, perception, orientation or memory that grossly impairs (i) judgement (ii) behaviour, (iii) capacity to recognise reality, or (iv) ability to meet the ordinary demands of life" (ss 8(1)(a) and 1(1)(g)). In finding that JH did not meet this test, Justice Eidsvik cited recent medical tests categorizing his impairment as "mild". She also noted that the treating doctor's evidence "consisted mainly of bald conclusions without much explanation about how he arrived at them or how he could reconcile serious differences in opinion [with other health professionals] on J.H.'s capacities" (para 25).

In addition to the presence of a "mental disorder", an additional requirement for involuntary admission is that the patient is "likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment" (s 8(1)(b)). Justice Eidsvik found that the risks created by JH's neuro-cognitive disorder were not "to the level that J.H.'s right to self-determination and freedom should be curtailed involuntarily" (para 28). Although Canadian provinces use a range of language to describe the level of harm required for involuntary admission, there has been a shift in several provinces towards less onerous requirements. For example, Alberta's standard for involuntary admission was once the onerous "likely to present a danger to the person or others", before the more lenient "or to suffer substantial mental or physical deterioration or serious physical impairment" was added to the law.

There are policy arguments in support of a less onerous standard, such as not wanting to wait until a patient deteriorates to the point of dangerousness before medical intervention. However, this case highlights how a less onerous standard gives doctors too much discretion to detain patients. One wonders how many other patients with "mild" impairments are currently detained

in Alberta hospitals. Compounding this concern is the fact that those who review involuntary admissions decisions can be deferential to the point of abdicating their responsibilities. Before proceeding to the Court of Queen's Bench, JH's involuntary admission was considered by a Review Panel. Justice Eidsvik criticized the Panel's reasons on the basis that they "basically say that they agreed with the Hospital" and "were wholly inadequate in that they did not discuss the factual basis upon which the criteria [for involuntary admission] have been met—they simply recited the criteria without more" (para 5).

Similar to Review Panels, Justice Eidsvik noted that "[n]ormally the Courts are very deferential to treating physicians" (para 25). If both Review Panels and Courts are deferring to doctors, who then is scrutinizing these decisions to detain patients—often for long periods of time? Justice Eidsvik cited evidence that between April 1, 2015 and March 31, 2016, there were 326 patients involuntarily admitted for more than six months and the average stay of these long term-patients was 476 days (para 24). Interestingly, in *PS v Ontario*, 2014 ONCA 900 (CanLII), the Court stated that the plaintiff's detention in a psychiatric hospital because he posed a risk to the public brought "his involuntary committal into the category of 'close or analogous to criminal proceedings', **where greater judicial vigilance is required**" (para 80, emphasis added).

Another issue highlighted by this case is the lack of community support for individuals with mental illnesses. JH was cooperative with treatment, was working diligently with a social worker, and his previous employer said he could have his job back upon his discharge from hospital. His treating physician even said that he would discharge JH "if community supports were in place" (para 10). It is concerning that patients are involuntarily hospitalized merely because there are insufficient community supports. Several cases raise constitutional arguments where the liberty of individuals with mental illnesses is jeopardized due to resource constraints. In *PS v Ontario*, the Court of Appeal found 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" (para 113). In *R v Conception*, 2014 SCC 60 (CanLII), a case relating to treatment orders in the criminal mental health context, the majority acknowledged that "bed shortages in mental health hospitals thus create an ongoing tension between medical resource constraints and the accused's medical, legal and liberty interests" (para 46).

Although the issue of JH's detention was resolved in 2015, the 2017 decision addressed his standing to proceed with his *Charter* claim. Justice Eidsvik agreed with the defendants that JH's discharge rendered the case moot, but allowed it to continue. She found that "considering the temporary nature of most certificates [of involuntary admission] and their short duration, a live controversy is not likely to be a common occurrence" (para 23). She also found that the "issues raised here are of public importance and their determination is in the public interest" (para 27). It is important that other judges follow Justice Eidsvik's lead, as many patients who are involuntarily detained are not in a position to pursue litigation. Furthermore, mental health statutes in most provinces have not been the subject of constitutional challenges, despite their significant impact on the right to liberty and the vulnerability of the populations to which they are applied.

Although JH challenges several provisions of Alberta's law, one particularly interesting issue is the constitutionality of forced treatment following involuntary admission. There is significant variation in how Canadian provinces address this issue. At one end of the spectrum is British Columbia, whose *Mental Health Act*, RSBC 1996, c 288, permits treatment without consent,

regardless of whether a patient has capacity. Specifically, if a patient is detained, "treatment authorized by the director [of a mental health facility] is deemed to be given with the consent of the patient" (s 31). The patient's only recourse is to request a second medical opinion on the appropriateness of the treatment, which the director must "consider". This approach can be criticized for its disregard of autonomy, its paternalism, and the fact that it may discourage patients from seeing psychiatric help. This provision is the subject of an ongoing constitutional challenge filed by two patients who were forced to receive medication and electroconvulsive therapy. The fact that this challenge to BC's law did not occur until 2016 underscores the importance of Justice Eidsvik's approach to standing.

At the other end of the spectrum from BC is Ontario. If an incapable patient has a prior capable wish, that wish must be followed. In *Fleming v Reid*, [1991] OJ No 1083 (QL), 1991 CanLII 2728, the Ontario Court of Appeal upheld the right of two incapable schizophrenic patients to refuse neuroleptic drugs, as both had previously expressed a refusal while they were capable. According to Justice Robbins,

> The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. …These traditional common law principles extend to mentally competent patients in psychiatric facilities. They, like competent adults generally, are entitled to control the course of their medical treatment. Their right of self-determination is not forfeited when they enter a psychiatric facility.

If an Ontario patient has no prior capable wish, then the patient's substitute decision-maker (SDM) will give or refuse consent in accordance with the patient's best interest. Ontario's best interest test, which is set out in the *Health Care Consent Act, 1996*, SO 1996, c 2, sch A, s 21(2), .blends non-medical considerations (i.e. the values and beliefs of the incapable person) with medical considerations (i.e. whether the treatment is likely to improve the patient's condition, whether the benefit of the treatment outweighs the risk, and whether a less restrictive or intrusive treatment would be as beneficial). Critics argue that Ontario's approach results in the long-term warehousing of patients without treatment, which may infringe liberty more than compelling treatment for a short period of time in order to stabilize the patient's condition. Furthermore, there are concerns about determining when a prior capable wish is applicable. For example, should a decades-old refusal to take psychiatric medication be applied to new drugs with greater efficacy and significantly fewer side effects?

In Alberta, if an involuntary patient is not competent, then a SDM is called upon to provide consent. However, unlike Ontario, where SDMs are bound by prior capable wishes and non-medical considerations such as the patient's beliefs and values, Albertan SDMs are only permitted to consider the medical implications of treatment for involuntary patients: whether the patient's condition is likely to improve with treatment, whether the patient's condition is likely to deteriorate without treatment, whether the benefit of treatment outweighs the risk, and whether the treatment is the least restrictive and intrusive with the same anticipated benefits and risks (s 28(4)). Also unlike Ontario, the refusal of a competent patient can be overridden. If a SDM or competent patient refuses consent, a physician can seek an order to compel treatment from a Review Panel, who will then consider the above-mentioned list of medical considerations (s 29). Alberta's approach, which is arguably closer to that of BC than Ontario, is certainly vulnerable to constitutional challenge.

This post may be cited as: Lorian Hardcastle "Is Alberta's *Mental Health Act* Sufficiently Protecting Patients?" (18 September, 2017), online: ABlawg, http://ablawg.ca/wp-content/uploads/2017/09/Blog_LH_Mental_Health.pdf

To subscribe to ABlawg by email or RSS feed, please go to **http://ablawg.ca**

Follow us on Twitter **@ABlawg**