

ALBERTA'S MENTAL HEALTH REVIEW PANELS: ACCOUNTABLE, TRANSPARENT ADJUDICATION?

ERIN NELSON*

This article examines issues of accountability and transparency in Alberta's Mental Health Review Panel process. A person who is involuntarily admitted to a mental health facility, or who is subject to a community treatment order (CTO), can appeal to the Review Panel to have their admission certificates or CTO cancelled. This process is intended to provide access to a decision-maker to review decisions that affect the liberty of those living with mental illness. Unfortunately, Alberta's Mental Health Review Panels are not transparent or accountable decision-makers.

The article begins with a brief outline explaining the delivery of mental health care in Canada, followed by a description of Canadian law on CTOs. The article then examines Alberta's Mental Health Review Panels — first in terms of their role in relation to CTOs, followed by concerns about accountability and transparency in the Review Panel process. Finally, the article looks at legal and system reforms that will enhance the accountability of the process.

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I. INTRODUCTION

Mental health law navigates a complex terrain, comprising three overlapping but distinct functions: mental health care and treatment, public safety, and the intersection of mental health and criminal law. In all of these contexts, the law seeks to achieve a balance between the needs and interests of persons with mental illness and the needs and interests of society. It must also respect individual rights while ensuring patient welfare.

Mental health laws can be heavy handed, even coercive. It is therefore critical that safeguards be built into these laws to ensure protection for the rights of those who suffer from mental illness. One such safeguard is access to a mental health tribunal or review panel,

* Professor and Katz Chair in Health Law and Policy, Faculty of Law, University of Alberta. I owe a huge debt of gratitude to the members and former members of Alberta's Mental Health Review Panels who agreed to be interviewed for this project. I cannot overstate the value of their willingness to make the time to speak with me about their work on the Review Panels. I would also like to thank Samantha Kampman for research assistance, and the anonymous reviewers for their helpful suggestions. I am grateful to the Faculty of Law, University of Alberta, for financial support.

which provides a route for those subject to restrictions on their liberty to appeal to a decision-maker other than their psychiatrist. A person who is involuntarily detained in a mental health facility, or who is subject to a community treatment order (CTO), can appeal to the Review Panel to have their admission certificates or CTO cancelled. These are important rights. But, in Alberta, we have no way to know whether these rights are being properly respected. We know little about how these administrative tribunals approach their work or about what kind of reasoning they use in concluding that a patient should remain subject to a CTO or remain in hospital.

My original aim for this article was to explore how Alberta's Mental Health Review Panels approach decision-making around CTOs, given the mixed evidence on whether CTOs are effective in treating mental illness. The effects of Review Panel decisions can be profound — as significant, for example, as a court deciding a criminal matter that has the potential to limit a person's liberty. As a result, their work is a key part of mental health law and policy and is important for lawyers, policy-makers, and the public to understand.

A typical place to begin analyzing reasoning around the appropriate use of CTOs in Alberta would be with the reasoning of the Panels themselves. Decisions of an equivalent tribunal (Ontario's Consent and Capacity Board) are available online, but that is not the case in Alberta. Upon discovering this, I sought access to the decisions from Alberta Health (the Ministry responsible for the *Mental Health Act*) and explained that I was interested in the reasoning used by the Review Panels when deciding whether to uphold or cancel a CTO. I asked whether it would be possible to have access to redacted reasons to do this work. I was informed that the decisions are not filed in a central repository or provided to Alberta Health and that the only individuals with copies of the reasons for decision are Review Panel chairs or vice-chairs. Because it would likely be very burdensome for the Panel chairs to review and redact their reasons in order to grant access to them, Alberta Health suggested that I speak to individual Panel members to gain a sense of the approach they use in making decisions related to CTOs.¹

I was able to meet with three panel members, including two chairs and another long-time panel member (non-lawyer) to discuss their approach to, and perceptions of, the Review Panel process. I asked each of them about whether, in their view, the system is accessible, accountable, and transparent. I asked for their views as to whether the decisions of Review Panels should be publicly available. I also asked them about decision-making respecting CTOs, including questions about the objectives of the CTO provisions, the factors they consider in making decisions about upholding or cancelling CTOs, and the frequency with which CTOs are cancelled. Although I was only able to speak with a small number of participants, I heard a wide range of views, at least on some issues. I am deeply grateful to

¹ The other possibility suggested by Alberta Health was to apply for research ethics approval to have the decisions disclosed for research purposes. If the decisions were to be disclosed on this basis, there would be no need to remove identifying information. However, in my own assessment, my research purpose would probably not justify the release of identifying health information and so would not be likely to gain ethics approval. Even if I could obtain ethics approval, disclosure remains at the discretion of the Review Panel as custodian of the health information. Instead of seeking access to unredacted decisions, I decided to take up the suggestion to interview panel members to gain a sense of their perceptions of the process and to understand the reasoning they use in reaching decisions. I obtained approval from the University of Alberta Research Ethics Board (REB) 1 to conduct this study, entitled "Evaluating Community Treatment Orders in Alberta" (Study ID Pro00051606).

the Review Panel members who agreed to speak with me to share their perceptions about the process and explain their approach to decision-making.

This article begins with a brief outline explaining the delivery of mental health care in Canada, followed by a description of Canadian law on CTOs. With that background out of the way, the focus shifts to Alberta's Mental Health Review Panels — first in terms of their role in relation to CTOs, and then specifically with respect to my concerns about accountability and transparency in the Review Panel process. The article concludes with a look at legal and system reforms that will enhance the accountability of the process.

II. A BRIEF LOOK AT MENTAL HEALTH CARE IN CANADA

The purpose of this article is to examine issues of accountability and transparency in Alberta's Mental Health Review Panel process. In order to provide some context for that discussion, it is useful to briefly describe the evolution of mental health care in Canada.

Health and health care are generally considered to be matters within the jurisdiction of the provinces and territories.² As a result, Canada does not have a unified, homogenous mental health care system. Instead, there are multiple, disparate systems across the country. Bearing in mind that variations exist, the aim of this section is to provide a general overview of the evolution of approaches to mental health care in Canada.

Canadian approaches to delivering mental health services have evolved over time to reflect changes in medical and scientific thinking around mental illness.³ Historically, the focus was on protecting society from those with mental illness.⁴ This aim was initially achieved by isolating those with mental illness and later by providing medical treatment with a view to reducing the likelihood of harm to others. The moral and humanitarian approach to mental health care pioneered in Europe was adopted in Canada in the late 19th century with the introduction of asylums as residential facilities for those living with mental illness.⁵ Over the first half of the 20th century, asylums and mental health hospitals proliferated. Though the aim was to provide treatment as well as a residential facility, most mental health facilities quickly became extremely overcrowded to the extent that therapeutic aims could not be sustained.⁶ Instead, these facilities were primarily used as housing for those with mental illness.⁷

² See e.g. Alana Klein, "Jurisdiction in Canadian Health Law" in Joanna N Erdman, Vanessa Gruben & Erin Nelson, eds, *Canadian Health Law and Policy*, 5th ed (Toronto: LexisNexis Canada, 2017) 29 at 30–33.

³ Many of these comments about treatment are also true of mental disability more broadly. The focus in this article is on mental health law and, therefore, on mental illness, rather than the more inclusive term "mental disability." Jennifer A Chandler, "Mental Health and Disability in Canadian Law: Evolving Concepts, Concerns and Responses" in Jennifer A Chandler & Colleen M Flood, eds, *Law and Mind: Mental Health Law and Policy in Canada* (Toronto: LexisNexis Canada, 2016) 1 at 3–5.

⁴ JS Tyhurst et al, *More for the Mind: A Study of Psychiatric Services in Canada* (Toronto: Canadian Mental Health Association, 1963) at 2.

⁵ *Ibid.*

⁶ Estimates suggest that in 1950, there were 66,000 patients in psychiatric hospitals and that this patient group "outnumbered patients in nonpsychiatric hospitals from all other causes." Cyril Greenland, Jack D Griffin & Brian F Hoffman, "Psychiatry in Canada from 1951 to 2001" in Quentin Rae-Grant, ed, *Psychiatry in Canada: 50 Years (1951 – 2001)* (Ottawa: Canadian Psychiatric Association, 2001) 1 at 2.

⁷ *Ibid.*

In the 1960s, Canadian jurisdictions, like many others, began (or in some cases continued) the process of deinstitutionalizing mental health care due, in part, to concerns about the care and treatment of those living with mental illness in mental health hospitals.⁸ The premise of the move toward deinstitutionalization was that mental illness should be treated more like physical illness was, in general hospitals and in the community, in keeping with more modern views of mental illness and of individual rights.⁹ The focus was on creating in-patient psychiatric units within general hospitals as well as on expanding the kinds of mental health care and supports available in the community.¹⁰ More recently, the focus has been on integrating mental health services and supports in the community.

The movement of mental health services out of psychiatric hospitals and into the community has not proceeded in a smooth or straightforward way in any region of the country. Early in the process, many in-patient psychiatric beds across Canada were closed (roughly 70 percent of the beds available nationally were closed over a 15-year period), while far fewer beds were added to psychiatric units in general hospitals.¹¹ Most of the patients who were admitted to general hospitals for psychiatric care were those with less severe mental illness; the most severely ill often remained in psychiatric hospitals that now had fewer resources with which to provide care.¹² To help meet the demand for support and health care services for those now living in the community with mental illness, provincial governments began to fund community mental health programs. These programs provided case management services, as well as assistance with social support and housing.¹³

In the 1980s, two decades after deinstitutionalization began, mental health services were still being provided in a fragmentary and uncoordinated manner.¹⁴ Some patients remained in psychiatric hospitals, which were segregated from the community and from the health care system. Others received care through psychiatric units in general hospitals, and still others lived in the community where small, community-based programs attempted to piece together supports and services.¹⁵

The modern approach to mental illness and disability, as explained by advocates and experts, recognizes that the focus of mental health interventions should be “recovery” and that services should be delivered in the community.¹⁶ A recovery-oriented approach recognizes that those with mental illness can live “a satisfying, hopeful, and productive life

⁸ Tyhurst et al, *supra* note 4; Ian Hector, “Changing Funding Patterns and the Effect on Mental Health Care in Canada” in Rae-Grant, *ibid*, 59 at 60; Donald Wasylenko, “The Paradigm Shift from Institution to Community” in Rae-Grant, *ibid*, 95 at 96–97. The activities of the Canadian Mental Health Association, including the publication of *More for the Mind*, played a significant role.

⁹ Wasylenko, *ibid*; Greenland, Griffin & Hoffman, *supra* note 6 at 13.

¹⁰ Wasylenko, *ibid*.

¹¹ *Ibid*. In the 16-year period from 1965–81, nearly 50,000 beds in psychiatric hospitals were closed: see Patricia Sealy & Paul C Whitehead, “Forty Years of Deinstitutionalization of Psychiatric Services in Canada: An Empirical Assessment” (2004) 49:4 *Can J Psychiatry* 249.

¹² Wasylenko, *ibid*.

¹³ *Ibid* at 97.

¹⁴ *Ibid*. See also Canada, Senate, Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness, and Addiction Services in Canada*, 38-1 (May 2006) (Chair: Michael JL Kirby), online: <bridgingthegap.mentalhealthcommission.ca/English/document/44501/out-shadows-last-transforming-mental-health-mental-illness-and-addiction-services-can> [*Out of the Shadows at Last*].

¹⁵ Wasylenko, *supra* note 8 at 97.

¹⁶ *Out of the Shadows at Last*, *supra* note 14.

even with limitations caused by the illness.”¹⁷ And, instead of isolating and institutionalizing those with mental illness, a recovery-based approach demands that we should strive to integrate them into society, to provide treatment within the community where possible and to support families living with and caring for those with mental illness and disability just as we do those whose families include persons with physical illness and disability. Unfortunately, we are still some distance from achieving that aim.¹⁸

One of the real challenges in mental health care over the years has been inadequate funding. Colleen Flood and Bryan Thomas point out that only 7.2 percent of total health care spending in Canada is allocated to mental health care.¹⁹ As Roy Romanow noted in his report on the future of healthcare in Canada, the shift from treatment in institutional settings to treatment in the community was not “accompanied by sufficient resources.”²⁰ It is a challenge to provide adequate care and support without also providing sufficient resources.

As is clear from this brief description, there is much work to be done if our system is to properly support and care for Canadians who suffer from mental illness. An important lesson from this history is that proposed solutions do not always align well with the problems that require solving.

III. MENTAL HEALTH LAW: COMMUNITY TREATMENT ORDERS

Before turning to a discussion of Alberta’s Review Panels and CTOs, it is necessary to provide some background about what a CTO is and how, in general terms, the CTO provisions adopted in various Canadian jurisdictions work.

Although treatment methods and delivery of mental health services have evolved to reflect society’s changing understanding of mental illness, Canada’s mental health laws remain largely focused on involuntary treatment for mental illness, often within an institutional setting.²¹ This has remained true even with the recognition that only a small number of Canadians suffer from the types of serious mental illnesses that might require involuntary admission and treatment.²²

¹⁷ *Ibid* at 42.

¹⁸ A study done in Toronto in the early 1980s followed 770 patients who had been discharged from psychiatric units. It showed that two years post-discharge, only 25 percent (193) of participants were still living in the community (in other words, had not been readmitted to hospital) or were “doing well.” See Donald Wasylenki et al, “Psychiatric Aftercare in a Metropolitan Setting” (1985) 30 *Can J Psychiatry* 329.

¹⁹ Colleen M Flood & Bryan Thomas, “Fragmented Law & Fragmented Lives: Canada’s Mental Health Care System” in Chandler & Flood, *supra* note 3, 29 at 31.

²⁰ Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Roy J Romanow) (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 179.

²¹ H Archibald Kaiser, “Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State” (2009) 17 *Health LJ* 139 at 145. It bears noting that this is not true of all Canadian jurisdictions. Ontario’s mental health law addresses involuntary detention, but treatment, particularly consent to treatment, is addressed in the *Health Care Consent Act 1996*, SO 1996, c 2.

²² Peter J Carver, “Mental Health Law in Canada” in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law & Policy*, 4th ed (Markham: LexisNexis Canada, 2011) 341 at 348–50.

An important reform to several provincial mental health statutes since the move toward deinstitutionalization has been to permit coercive treatment within the community.²³ Though the science behind treatment has improved since the early days of psychiatric treatment using unspecific and sometimes dangerous methods, it can be a challenge for patients to comply with treatment.²⁴ One reason is that psychoactive medications for conditions such as schizophrenia and bipolar disorder can have serious side effects, including movement disorders, weight gain, heightened risk of diabetes, and sexual dysfunction, to name just a few.²⁵ For many patients, the side effects of these medications can make treatment adherence difficult, particularly when combined with the individual's lack of insight into the need for treatment that is a feature of some mental illnesses.²⁶

For persons with mental illness who stop taking their medications, it can become difficult to manage in the community. Alone or in combination with other factors, including lack of access to services in the community, this can often lead to the need for readmission to hospital.²⁷ In view of concerns related to the “revolving door” of admission — discharge, treatment discontinuation, readmission — it is no surprise to see policy-makers seeking solutions that permit longer-term success in adhering to treatment while living in the community. One such approach is to permit coercive treatment in the community in the form of a CTO, a step that several Canadian jurisdictions have taken.²⁸ As the label implies, a CTO is an order for mental health treatment in the community. Such orders take slightly distinct forms in different jurisdictions, but what all have in common is that they confer the power on mental health professionals to impose some form of treatment in the outpatient setting, provided that legislative criteria are met.²⁹

The rationale typically offered to justify the addition of CTO provisions to mental health legislation is their potential to help break the cycle of admission to hospital, discharge, and

²³ Kaiser, *supra* note 21 at 144–45.

²⁴ Julia Kim et al., “Insight and Medication Adherence in Schizophrenia: An Analysis of the CATIE Trial” (2020) 168 *Neuropharmacology* 107634.

²⁵ See e.g. Christine Rummel-Kluge et al., “Head-to-Head Comparison of Metabolic Side Effects of Second Generation Antipsychotics in the Treatment of Schizophrenia: A Systematic Review and Meta-Analysis” (2010) 123:2/3 *Schizophrenia Research* 225; S Leucht et al., “Efficacy and Extrapyramidal Side-Effects of the New Antipsychotics Olanzapine, Quetiapine, Risperidone, and Sertindole Compared to Conventional Antipsychotics and Placebo. A Meta-analysis of Randomized Controlled Trials” (1999) 35:1 *Schizophrenia Research* 51; Stefan Leucht et al., “Comparative Efficacy and Tolerability of 15 Antipsychotic Drugs in Schizophrenia: A Multiple-Treatments Meta-Analysis” (2013) 382 *Lancet* 951.

²⁶ See e.g. Donald C Goff, Michele Hill & Oliver Freudenreich, “Strategies for Improving Treatment Adherence in Schizophrenia and Schizoaffective Disorder” (2010) 71:Suppl 2 *J Clinical Psychiatry* 20; E Barkhof et al., “Interventions to Improve Adherence to Antipsychotic Medication in Patients with Schizophrenia — A Review of the Past Decade” (2012) 27:1 *European Psychiatry* 9.

²⁷ See e.g. Nawaf Madi, Helen Zhao & Jerry Fang Li, “Hospital Readmissions for Patients with Mental Illness in Canada” (2007) 10:2 *Healthcare Q* 30 (one-year readmission rates for patients with mental illness were 37 percent, which is approximately 10 percent higher than the rate for patients with non-mental illness); Sheng Chen, April Collins & Sean A Kidd, “Thirty-Day and 5-Year Readmissions Following First Psychiatric Hospitalization: A System-Level Study of Ontario’s Psychiatric Care” (2018) 63:6 *Can J Psychiatry* 410 (noting a 7.2 percent 30-day readmission rate and a 35.1 percent five-year readmission rate for Ontario psychiatric patients). See also Kaiser, *supra* note 21 at 145; Jennifer A Chandler, “Mental Health Law” in Erdman, Gruben & Nelson, *supra* note 2, 375 at 389; *Mental Health Act*, RSO 1990, c M.7, s 33.1(3) [*MHA* (Ont)].

²⁸ *The Mental Health Services Act*, SS 1984-85-86, c M-13.1, s 24.3 [*MHSA* (Sask)]; *MHA* (Ont), *ibid.*, s 33.1; *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s 47 [*IPTA* (NS)]; *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1, s 40 [*MHCTA* (NL)]; *Mental Health Act*, RSA 2000, c M-13, s 9.1 [*MHA* (Alta)].

²⁹ See sources cited, *ibid.* In some jurisdictions (for example, Ontario), a CTO may be issued by a psychiatrist. In Alberta, by contrast, a CTO may be issued by two qualified professionals, one of whom must be a psychiatrist. The other could be a physician or a nurse practitioner.

readmission.³⁰ These orders are also often justified as a less intrusive treatment option when compared to involuntary admission to hospital and treatment as an inpatient.³¹ Another somewhat common element is that CTO provisions are often implemented in response to a high-profile, tragic incident where a person is harmed by someone who is suffering from a mental illness and living in the community without treatment.³² The argument in favour of enabling CTOs in this context (which relies on the contentious view that persons suffering from mental illnesses are dangerous³³) is that the tragedy could have been avoided if the individual had been subject to a CTO and therefore receiving treatment for their mental illness at the time.³⁴

Like mental health laws that permit involuntary admission to hospital, CTO provisions incorporate criteria outlining when they can be used. Alberta's legislation requires that two qualified health professionals, one of whom must be a psychiatrist, determine that the person who will be subject to the CTO is suffering from a mental disorder and meets *one or more* of the following conditions:

- In the immediately preceding 3-year period, the person has been a formal patient or been in an approved hospital or detained in a custodial institution and clearly would have met the criteria for detention as a formal patient on two or more occasions totalling at least 30 days; or
- In the immediately preceding 3-year period, has been subject to a CTO; or
- Has, while living in the community, shown a pattern of recurrent or repetitive behaviour that indicates that the person is likely to harm himself or others or to suffer substantial mental or physical deterioration or serious physical impairment

³⁰ See e.g. *MHA* (Ont), *ibid*, s 33.1(3). See also Alberta Health Services MHA & CTO Provincial Team, *Community Treatment Orders (CTO) Information Sheet* (Edmonton: Alberta Health Services, 2020), online at: <www.albertahealthservices.ca/assets/info/hp/mha/if-hp-mha-cto-infosheet.pdf>.

³¹ *MHA* (Ont), *ibid*.

³² Ontario's legislation is known as "Brian's Law," named after an Ottawa radio broadcaster who was killed by Jeffrey Arenburg, who was not being treated for his schizophrenia at the time (*Thompson v Ontario (Attorney General)*, 2013 ONSC 5392 at para 2). Likewise: New York has "Kendra's Law," California has "Laura's Law": Ali Watkins, "A Horrific Crime on the Subway Led to Kendra's Law. Years Later, Has It Helped?" *The New York Times* (11 September 2018) A1, online: <www.nytimes.com/2018/09/11/nyregion/kendras-law-andrew-goldstein-subway-murder.html>; Gary Warth, "Laura's Law Still Unused, but Called Effective in Dealing with Mentally Ill in County," *The San Diego Union Tribune* (28 January 2018) online: <www.sandiegouniontribune.com/news/homelessness/sd-melauras-law-20180125-story.html>. Alberta's CTO provisions were put into place as a recommendation made by a judicial inquiry into the deaths of RCMP Officer Jim Galloway and Martin Ostopovich, a man living in the community without consistent treatment for his mental illness. Peter Carver, "Fact or Fashion? Alberta Adopts the Community Treatment Order" (2010) 19:1 Health L Rev 17 [Carver, "Fact or Fashion"].

³³ See e.g. Graham Thornicroft, "People with Severe Mental Illness as the Perpetrators and Victims of Violence: Time for a New Public Health Approach" (2020) 5:2 Lancet Public Health E72; Heather L Stuart & Julio E Arboleda-Flórez, "A Public Health Perspective on Violent Offenses Among Persons with Mental Illness" (2001) 52:5 Psychiatric Services 654; Heather Stuart, "Violence and Mental Illness: An Overview" (2003) 2:2 World Psychiatry 121.

³⁴ Of course, this argument does not address the reality that in at least some of these cases, the person who committed the crime may have been experiencing their first episode suggesting the presence of a mental illness and, if so, would not have been eligible for a CTO (Carver, "Fact or Fashion," *supra* note 32 at 19).

if he or she does not receive ongoing mental health treatment while living in the community.³⁵

The two qualified health professionals must examine the individual separately, within a 72-hour time frame, and must both be of the opinion that the person is likely to cause harm to self or others, or suffer substantial mental or physical deterioration, or serious physical impairment, if not receiving care while living in the community.³⁶ The CTO provisions also stipulate that treatment being ordered must exist and be available within the community and will be provided to the person.³⁷ The qualified health professionals must also be of the view that the person is able to comply with the treatment or care requirements set out in the CTO.³⁸ Finally, the person must be willing to consent to the CTO, unless the circumstances are such that consent is not required.³⁹

Five Canadian provinces have passed specific legislation permitting the use of CTOs in mental health treatment, and Quebec law also permits the use of CTOs based on the Court of Appeal's decision in *Institut Philippe Pinel de Montréal v. A.G.*⁴⁰ For the purposes of this article, the focus is on the common law provinces with CTO legislation; Quebec's approach will not be considered further. Although all of the Canadian statutes envision some form of compelled adherence to a treatment plan while living in the community, there are several variations among the CTO regimes. Some provinces permit a CTO to be imposed without the consent of the person subject to the order (Saskatchewan⁴¹ and Newfoundland⁴²). In contrast, Ontario and Alberta require that consent be obtained from either the person who will be subject to the CTO or from the person's substitute decision-maker (SDM).⁴³ Alberta law also provides an exception to the consent requirement in circumstances where the person has a history of failing to obtain or comply with treatment while living in the community and the treatment is needed in order to prevent "negative effects to the person, ... or harm to others."⁴⁴ A CTO can be imposed without consent in such circumstances, provided that the CTO is "reasonable in the circumstances" and less restrictive than admission as a formal patient.⁴⁵ In Nova Scotia, one of the criteria that must be met before a person can be placed on a CTO is that the person must lack the "full capacity to make treatment decisions."⁴⁶ Notably, Alberta is the only province whose CTO legislation permits a CTO to be imposed

³⁵ The criteria for the imposition of a CTO in Alberta are found in the *MHA* (Alta), *supra* note 28, s 9.1. "Qualified health professionals" include physicians and nurse practitioners, as well as other health professionals designated in the regulations (*MHA* (Alta), s 1(1)(n.1)). As noted above in note 29, in Ontario, a CTO may be imposed by a psychiatrist.

³⁶ *Ibid*, s 9.1(c).

³⁷ *Ibid*, s 9.1(d).

³⁸ *Ibid*, s 9.1(e).

³⁹ *Ibid*, s 9.1(f).

⁴⁰ [1994] RJQ 2523. The procedural details of the decision are described in Arash Nakhost, John Christopher Perry & Daniel Frank, "Assessing the Outcome of Compulsory Treatment Orders on Management of Psychiatric Patients at 2 McGill University-Associated Hospitals" (2012) 57:6 Can J Psychiatry 359 at 360. The provinces with CTO legislation are Alberta, Saskatchewan, Newfoundland and Labrador, Nova Scotia, and Ontario, see *supra* note 28.

⁴¹ Indeed, in Saskatchewan the person subject to a CTO must lack the capacity to consent to treatment. The *MHSA* (Sask), *supra* note 28, s 24.3(1)(a)(v).

⁴² *MHCTA* (NL), *supra* note 28, s 40 (nothing is said at all about consent, simply that a psychiatrist can issue a CTO when the statutory conditions are met). Consent is not a statutory condition.

⁴³ *MHA* (Alta), *supra* note 28, s 9.1(f)(i); *MHA* (Ont), *supra* note 27, s 33.1(4)(f).

⁴⁴ *MHA* (Alta), *ibid*, s 9.1(f)(ii).

⁴⁵ *Ibid*, s 9.1(f)(ii)(B).

⁴⁶ *IPTA* (NS), *supra* note 28, s 47(3)(a)(iii).

even if the individual who will be subject to it has not been previously admitted to a mental health facility as a formal (involuntary) patient.

While the label “community treatment *order*” certainly suggests that treatment is compulsory, some jurisdictions treat consent to treatment as a distinct consideration from consent to the imposition of the CTO. In Alberta, for example, the patient, or the patient’s SDM, must consent to the imposition of the CTO, except in the limited circumstances described above.⁴⁷ Even where the CTO itself is consented to, the patient’s consent is required before treatment can be administered pursuant to the CTO.⁴⁸ Whether this requirement for consent to treatment is meaningful is a matter for interpretation. If a person who is subject to a CTO refuses to comply with the treatment outlined in the CTO, typically medication, then one of the individuals identified on the order as a care provider must report the failure to the relevant health authority within 24 hours of becoming aware of it.⁴⁹ The qualified health professional responsible for supervising the CTO may then issue an apprehension order authorizing a peace officer to apprehend and convey the person to a facility for examination where he or she may face admission and detention as a formal patient.⁵⁰ In other words, although consent is required for treatment under a CTO, the consequences for refusing treatment are such that it is fair to question whether consent is genuine in these circumstances.

It is worth noting here that while not all Canadian jurisdictions have incorporated CTO provisions into their mental health laws, a similar approach may be possible using the leave of absence provisions found in most Canadian jurisdictions.⁵¹ The leave provisions can function like CTOs in that they involve mental health treatment in the community upon temporary leave from the hospital to which the individual has been admitted as a formal (involuntary) patient. Patients are granted extended, conditional leaves of absence from the facility in which the patient has been treated. The leave of absence provisions in some provinces, including British Columbia and Manitoba, are used to help facilitate the reintegration of patients into the community, while they remain under the supervision of the facility.⁵² Treatment can be made mandatory under leave of absence provisions and if the patient fails to comply with the treatment plan, the leave can be rescinded and the patient returned to hospital.⁵³

⁴⁷ See notes 44–45 and accompanying text.

⁴⁸ As with consent to the CTO itself, consent to treatment can be obtained from the patient or, where appropriate, the patient’s SDM.

⁴⁹ *MHA* (Alta), *supra* note 28, s 9.6; *Community Treatment Order Regulation*, Alta Reg 337/2009, ss 6(1)–(2).

⁵⁰ *Ibid.*

⁵¹ Most of the other Canadian provinces, with the exception of New Brunswick, have leave of absence provisions in their mental health laws. See e.g. *Mental Health Act*, CCSM, c M-110, s 46 [*MHA* (Man)]; *Mental Health Act*, RSBC 1996, c 288, s 37 [*MHA* (BC)]. The Yukon (*Mental Health Act*, RSY 2002, c 150, s 26) and Northwest Territories also have short-term leave provisions, and the Northwest Territory also has provisions that permit “assisted community treatment certificates,” which authorize “the patient to reside outside a designated facility while receiving supervision and treatment or care” (*Mental Health Act*, SNWT 2015, c 26, ss 35 (Short-term Leave) and 37 (Assisted Community Treatment Certificate) [*MHA* (NWT)]).

⁵² *Ibid.*, ss 35–37.

⁵³ See e.g. Carver, “Mental Health Law in Canada,” *supra* note 22 at 367–68. See also Steve Kisely, “Canadian Studies on the Effectiveness of Community Treatment Orders” (2016) 61:1 Can J Psychiatry 7 [Kisely, “Canadian Studies on CTOs”].

As is the case with other aspects of mental health law, CTOs are contentious because of their coercive potential. Though less intrusive to individual liberty than involuntary hospital admission, CTOs require adherence to the treatment plan in order to avoid admission and detention. CTOs also provide the possibility that patients with severe and persistent mental illness might be able to be effectively cared for in the community, which seems a more compassionate option than admission to a mental health facility. It is perhaps not surprising that those subject to CTOs tend to perceive them as less positive than their families do. The families of those subject to CTOs are generally positive about CTOs and relieved to know that their loved one is being closely monitored.⁵⁴ But some individuals subject to CTOs feel stigmatized and forced into unwanted treatment instead of being allowed to live freely in the community.⁵⁵

It is important to acknowledge as well the reality that CTOs are of uncertain utility. The medical and scientific literature is — at best — inconclusive as to their efficacy.⁵⁶ Indeed, the most recent empirical work on CTOs has described the evidence as “now strong that the use of CTOs does not confer early patient benefits despite substantial curtailment of individual freedoms,”⁵⁷ and some scholars have claimed that the evidence does not support the use of CTOs “in their current form.”⁵⁸

IV. ALBERTA’S MENTAL HEALTH REVIEW PANELS AND CTOs

Mental health laws — including laws that permit the imposition of a CTO — can threaten the liberty of those who are living with mental illness. It is therefore critical that safeguards and appeal mechanisms be incorporated into these laws. In most Canadian mental health legislation, this is achieved through the creation of a process whereby a patient can appeal to a neutral arbiter that is empowered to review the decision of the medical professionals who have decided that institutionalization or a CTO is warranted. In most Canadian jurisdictions,

⁵⁴ John E Gray, Margaret A Shone & Peter F Liddle, *Canadian Mental Health Law and Policy*, 2nd ed (Markham: LexisNexis Canada, 2008) at 305; RA Malatest & Associates Ltd, “The Legislated Review of Community Treatment Orders: Final Report” (23 May 2012) at 43–44, online: <www.health.gov.on.ca/en/public/programs/hepatitis/docs/cto_review_report.pdf>.

⁵⁵ See Gray, Shone & Liddle, *ibid* at 304–306; Carver, “Fact or Fashion,” *supra* note 32; Karen Schwartz et al, “Community Treatment Orders: The Service User Speaks Exploring the Lived Experience of Community Treatment Orders” (2010) 15:1 Intl J Psychosocial Rehabilitation 39.

⁵⁶ See e.g. Kisely, “Canadian Studies on CTOs,” *supra* note 53; T Burns et al, “Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Controlled Trial” (2013) 381 Lancet 1627; J Rukgåsa et al, “Community Treatment Orders: Clinical and Social Outcomes, and a Subgroup Analysis from the OCTET RCT” (2015) 131 Acta Psychiatrica Scandinavia 321; Marvin S Swartz et al, “Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?: Findings from a Randomized Trial with Severely Mentally Ill Individuals” (1999) 156:12 American J Psychiatry 1968; Henry J Steadman et al, “Assessing the New York City Involuntary Outpatient Commitment Pilot Program” (2001) 52:3 Psychiatry Services 330; Steve Kisely et al, “An Eleven-Year Evaluation of the Effect of Community Treatment Orders on Changes in Mental Health Service Use” (2013) 47:5 J Psychiatric Res 650; Jorun Rukgåsa, “Effectiveness of Community Treatment Orders: The International Evidence” (2016) 61:1 Can J Psychiatry 15; Daniel Maughan et al, “A Systematic Review of the Effect of Community Treatment Orders on Service Use” (2014) 49 Soc Psychiatry & Psychiatric Epidemiology 651; Marvin S Swartz & Jeffrey W Swanson, “Involuntary Outpatient Commitment, Community Treatment Orders and Assisted Outpatient Treatment: What’s in the Data?” (2004) 49:9 Can J Psychiatry 585; RL O’Reilly & JE Gray, “Is Mandatory Outpatient Treatment Effective?” (2005) 24:2 Can J Community Mental Health 77.

⁵⁷ Burns et al, *ibid* at 1632.

⁵⁸ Jorun Rukgåsa, John Dawson & Tom Burns, “CTOs: What is the State of the Evidence?” (2014) 49 Soc Psychiatry & Psychiatric Epidemiology 1861 at 1869.

the arbiter is an administrative tribunal exercising a quasi-judicial function.⁵⁹ In Alberta, these tribunals are known as Mental Health Review Panels.

There are three Review Panels in Alberta (Edmonton & North, Central Alberta, and Calgary & South). They are specialized tribunals created by Part 5 of the Alberta *Mental Health Act*.⁶⁰ Their role is to deal with involuntary detention and treatment decision making for formal patients, the continuation or cancellation of CTOs, and questions of competence to make treatment decisions.⁶¹

Although their role involves adjudication, Review Panels function differently than courts. They are less formal than courts, both in setting (often, hearings are held in the hospital) and procedurally. Unlike a court, Review Panel members participate in questioning the parties. Review Panels are more accessible and can act more swiftly than courts can. In addition, Review Panel members include experts in their area of decision-making. In Alberta, Review Panels are composed of a chair or vice-chair (who must be a lawyer), a psychiatrist, and a member of the public.⁶²

Community treatment orders come before Review Panels in one of two ways: a patient-initiated application seeking to have the CTO cancelled, or a deemed application (which occurs the first time that a CTO is being renewed, and every second renewal thereafter).⁶³ There is an important difference in approach between the two different kinds of CTO-related applications. Under section 38(1.1) of the *Mental Health Act*, a person who is subject to a CTO may apply to have the CTO cancelled.⁶⁴ In reviewing CTOs on application by the individual who is subject to the CTO, the Review Panel decision is to be based on the criteria outlined in section 9.1(1)(f)(ii) of the *Act* for imposing a CTO in the absence of consent. In order to keep the CTO in place, the Panel must find that the individual has, while living in the community, failed to obtain or continue with treatment that is required in order to “prevent the likelihood of negative effects to the person ... or harm to others,” and that a CTO is reasonable and would be less restrictive than detention as a formal patient.⁶⁵ In contrast, when hearing a deemed application under section 39 of the *Act* and where consent is present, the Review Panel evaluates whether the patient continues to meet the criteria for the imposition of a CTO.⁶⁶

The *Act* gives Review Panels fairly limited discretion in making a decision about whether or not to cancel a CTO. The Review Panel must simply decide whether the legislative

⁵⁹ See e.g. *MHA* (Alta), *supra* note 28, ss 34–43; *MHSA* (Sask), *supra* note 28, ss 32–36; *MHA* (NWT), *supra* note 51, ss 60–76; *Health Care Consent Act* (Ont), *supra* note 21, Part II.

⁶⁰ *Supra* note 28, ss 34–43.

⁶¹ *Ibid*, ss 37–41.

⁶² *Ibid*, s 34(4).

⁶³ *Ibid*, s 38(1.1) (application by person subject to a CTO) and s 39(2) (deemed application). Section 39(2) states that the deemed application will not proceed if the person subject to the CTO has applied for cancellation of the CTO within the month preceding a renewal that would otherwise trigger a deemed application.

⁶⁴ *Ibid*.

⁶⁵ *Ibid*, s 9.1(f)(ii).

⁶⁶ As outlined above, these criteria require that the person must be suffering from a mental disorder and that they have either been detained as a formal patient on two or more occasions in the preceding three-year period, been subject to a CTO in the preceding three-year period, or shown a pattern of behaviour indicating that the person is likely to harm him/herself or others or suffer substantial mental or physical deterioration if treatment is not provided. See *ibid*, s 9.1(1).

prerequisites for a CTO are met or not. If they are, the CTO remains in place; if not, the CTO is cancelled. The Review Panel does not have the authority to amend or modify the CTO, only to uphold or cancel it.⁶⁷ Notably, recent amendments to the *Act* permit the Review Panels to seek “a further psychiatric assessment and examination” of the person subject to the CTO in the course of a hearing.⁶⁸ Review Panels also now have the authority to order that a CTO be issued in respect of a patient seeking to have their admission or renewal certificates cancelled.⁶⁹ As explained further below, Review Panel decisions can be appealed to the Court of Queen’s Bench.⁷⁰

A. REVIEW PANEL REASONING AND CTOS

As noted in the introduction, a typical place to begin analyzing reasoning around the appropriate use of CTOS in Alberta would be with the reasoning of the Panels themselves. Because the reasons for decision are not publicly accessible, I interviewed members of two of Alberta’s Review Panels to learn about their approach to decision-making.

In speaking with members or former members of two of Alberta’s Mental Health Review Panels, I was told that the limited scope of decision-making outlined above is indeed the approach employed by the Review Panels. In CTO appeals, the Panels ask whether the person subject to the CTO meets the legislative criteria for imposition of a CTO.⁷¹ If yes, then the CTO remains in place. The Annual Reports filed by the Mental Health Review Panels make it clear that in the overwhelming majority of CTO appeals, the Panel takes the view that the criteria are indeed met and the CTO should remain in place.⁷² Between 2015–2018, Review Panels have cancelled the CTO in, on average, under 2 percent of hearings.⁷³

In one sense, this low rate of cancellation is reassuring in that it suggests that, in the Review Panels’ view at least, the psychiatrists who order CTOS are doing their jobs properly and are imposing CTOS only in appropriate circumstances. It is also worth mentioning that the Review Panels see a subset of all patients subject to CTOS — those applicants whose psychiatrists are of the view that the CTO should remain in place. This too may help to explain why the proportion of CTOS upheld is vastly greater than the proportion cancelled. Another reason for the low proportion of CTOS cancelled by the Review Panels may be that suggested by one of the Review Panel members that I interviewed for this project, who expressed the view that Review Panels tend to show considerable deference to the patient’s treating psychiatrist.⁷⁴

⁶⁷ *Ibid*, s 41(1)(a.1). Although the Review Panel has recently been granted the power to issue a CTO (see *ibid*, s 41(1)(a)(iii)).

⁶⁸ *Ibid*, s 40.1.

⁶⁹ *Ibid*, s 41(1)(a)(iii).

⁷⁰ *Ibid*, s 43(1).

⁷¹ See pages 567–72 of this article.

⁷² I should note here that the Annual Reports are not publicly available. I was able to access reports for the years 2011–2018 by requesting them directly from Alberta Health.

⁷³ This conclusion is based on data from the 2011–2018 Annual Reports provided by each Mental Health Review Panel to Alberta Health. There are differences in the rate at which CTOS are cancelled by Review Panels, with the Edmonton & North Panel cancelling CTOS at an average rate of 1.9 percent, Calgary & South at a rate of 1.6 percent, and Central Alberta cancelling CTOS in 1 percent of hearings.

⁷⁴ There is, of course, no way to test this claim in absence of access to the Review Panel decisions themselves.

I have said that it is somewhat reassuring to know that the psychiatrists who impose CTOs on their patients appear, by and large, to be doing so in pursuit of the legislated criteria and to be imposing such orders appropriately. If a Review Panel cancels a CTO, this means that the Panel is of the view that the CTO is inappropriate because the patient's circumstances do not meet the legislative criteria. A high proportion of CTOs being cancelled would suggest that CTOs are frequently imposed when they are not appropriate or necessary. It would be more reassuring, however, if the reasons for decision given by the Review Panels for upholding the majority of CTOs were available for review and consideration. This would permit independent assessment by patients, families, policy-makers, and the community more broadly and would certainly make the foundation for decision-making around CTOs much more clear.

Mental Health Review Panels hold considerable power over the lives of individuals living with serious mental illness. Review Panels have the authority to cancel or uphold renewal certificates, certificates of incompetency, and CTOs. After recent amendments to the *Mental Health Act*, they also have the power to order that a CTO be issued in respect of a formal (involuntary) patient who has applied for the cancellation of admission or renewal certificates.⁷⁵ The effects of these decisions on the lives of those subject to the mental health regime are considerable. As such, Review Panels play an important part in mental health law and policy, and their work, including the manner in which they carry it out, is something that is important for lawyers, policy-makers and the public to understand. This seems particularly true in the case of CTOs, given the concerns raised in the literature about the questionable efficacy of compulsory treatment in the community.⁷⁶

V. ACCOUNTABILITY, TRANSPARENCY, AND ALBERTA'S MENTAL HEALTH REVIEW PANELS

As with all administrative tribunals, Alberta's Mental Health Review Panels are created by legislation and exercise authority delegated to them by the provincial government. The powers exercised by such agencies are limited to those set out in the enabling legislation; the limits of their jurisdiction, and how that jurisdiction is exercised, are circumscribed by the statute. As administrative bodies created by the *Mental Health Act*, the mandate of Alberta's Mental Health Review Panels is limited to what is provided for in the *Act*.

Administrative agencies play numerous roles in the modern state. As the work of government has become more complex, governance itself has been entrusted to agencies set up to administer government policies — in some cases by interpreting legislation — in a wide array of contexts. These tribunals exercise administrative as well as quasi-judicial functions and can do so with a degree of expertise, flexibility, and efficiency that the government itself cannot accomplish. They are more informal than courts and also more

⁷⁵ *MHA (Alta)*, *supra* note 28, s 41.1(1)(a)(iii).
⁷⁶ See Part III, above.

accessible.⁷⁷ But these benefits come at a potential cost in terms of the loss of direct accountability and independence of the decision-makers.⁷⁸

Are Alberta's Mental Health Review Panels accountable? In a word, no. Accountability is a term that can be difficult to define with precision,⁷⁹ but at a minimum, accountability requires oversight.⁸⁰ Alberta's Mental Health Review Panel process does not meet even this most basic understanding of accountability. As I will explain in more detail below, there is no meaningful oversight, by any institution or individual, of the work the Review Panels do.

Transparency is a fundamental component of accountability.⁸¹ Alberta's Review Panels are not transparent. The *Mental Health Act* provides that all Review Panel proceedings "shall be conducted in private."⁸² Indeed, no one other than the applicant and the applicant's representative has the right to be present for the provision of evidence to the Review Panel. All others may attend proceedings only with the prior consent of the Panel Chair.⁸³ There is no provision in the *Mental Health Act* whereby the applicant could request that the hearing be open to the public nor is there any discretion afforded to the Panel itself to hold a hearing in public.⁸⁴ This is similar to the rules in many Canadian (and international) jurisdictions, although several do offer the possibility of public hearings.⁸⁵ In contrast, Ontario's Consent and Capacity Board conducts hearings in public, unless the Board is of the view that "desirability of avoiding disclosure [of personal matters] in the interests of any person

⁷⁷ These are among the often-cited benefits of delegating authority to administrative decision-makers: see e.g. JM Evans, HJ Janisch & David J Mullan, *Administrative Law: Cases, Text, and Materials*, 5th ed (Toronto: Emond Montgomery, 2003) at 13–14; Sara Blake, *Administrative Law in Canada*, 6th ed (Markham: LexisNexis Canada, 2017) at para 1.3.

⁷⁸ See e.g. Lorne Sossin, "The Puzzle of Administrative Independence and Parliamentary Democracy in the Common Law World: A Canadian Perspective" in Susan Rose-Ackerman & Peter L Lindseth, eds, *Comparative Administrative Law* (Cheltenham, UK: Edward Elgar, 2010) 205 at 205; Lorne Sossin & Steven J Hoffman, "The Elusive Search for Accountability: Evaluating Adjudicative Tribunals" (2010) 28 Windsor YB Access Just 343 at 344–46.

⁷⁹ See e.g. Mark Bovens, Thomas Schillemans & Robert E Goodin, "Public Accountability" in Mark Bovens, Robert E Goodin & Thomas Schillemans, eds, *The Oxford Handbook of Public Accountability* (Oxford: Oxford University Press, 2014) at 2–20; Richard Mulgan, *Holding Power to Account: Accountability in Modern Democracies* (London: Palgrave MacMillan, 2003) at 5–14.

⁸⁰ Mulgan, *ibid* at 7–11.

⁸¹ See e.g. Albert Meijer, "Transparency" in Bovens, Goodin & Schillemans, *supra* note 79, 507 at 507–24.

⁸² *MHA* (Alta), *supra* note 28, s 37(2).

⁸³ *Ibid*.

⁸⁴ While the Chair could presumably exercise discretion and grant prior consent to a large number of persons who wish to attend, these people would all have to request the Chair's consent to be present.

⁸⁵ See e.g. *MHA* (BC), *supra* note 51, s 25(2.5) ("[u]nless the panel orders otherwise, the hearing must be held in private"); *MHA* (Man), *supra* note 51, s 53(5) ("[a] hearing must be held in private, but the review board may permit the public to be present during all or part of a hearing if the patient consents and the board is of the opinion that there is no risk of serious harm or injustice to any person"); *IPTA* (NS), *supra* note 28, s 71(1) (hearings "shall be closed except for the parties, the patient advisor, any person having material evidence, any person required for security and any other person the Review Board determines"); *Mental Health Act 2014* (Vic), 2014/26, s 193(2) (tribunal proceedings may be open to the public where it is in the public interest) (Victoria, Australia); *The Tribunal Procedure (First-Tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008*, SI 2008 No 2699 (L 16), r 38 (1) All hearings must be held in private unless the Tribunal considers that it is in the interests of justice for the hearing to be held in public; *The Mental Health Tribunal for Scotland (Practice and Procedure) Rules 2005* (Scot), SSI 2005 No 420, rr 66–67 (which provide that the Tribunal may order a hearing to be public upon application by the patient, and that the Tribunal may limit the degree of publicity of the hearing where appropriate).

affected or in the public interest outweighs the desirability of adhering to the principle that hearings be open to the public.”⁸⁶

The Alberta *Mental Health Act* requires that if a Review Panel decides not to cancel a CTO or admission or renewal certificates, the Panel “shall give written reasons for its decision.”⁸⁷ As explained above, the Panel’s reasons are not available for public review. Reasons for decision must be provided to a limited class of persons, including: the person who is subject to a CTO and their SDM (if any), the patient’s designate, nearest relative, any other person the chair considers may be affected by the application, the issuing qualified health professional, and the person responsible for supervising the CTO.⁸⁸ The *Act* does not require that the Panel’s reasons be provided to any other individual or organization (including, for example, Alberta Health — the government department responsible for administering the *Mental Health Act*). Indeed, one of the reasons that I spoke to Review Panel members for the purposes of this research was because there was no way to gain access to the decisions other than by requesting the decisions directly from the Review Panel chairs.

There is potential for transparency in the process, in that the reasons of the Review Panel could be reviewed and assessed in the context of an appeal of the Panel’s decision to the Court of Queen’s Bench.⁸⁹ But a closer look at the legislation and at the practice around Queen’s Bench appeals makes it clear that they do not function as an effective check on the power of the Review Panels. First, the structure of the appeal itself is, per the legislation, “a rehearing of the matter on the merits.”⁹⁰ This means that the Court is not bound by the decision of the Review Panel nor by its interpretation of the evidence. In short, there is no real need for the Court to review or comment on the written decision of the Review Panel. Second, appeals to the Court of Queen’s Bench are infrequent. A search of the case law for reported appeals from Review Panels to the Court of Queen’s Bench turned up fewer than a dozen cases, none of which relate to a decision regarding a CTO.⁹¹ A search like this is of course imperfect, but nevertheless provides some indication of how often persons subject to a CTO proceed to Queen’s Bench after learning the outcome of a Review Panel hearing. The appeal mechanism has the potential to operate as a check on the Review Panels, but this potential is not realized in practice.

In a recent reported Queen’s Bench appeal (heard in Calgary in 2015), a formal patient appealed the decision of the Calgary & South Review Panel, which declined to cancel his renewal certificates and permit his discharge from the hospital. By the time of the Queen’s Bench hearing, the applicant had been detained as a formal patient in the Foothills Hospital

⁸⁶ *Statutory Powers Procedure Act*, RSO 1990, c S.22, s 9(1). See also Ontario, Consent and Capacity Board, *Rules of Practice* (Toronto: Consent and Capacity Board, 16 June 2019), s 26.1, online: <www.ccb.on.ca/english/legal/documents/CCB_Rules_of_Practice_June_19_2019_FINAL-S.pdf>.

⁸⁷ *MHA* (Alta), *supra* note 28 at s 41(4).

⁸⁸ *Ibid*, s 41(2)(b).

⁸⁹ *Ibid*, s 43.

⁹⁰ *Ibid*, s 43(4). In Ontario, by contrast, an appeal from a decision of the Consent and Capacity Board can be made to the “Superior Court of Justice on a question of law or fact or both.” See *Health Care Consent Act 1996*, SO 1996, c 2, Sched A, s 80(1).

⁹¹ The cases are: *EW v Alberta Hospital (Edmonton)* 1999 ABQB 566; *E v Board of the Foothills General Hospital*, 2003 ABQB 1031; *M v Alberta*, [1985] 63 AR 14 (QB); *MB v Alberta (Minister of Health)* (1997) 149 DLR (4th) 363 (Alta QB); *MR C v Rockyview General Hospital*, 2003 ABQB 366; *Rogerson v Alberta Hospital (Edmonton)*, 1999 ABQB 412; *AAR v Alberta Hospital (Edmonton)*, 1999 ABQB 573; *JH v Alberta Health Services*, 2015 ABQB 316.

for approximately eight months. While this case does not deal with a CTO, some of the trial judge's comments are noteworthy from the perspective of my argument about accountability, specifically, that Review Panel reasons for decision ought to be publicly accessible. As Justice Eidsvik noted in her reasons, she was not required to consider the Review Panel's reasons for decision, as the hearing before her was a rehearing on the merits. She nevertheless felt it worth commenting on the reasons in fairly strong terms. As she explained, the Panel's reasons

consist of 10 paragraphs which basically say that they agreed with the Hospital and that the patient met the criteria, which they then listed. These reasons were wholly inadequate in that they did not discuss the factual basis upon which the criteria had been met — they simply recited the criteria without more. As noted, this is a re-hearing on the merits, but I point out that these Reasons were wholly unhelpful in determining why the hospital's evidence was accepted and the evidence of the patient and his advocate were completely ignored.⁹²

Justice Eidsvik's comment on its own does not indicate a problem with Review Panel decision-making in general. But it certainly could. And the problem is that we do not — and cannot — know whether there is a problem with Review Panel decision-making because we cannot access the Panels' reasons for decision.

Why, if at all, should we be concerned about these questions of transparency and accountability in the mental health context? As noted in one commentary on this issue, “[w]ithout transparent and accountable mental health tribunals, society does not have a means of ensuring civil commitment strikes the correct balance between individual autonomy and the medical benefits of any involuntary treatment.”⁹³ The authors go on to note that studies have shown that tribunals over-emphasize “medical objectives to the detriment of civil rights of individuals”⁹⁴ and defer to treating psychiatrists, and that patients often do not understand their legal rights and appear at hearings without legal representation. Might these concerns also be applicable in Alberta? We have no way to know the answer to this question without access to the Review Panels' reasons.

A. TRANSPARENCY, ACCOUNTABILITY, AND PRIVACY

In the course of my research for this article, I spoke to Review Panel members about their views around transparency and confidentiality. One of the Review Panel members whom I interviewed for this project felt very strongly that Panel decisions should remain confidential because, even if identifying information about the patient is redacted, the specific and often unusual nature of the facts would likely make it possible to identify the applicant. The other Review Panel members I spoke to felt that the decisions should be made publicly available. One took the view that the applicants would, in many cases, welcome publication of the decisions. Another thought that there would be a significant benefit in the three Review Panels being able to compare and contrast approaches, learn from one another's reasoning and approach, and contribute to the development of a body of law that would help both

⁹² *JH v Alberta Health Services*, *ibid* at para 5.

⁹³ Alison Smith & Andrew Caple, “Transparency in Mental Health: Why Mental Health Tribunals Should Be Required to Publish Reasons” (2014) 21:4 *JL & Medicine* 942 at 944.

⁹⁴ *Ibid*.

current and future decision-makers. In turn, this would benefit those who find themselves before a Review Panel arguing for their freedom from involuntary detention or mandatory treatment in the community.

As noted above, an administrative tribunal, such as a Mental Health Review Panel, is not a court. But the Mental Health Review Panels play a quasi-judicial role. The Review Panels interpret aspects of the *Mental Health Act* and apply those legislative criteria to sets of facts. This is clearly a judge-like function. Moreover, Review Panels make decisions that implicate important individual liberties. Review Panels may make decisions respecting a person's admission to and detention in a mental health facility, whether a person should remain subject to a mandatory treatment in the community based on a CTO, whether a person is capable of making his or her own treatment decisions, and whether treatment should be ordered in spite of a competent refusal of that treatment by a formal patient or their SDM. In other words, the decision of a Review Panel can directly affect an individual's freedom to leave the hospital or to refuse an unwanted injectable psychoactive medication. For those living in the community subject to a CTO, the Review Panel has the authority to cancel the CTO, meaning that the individual is free to live as he or she wishes in the community, without being subject to a mandatory treatment plan. To say that Review Panels have substantial power is no exaggeration. Indeed, in some respects they have as much power as a court does — particularly with respect to individual civil liberties.

One manner in which Alberta's Review Panels are very unlike courts is in relation to transparency and open justice. Canadian courts have long subscribed to the value of open justice, recognizing the importance of public scrutiny of the courts and the judiciary.⁹⁵ Fundamentally, the advantage of an open court approach lies in its ability to permit insight into the work of courts and judges, and thereby to ensure that the incredible power of the judicial office is not misused.⁹⁶

Jeremy Bentham is often quoted in support of open justice. As quoted by the House of Lords, he explained:

"In the darkness of secrecy, sinister interest and evil in every shape have full swing. Only in proportion as publicity has place can any of the checks applicable to judicial injustice operate. Where there is no publicity there is no justice." "Publicity is the very soul of justice. It is the keenest spur to exertion and the surest of all guards against improbity. It keeps the judge himself while trying under trial."⁹⁷

In an early Canadian decision recognizing the principle of open justice as a constitutional value, Justice Bertha Wilson enumerated several distinct benefits of the open court, including ensuring that the decision-makers behave fairly and consistently with societal values, maintaining public confidence in the justice system, and educating the public about the operation of the judicial system and the application of the law.⁹⁸ These benefits apply equally

⁹⁵ *Scott v Scott*, [1913] AC 417 at 477 (HL Eng); *Edmonton Journal v Alberta (Attorney General)*, [1989] 2 SCR 1326 at 1337–39.

⁹⁶ *Ibid.* See also Jane Bailey & Jacquelyn Burkell, "Revisiting the Open Court Principle in an Era of Online Publication: Questioning Presumptive Public Access to Parties' and Witnesses' Personal Information" (2017) 48:1 Ottawa L Rev 143 at 152.

⁹⁷ Cited in *Scott v Scott*, *supra* note 95 at 477.

⁹⁸ *Edmonton Journal v Alberta (Attorney General)*, *supra* note 95 at 1361.

in the case of many administrative tribunals, including Mental Health Review Panels.⁹⁹ Access to Review Panel reasoning, like access to judicial reasoning, can improve access to justice and increase the transparency and accountability of the process.¹⁰⁰

Though the principle of open justice is obviously based on far broader concerns about justice than lie within the purview of Mental Health Review Panels, similar considerations about the importance of transparency and public confidence apply to the work carried out by Review Panels. And yet the system within which the Panels are situated offers no insight into their reasoning nor any significant oversight of their work. The hearings are held in private, the reasons are confidential and only provided to a very limited group. Although the *Mental Health Act* provides for oversight in granting a right to appeal to the Court of Queen's Bench, it appears that this right is seldom exercised. The potential for oversight is thus theoretical rather than practical.

Do the differences between courts and Mental Health Review Panels justify these distinct approaches? After all, Review Panels are operating within a far more limited mandate than courts. The only argument that can be raised in support of maintaining the current practice of secrecy around Review Panel reasons is that such secrecy is essential to safeguard patient confidentiality and informational privacy. To be clear: I fully appreciate the legitimacy and importance of privacy concerns in the mental health context. However, it is important to point out that this is the *sole* objective or benefit of keeping Review Panel reasoning out of the public sphere. And in fact, it is probably a stretch to refer to privacy protection as an objective of the *Mental Health Act*.¹⁰¹ The protection of applicant (or patient) privacy is the outcome of a process that avoids publishing reasons for decision, but the need for protection of privacy is, if anything, implicit within the legislative scheme rather than being explicitly referenced as its aim.

Protection of privacy is clearly a commendable and important goal. Indeed, the incredible ease of access to judicial decisions facilitated by technology has led the courts themselves to consider whether and how personal information should be protected in an otherwise transparent and open process. In 2005, the Canadian Judicial Council approved a protocol related to the use of personal information in judgments.¹⁰² One of the aims of the protocol was to encourage courts to publish all judgments online, given the benefit of such publication from the perspective of access to justice.¹⁰³ Although there are classes of cases in particular in which privacy interests are implicated, the protocol urged courts to reassess the need to exclude certain classes of cases from online publication because of privacy concerns. The protocol identifies distinct levels or types of privacy protections and notes that simply

⁹⁹ *Ibid.* Justice Wilson also noted the benefit of maintaining an "effective evidentiary process," as well as the benefit to litigants of a public airing of the injustices they feel they have suffered, but these are less applicable in the case of Mental Health Review Panels.

¹⁰⁰ David Loukidelis, "Privacy and Openness in Administrative Tribunal Decisions" (2009) 22 Can J Admin L & Prac 75 at 76.

¹⁰¹ Indeed, Alberta's *Mental Health Act* has no explicit purpose or objective, nor does it have a preamble indicating its aims.

¹⁰² Canadian Judicial Council, Judges' Technology Advisory Committee, *Use of Personal Information in Judgments and Recommended Protocol* (Ottawa: Canadian Judicial Council, 2005), online: <www.cjc-ccm.gc.ca/cmslib/general/news_pub_techissues_UseProtocol_2005_en.pdf> [CJC, *Use of Personal Information*].

¹⁰³ *Ibid.* at para 10.

omitting personally identifying information may not be sufficient to fully address such concerns.¹⁰⁴ In cases where specific factual information may permit the identification of a party or individual referred to in a judge's reasons for decision, even absent the presence of personally identifying information, the protocol notes that the "possibility that some people in the local area may be able to deduce the individual involved by piecing together the specific factual information should not outweigh the public interest in providing a cohesive, reasoned decision."¹⁰⁵

In other words, without discounting the importance of protecting privacy, it is preferable in almost all circumstances to publish reasons for decision in a manner that facilitates access to justice and that respects the open court principle. Most of the time, privacy can be adequately protected by removing personally identifying information and by ensuring that the inclusion of information that could be used to identify an individual is limited to information that is necessary and relevant in the circumstances. This balancing of privacy and other interests is routinely accomplished by courts in all contexts — where statute prevents the publication of identifying information (including in *Youth Criminal Justice Act*¹⁰⁶ matters or child protection matters), where the common law requires the non-publication of identifying information, or where a judge decides to exercise discretion to omit identifying information from a judgment in a case involving exceptional circumstances.¹⁰⁷ This approach may not protect privacy absolutely. It is certainly possible that someone with sufficient time and ingenuity might be able to piece together the identity of the witness or party in question from information included in the judgment. But that reality does not lead courts to refrain from publishing their reasons, nor should it be viewed as a justification for Mental Health Review Panels to continue to maintain secrecy around their reasons.

It is clear that protection of privacy is a primary concern in the mental health context. Indeed, although this is not explicitly stated in the *Mental Health Act* provisions relating to dissemination of reasons and to who may attend Review Panel hearings, worries about confidentiality of medical information likely lie behind these rules.

In some ways, the Review Panel regime may simply be seen as an extension of the care of the patients being treated within the mental health system. This may actually go some distance to explain why reasons are kept confidential, in that they are viewed as part of the patient's medical record, all of which is kept confidential. If this is indeed the (or a) reason for maintaining secrecy around Review Panel reasons, it seems rational. But it is critical to remember that once the Review Panel mechanism is engaged, the patient is involved in a legal — not a medical — process, where legislation outlines procedures to be followed and tests to be applied. Typically, even where legal processes are related to a health care context, those processes are subjected to the values and traditions relevant in law, rather than to those that govern health care. For example, in the case of medical malpractice claims — which clearly also deal with sensitive personal and medical information — there is no routine bar to publishing reasons nor rules requiring the redaction of all personally identifying information from the reasons. It may well be that there are important distinctions between

¹⁰⁴ *Ibid* at para 21.

¹⁰⁵ *Ibid* at para 30.

¹⁰⁶ SC 2002, c 1.

¹⁰⁷ CJC, *Use of Personal Information*, *supra* note 102 at paras 24, 31.

the ordinary health care context and the mental health care context that explain the different approach, but at the very least, those distinctions should be explicitly articulated in justification and support of the practice.

Review Panels are in place to act as a check on the power of psychiatrists (and other health professionals) to detain individuals in psychiatric facilities or to impose treatment on individuals living in the community under threat of hospitalization if the treatment plan is not followed. But they cannot properly fulfil this mandate if they defer to the treating psychiatrist to decide whether it is appropriate to detain the patient or keep a CTO in place, and we cannot assess whether Review Panels are inappropriately deferential to treating psychiatrists without being able to access their reasons for decision. Review Panels also cannot exercise their function properly if they see themselves as an extension of the therapeutic efforts for the benefit of the patient. A better perspective is to understand that they have a role in ensuring that the psychiatrist and hospital are carefully balancing the need for treatment, its potential benefits, and the wishes, needs, and interests of the patient.

In addition to the transition from provision of health care to a legal process aimed at determining who may decide what that care entails, there is another issue that bears consideration here. The treatment of mental illness and disability, in medicine, law, and society generally, has traditionally been different from the treatment of physical illness and disability. Persons with mental illness have historically been separated from their families and communities and institutionalized in isolated facilities. In marked contrast, persons with physical illness are treated in local, community hospitals — close to their families and within their communities.¹⁰⁸ In the common law, claims for mental harm resulting from negligence have been much more difficult to recover than claims for physical harm.¹⁰⁹ Media and popular culture represent persons with mental illness as violent and unpredictable. Those who care for people with mental illnesses are portrayed as deviant or deficient and are often caught up in the same stigma as the individuals they care for.¹¹⁰

The need to dispel the stigma and prejudice that lead to discrimination against those suffering from mental illness is beginning to be recognized in legal decision-making and in society more generally, but there is much work yet to be done. According to Chief Justice McLachlin (as she then was) in a personal injury case, “[t]he distinction between physical and mental injury is elusive and arguably artificial in the context of tort.”¹¹¹ And yet law and society continue to treat the two very differently — as did Chief Justice McLachlin in that same case, holding that in order for psychiatric harm to be compensable, the plaintiff must show that such harm could be suffered in the circumstances by a “person of ordinary fortitude.”¹¹²

¹⁰⁸ Julio Arboleda-Flórez, “Consideration on the Stigma of Mental Illness” (2003) 48:10 Can J Psychiatry 645 at 646.

¹⁰⁹ See e.g. *Saadati v Moorhead*, 2017 SCC 28 at paras 14–16 [*Saadati*]. See also Harvey Teff, *Causing Psychiatric and Emotional Harm: Reshaping the Boundaries of Legal Liability* (Oxford: Hart, 2009). See e.g. Jo C Phelan et al, “Public Conceptions of Mental Illness in 1950 and 1996: What Is Mental Illness and Is It to Be Feared?” (2000) 41:2 J Health & Soc Behavior 188.

¹¹¹ *Mustapha v Culligan of Canada Ltd*, 2008 SCC 27 at para 8.

¹¹² *Ibid* at paras 14–18.

Unlike physical ill health (which is viewed as misfortune for which the ill person is blameless), mental illness and disability were traditionally seen as a character weakness or personal failing.¹¹³ There remains a prevalent belief that mental illness is a problem that can be addressed or remediated by the individual him or herself — a view with no parallel in the physical illness or injury context.¹¹⁴ No one expects that breast cancer or Crohn's disease can be made well by a change in attitude or a willingness to "get over it." Yet the sense that mental illness can be sorted out in this fashion persists.

All of these social attitudes toward mental illness are possibly related to the perceived need to keep Review Panel reasons confidential. And given the stigma and discrimination often faced by those with mental illnesses and their families,¹¹⁵ confidentiality seems to be a sensible default position. But I wonder to what extent that view simply feeds back into the stigma itself. In asserting or agreeing that it would, all things considered, be bad for people to be able to learn the identity of the applicant in a Review Panel decision, do we not implicitly lend some legitimacy to the idea that one should be ashamed of having a mental illness?

Can the current approach be justified? Any method of maintaining confidentiality of judicial reasons for decision is inevitably partial and imperfect, including the above-described approaches to youth criminal justice matters and child protection matters. An acquaintance or neighbour with the time and the inclination might be able to ascertain the identity of the accused or the abused child by piecing together known circumstances and the facts that are included in the reasons. Our response to this is not to say that all such judgments must be kept from publication. Instead, the consensus seems to be that the value in publishing these decisions outweighs the risk that someone might be able to identify the individual referred to in the reasons. Likewise in the case of Review Panel decisions, I argue that the value in publishing reasons should prevail over the concern that someone with enough time on their hands might search through the decisions looking for someone they know.

VI. LAW AND SYSTEM REFORM TO IMPROVE ACCOUNTABILITY

What, if anything, can we do to address these concerns and improve accountability and transparency in the Alberta Mental Health Review Panel system? In my view, these concerns can be ameliorated — at least to some extent — even with only modest changes to the law.

¹¹³ See e.g. Jack K Martin, Bernice A Pescosolido & Steven A Tuch, "Of Fear and Loathing: The Role of 'Disturbing Behavior,' Labels, and Causal Attributions in Shaping Public Attitudes Toward People with Mental Illness" (2000) 41:2 J Health & Soc Behavior 208; Jason Schnittker, "An Uncertain Revolution: Why the Rise of a Genetic Model of Mental Illness Has Not Increased Tolerance" (2008) 67:9 Soc Science & Medicine 1370; Patrick Corrigan et al, "An Attribution Model of Public Discrimination Towards Persons with Mental Illness" (2003) 44:2 J Health & Soc Behavior 162.

¹¹⁴ *Ibid.*

¹¹⁵ Indeed, Justice Brown refers to the stigma faced by persons with mental illness as "notorious" (*Saadati*, *supra* note 109 at para 21). For an extensive list of resources on this issue, see M Aichberger & N Sartorius, "Annotated Bibliography of Selected Publications and Other Material Related to Stigma and Discrimination: An Update for the Years 2002 to 2006" (2006), online: <www.opentheodoors.com/english/media/Bibliography.pdf>.

But it is important to acknowledge that resolving the accountability problems identified here will be a significant challenge.

Minor amendments to the *Mental Health Act* could lead to substantial improvements in transparency. For example, the *Act* could be amended to give Review Panels the discretion to hold hearings in public, particularly in circumstances where the person before the Panel requests a public hearing. Public hearings are the norm in Ontario, where the Consent and Capacity Board holds hearings in public unless it is of the view that the need to avoid disclosure of personal information outweighs the benefits of respecting the principle that such hearings should in general be held in public.¹¹⁶ In addition, the provisions of the *Act* that list those to whom the reasons are to be provided could be changed to permit publication of redacted reasons. As noted, the risk remains that a person who was so inclined might be able to figure out who is involved based on the facts. But this risk exists in other contexts as well, and the courts generally take the view that access to justice and the open court principle require publication of reasons in almost all circumstances and that privacy concerns rarely outweigh these important aims.¹¹⁷

Another option, which would be less open but still far preferable to the current non-transparent system, could be to move to an archive-like model, where a person seeking access to the reasons would be required to apply for access and state their reasons for seeking access. Rules could be imposed to prevent or limit making copies or images of reasons and to outline how the reasons can be used or referred to in research or other publications.¹¹⁸

While these changes can be easily accomplished and would meaningfully address concerns about transparency, they will not resolve the larger accountability problem. Creating an accountable system requires an approach that looks beyond the *Mental Health Act* itself to other system reforms. A change to the *Act* — so that appeals are structured as judicial review, instead of a rehearing on the merits — would be a good starting point. It would permit meaningful review of Panel reasons which, in turn, could lead to judicial commentary and guidance on the Panels' reasoning and interpretation of the *Act*. It might also lead to increased numbers of appeals by reducing the cost of an appeal. But given the infrequency of appeals, this change on its own will not ensure that the Review Panel process is accountable.

Further steps toward accountability will require a creative and multifaceted approach. Improving access to legal representation for Review Panel appeals would very likely create some pressure on Review Panels to fully explain the foundations for their reasoning. One way to improve access to legal representation would be to follow the approach adopted by the Review Panel in the Central Alberta region. In the Central region, duty counsel is present on hearing days, whether or not they have been asked by patients to be present for the hearing. While not all patients wish to have a lawyer present in the hearing, most do accept

¹¹⁶ *Supra* note 86.

¹¹⁷ See CJC, *Use of Personal Information*, *supra* note 102.

¹¹⁸ Thanks to my colleague Ubaka Ogbogu for this suggestion.

the offer of representation.¹¹⁹ In the Edmonton & North and Calgary & South regions, patients must contact Legal Aid in advance to ensure that duty counsel will be present at their Review Panel hearing. While this might seem like an unimportant distinction, for a vulnerable population, it could make an enormous difference. Not all patients will be aware of their right to seek legal representation, and even if they are informed, they may not be able to arrange for duty counsel to be present at their hearing. This is something that could easily be accomplished by a minor amendment to existing legislation along the lines of the approach taken in Ontario, where the *Mental Health Act* provides that a physician who completes admission or renewal certificates “shall ... promptly notify a rights adviser.”¹²⁰

Ensuring that patients have legal representation at a higher number of Panel hearings could also lead to a higher number of appeals of Panel decisions, particularly if combined with improved access to Legal Aid. This is one area where system reform beyond the *Mental Health Act* is required. The current Legal Aid eligibility guidelines specify that a single person can qualify for Legal Aid funding if their monthly income is below \$1,668.00 and annual income is below \$20,021.00.¹²¹ To put this number into some perspective, recipients of Assured Income for the Severely Handicapped (AISH) who earn no additional income are receiving a monthly benefit that exceeds Legal Aid’s financial eligibility limit in Alberta.¹²² The AISH benefit is \$1,685 per month, which is \$17 per month more than the eligibility limit for Legal Aid.¹²³ It is hard to imagine that a program like Legal Aid, which is a plan designed to “provide legal aid to persons in need of it”¹²⁴ would deliberately set its eligibility ceiling to exclude Albertans with disabilities that are severe enough to prevent them from earning an income. It is more likely the case that the two programs are operated by different organizations, affiliated with different parts of the government, and that there is no (or limited) communication between the two programs.

Another step that could lead to improved accountability over the long-term include funding and facilitating research into the Review Panel process, with a view to identifying areas for change. This could be accomplished through projects involving collaboration between Alberta Health and independent researchers.

Lastly, it would be extremely useful to see reform of the *Mental Health Act* to include objectives or statements of purpose. This will require that some thought be given to the aims of the system as a whole. Is the system in place to provide health care for those with mental illness? To help ensure the safety of those suffering from serious mental illness? Or to ensure public safety? It is clear that each of these potential objectives will lead to different legal rules. As it stands, our *Mental Health Act* does not spell out any objectives. Without objectives, it is impossible to evaluate whether the system is meeting policy aims or to assess

¹¹⁹ This was explained to me by study participants. It is also noted by the Alberta Ombudsman in its recent report: Alberta Ombudsman, *Treating People with Mental Illness Fairly: Report on Mental Health Review Panels* (Edmonton: Alberta Ombudsman, June 2019) at 11–12, online: <www.ombudsman.ab.ca/wp-content/uploads/2019/06/2019June17-Treating-people-with-mental-illness-fairly.pdf>.

¹²⁰ *Supra* note 27, s 38.

¹²¹ Legal Aid Alberta, “Eligibility,” online: <www.legalaid.ab.ca/resources/#eligibility>.

¹²² The current monthly living allowance received from the AISH program is \$1,685.00 (see Alberta, *AISH Program Policy: Benefits: Living Allowance* (Edmonton: Government of Alberta, 1 January 2019), online: <www.humanservices.alberta.ca/AWOnline/AISH/7242.html>).

¹²³ And amounts to less than what one could earn working 30 hours per week for minimum wage.

¹²⁴ *Legal Profession Act*, RSA 2000, c L-8, s 4(1).

whether the Review Panels are applying the law correctly and are properly respecting patients' rights. If we do not know what the system is trying to achieve, we have no benchmark against which to evaluate its success.

Unfortunately, the government seems to lack interest in most of these suggestions. In 2020, the *Mental Health Act* was amended in response to *J.H. v. Alberta Health Services*,¹²⁵ in which the Court held that several sections of the *Act* were unconstitutional. During the Government's consultation around potential amendments, I spoke with personnel in the Addiction and Mental Health Branch (a branch of Alberta Health) about some of the ideas proposed here. Those I spoke with seemed interested in considering changes to the legislation beyond what was contemplated in *JH*. However, none of these ideas were adopted in the recently passed Bill amending the *Act*.¹²⁶

VII. CONCLUSION

Alberta's Mental Health Review Panels are not accountable decision-makers. Their work addresses the welfare and rights of some of the most vulnerable Albertans yet is not subject to meaningful oversight. And unfortunately, the Government does not seem to be concerned, or at least not sufficiently concerned to change the status quo. When the *Mental Health Act* was amended last year, the Government passed up the opportunity to implement reforms that could help address the accountability gap. Instead of making such changes, the Government granted Review Panels "more power to tailor solutions to help long-term patients reintegrate into the community."¹²⁷

It is dismaying to see the Government grant "more power" to a non-accountable administrative decision-maker that already holds enormous power over the lives and liberty of those with serious mental illnesses. I am hopeful that, by highlighting these issues, this article will improve the chances that the Government will soon take steps toward a transparent and accountable system.

¹²⁵ 2019 ABQB 540 [*JH*].

¹²⁶ *Mental Health Amendment Act*, SA 2020, c 15.

¹²⁷ Alberta, Legislative Assembly, *Hansard*, 30-2, No 28 (9 June 2020) at 1203 (Tyler Shandro).