**IN THE SUPREME COURT OF NEWFOUNDLAND AND LABRADOR**
**TRIAL DIVISION**

**Citation**: *P.H. v. Eastern Regional Integrated Health Authority*, 2010 NLTD 34
**Date**: 20100217
**Docket**: 200901T5556

BETWEEN:
**P.H.**

APPLICANT

AND:
**EASTERN REGIONAL INTEGRATED HEALTH AUTHORITY**

FIRST RESPONDENT

AND:
**S.J.L.**

SECOND RESPONDENT

**Ban on Publication:** The proceedings of this case, including these Reasons for Judgment, are subject to an Order made by order of this court in exercise of its *parens patriae* jurisdiction that the identity of the Second Respondent herein and any information that could disclose the identity of the Second Respondent herein, including the name of the Applicant, shall not be published in any document or broadcast in any way.

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**Before:** The Honourable Mr. Justice Richard D. LeBlanc

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| **Place of hearing:** | St. John's, Newfoundland and Labrador |
| **Dates of hearing:** | December 3, 11 and 18, 2009; January 5, 14, 15, 18, 19. 21, 26 and 29, 2010; and February 3 and 10, 2010 |

**Appearances:**

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| Robert W. Buckingham | Counsel for Applicant |
| Rodney J. Zdebiak and R. Wayne Bruce | Counsel for First Respondent |
| Rosellen Sullivan | Counsel for Second Respondent |
| David C. Day, Q.C. | Counsel for the Best Interests of S.J.L. |

**Authorities Cited:**

**CASES CONSIDERED: Re Strong** (1993), 107 Nfld. & P.E.I.R. 350 (Nfld. S.C.(T.D.)); **Starson v. Swayze**, [2003] 1 S.C.R. 722; **Malette v. Shulman** (1990), 72 O.R. (2d) 417 (C.A.); **Fleming v. Reid** (1991), 4 O.R. (3d) 74 (C.A.); **Rodriquez v. British Columbia (Attorney General)**, [1993] 3 S.C.R. 519; **A.C. v. Manitoba (Director of Child and Family Services)**, [2009] S.C.J. No. 30; **C.(J.S.) v. Wren** (1986), 76 A.R. 45 (C.A.); **Re A.Y.** (1993), 111 Nfld. & P.E.I.R. 91 (Nfld. U.F.C.); **Re Jane Doe (Guardian ad litem),** 2005 NLTD 72; **Eastern Regional Integrated Health Authority v. B.A.H.**, 2007 NLTD 30.

**STATUTES CONSIDERED:** *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1; *Age of Majority Act*, S.N.L. 1995, c. A-4.2, section 2; *Advance Health Care Directives Act*, S.N.L. 1995, c. A-4.1; *Child, Youth and Family Services Act*, S.N.L. 1998, c. C-12.1 sections 2(1) and 32; *Neglected Adults Welfare Act*, R.S.N.L. 1990, c. N-3, section 2; *Child and Family Services Act*, C.C.S.M. c. C80.

## REASONS FOR JUDGMENT

**LEBLANC, J.:**

**INTRODUCTION**

[1] P.H. is the mother of S.J.L. who is presently 16 years of age and has completed her grade nine education. On December 3, 2009, P.H. applied to this Court for, and was granted, an order detaining S.J.L. in the Waterford Hospital based upon a concern that, if released from the Waterford Hospital, S.J.L. would commit serious bodily harm to her that could cause her death. The Waterford Hospital has as its primary function the treatment of adults suffering from a mental or psychiatric condition. At that time, S.J.L. planned to discharge herself from the hospital, which discharge would not have been prevented by her doctors. The order made on December 3, 2010 was extended by me on December 11, 2009 in order to permit the application filed by S.J.L.'s mother to be heard with the preliminary focus of the hearing to determine if S.J.L. was not legally competent to make her own health care decisions.

[2] At issue here is a very difficult matter, reconciling the right of S.J.L. to make her own decisions with regard to her mental health treatment versus the asserted need to detain S.J.L. to safeguard her own well-being pending appropriate treatment. While the circumstances of this case might appear to suggest a lack of rationale thinking on the part of S.J.L. based upon her actions described throughout this process before me, that does not mean I am permitted to readily disregard the autonomy and presumed competence of S.J.L. to make her own mental health treatment decisions. The reasons for this approach will be referred to subsequently.

[3] The preliminary determination I must make here is whether S.J.L. has the legal competence to seek treatment for her mental health condition and to appropriately be capable of making necessary future treatment decisions. Unlike cases of this kind related to a refusal to accept treatment for a physical ailment or the existence of the illness that is tangibly proven with a recognized and proven treatment option, where the area of disability is said to affect the mind, there is less medical certainty about diagnosis and appropriate treatment. As well, the duration for any order for detention and treatment is likely to be longer, if not also uncertain for a mental disorder.

[4] It is with this in mind that I now turn to the decision to be made in this case.

**THE APPLICATION AND HEARING:**

[5] As referred to earlier, P.H., in her originating application, requested that S.J.L. be detained pending a hearing related to her capacity to make decisions related to her medical and mental care and attention. It was in response to that application that the first order was made by Faour, J. to detain S.J.L. at the Waterford Hospital. A second application was filed shortly after seeking a determination of S.J.L.'s capacity to make informed decisions about her health and medical treatment and, if necessary, to appoint a guardian to make decisions in relation to S.J.L.'s health care and treatment.

[6] Subsequent to filing the second application, David Day, Q.C. was appointed by the Chief Justice to act on behalf of S.J.L. in this matter. When the application was called before me, I was advised by Mr. Day that S.J.L. had no desire to involve herself in the proceeding and did not wish to have counsel. As a result, I appointed Mr. Day to represent S.J.L.'s best interests. Mr. Day advised S.J.L., pursuant to my request, that should she change her mind and wish to have counsel represent her at a later date, I would accommodate this request. It was only after the evidence in the competency hearing concluded and when I met with S.J.L. at the Waterford Hospital that S.J.L. decided she wanted to have a lawyer represent her. As a result, Rosellen Sullivan was appointed by order of this Court to act for S.J.L.

[7] When I extended Faour, J's order of December 3, 2009, certain other directives were given at that same time by myself, including giving directions regarding emergency medical treatment for S.J.L. in the interim, if required, as well as authorizing Mr. Day to obtain the services of two psychiatrists, Dr. Michael Charles Nurse and Dr. Michel Silberfeld, to conduct assessments with regard to S.J.L.'s competence in two respects:

i) To make her own decisions related to her health care of whatever medical conditions the assessments present as requiring treatment; and

ii) To maintain and to seek treatment and otherwise provide for her healthy physical and emotional well-being.

[8] At my request, a full report outlining the treatment and diagnosis of S.J.L. was prepared and filed by Dr. Kim St. John, her primary treating psychiatrist from November 2008 until the end of November 2009. As well, Dr. David Day, a psychologist who had been involved with the treatment of S.J.L. for some time, filed a report related to his involvement, diagnosis and position on competency. A further report prepared by Dr. Ronald Fraser, titled as being a "Psychiatric Assessment", dated December 21, 2009, was provided. That report referred to S.J.L.'s course of treatment and, in some respects, her competency. This report was apparently requested by the Eastern Regional Integrated Health Authority ("Eastern Health") as a result of a request from the Minister of Health for the Province of Newfoundland and Labrador for a review of S.J.L's treatment up to that time.

[9] All four of the psychiatrists referred to above, Drs. Nurse, Silberfeld, Fraser and St. John, along with the psychologist, Dr. David Day, testified at the competency hearing. It is this testimony with the reports filed along with the affidavit filed by S.J.L. and the evidence of P.H. that I must assess in deciding whether the order sought for a declaration of incompetency should be granted.

[10] I would also point out that while the full medical and school records have been made available to the Court-appointed doctors and psychologist, Mr. Day representing S.J.L.'s best interests and the Court, they have not been disclosed to the other parties due to the privacy interests as related to S.J.L., particularly with regard to her medical records. While admittedly perhaps providing some limitation on counsel for the mother of S.J.L. and Eastern Health, I am satisfied that this lack of disclosure has not resulted in any unfairness to either party or to a situation that deprives me of having full information upon which to decide this matter. The medical witnesses who testified all had the opportunity to fully review the medical and school records of S.J.L. They are the persons qualified to provide opinion evidence with regard to the issue of S.J.L.'s competency based upon their special experience and expertise. Saying this, I do not wish to be seen as suggesting that

the mother's evidence in this matter is of no assistance and, similarly, the same can be said for the affidavit of S.J.L.

**S.J.L.'S CIRCUMSTANCES**

[11] As stated above, S.J.L. is currently just over sixteen and a half years of age. Prior to admission to a hospital related to her psychological condition, she resided with her mother as well as her two brothers. The father and mother of S.J.L. have been separated since early 2006 but the father is said in the application before me to remain "an active participant in family decision making".

[12] S.J.L. first presented at the Janeway Hospital for psychiatric issues in November 2007 following her taking an overdose of acetaminophen. While it was felt by her doctors that a traumatic event had triggered this, no disclosure was made. In April 2008, a further overdose incident occurred requiring admission to the Janeway Hospital for medical services and, subsequently, for psychiatric services. She remained at the Janeway Hospital until May 16, 2008, and thereafter was seen on a weekly and outpatient basis. On July 13, 2008, S.J.L. was once again admitted to the Janeway due to an overdose and she remained on the psychiatric unit there until she was transferred to the Waterford Hospital. This transfer occurred due to a shortage of nurses, prompted primarily by what I understand was a problem that had developed related to another female patient. S.J.L. has remained at the Waterford Hospital since, except for some short periods of time on discharges or on day passes.

[13] From all the information provided to me, it seems that S.J.L. has been a challenging patient to treat. This is based upon her unwillingness to accept treatment, including the taking of medication or participating in various therapies suggested to her for treatment purposes. It is also my conclusion from the information provided to me that S.J.L. has not yet connected in a meaningful way with any of treating psychiatrists or psychologist. While she has responded to them to various degrees, it seems obvious to me that S.J.L. only participates in discussions regarding treatment that she believes herself will be of some affect or is

something she can agree with. While not at all here indicating any negativity towards S.J.L. or her treating psychiatrists or psychologist, it appears that she has managed, to some degree, the professionals she has been dealing with as opposed to them being able to manage her treatment. In many respects, S.J.L. has been actively determining her own course while in hospital. Whether this is being done of her own conscious free will or is occurring as her condition manifests itself is an issue to be considered here.

[14] S.J.L. has had a number of treating doctors for physical injuries as well as a number of psychiatrists treating her mental health. She was initially being treated by Dr. White when admitted to the Janeway Hospital in July, 2008. She agreed to take medication prescribed to her and she reportedly responded well to this for a brief period of time. However, she began to refuse to take this medication, without giving any reason, within a number of weeks. Subsequently, she left the Janeway Hospital without permission, possibly with scissors in her possession. She was found the next day but was then sick due once again to a probable ingestion of acetaminophen. She then agreed to take a different type of medication, an anti-depressant, but subsequently overdosed again in mid-August, 2008.

[15] It was after this that a new psychiatrist was requested and Dr. Bonnell took over her treatment. In September 2008, she once again began to refuse taking any medication. When out of the Janeway Hospital on a day pass shortly after, she again ingested acetaminophen and had to be treated for this. She thereafter remained at the Janeway Hospital but throughout October 2008 she attempted to hang or strangle herself and also engaged in intentionally cutting herself.

[16] In November 2008, Dr. Kim St. John took over the psychiatric care of S.J.L. This occurred at the time when S.J.L. was moved to a security unit at the Janeway Hospital due to increasing concerns for her safety. During this time she reportedly swallowed clips from the bed frame, was banging her head against the wall and used a string from her clothing in an attempt to strangle herself. S.J.L. agreed to take Paxil in late November 2008 but continued to attempt to harm herself by asphyxiation by way of swallowing bottle caps, a peanut butter package, batteries,

a sock, and puzzle pieces. She is also reported to have cut her wrists during this time.

[17] It was on December 13, 2008, that S.J.L., together with another female patient, was transferred to the Waterford Hospital from the Janeway Hospital. I am satisfied that this transfer did not occur in the manner that readily displays sensitivity to S.J.L.'s condition or to her age. Notwithstanding this, this transfer occurred due to some practical realities related to the availability of nurses to work on the unit at the Janeway Hospital at that time. I am also satisfied that Dr. Kim St. John was of the belief at that time that the transfer was to be for a short period only but this proved to be inaccurate.

[18] Notwithstanding that S.J.L. was then only 15 years of age, she thereafter remained at the Waterford Hospital (when not requiring surgery or other care at the Janeway Hospital or Health Sciences Hospital due to her self-harming behaviors). Dr. St. John remained involved in S.J.L.'s treatment during that time despite the transfer and did so in consultation with S.J.L.'s then attending physician, Dr. Neil Young.

[19] During the following Christmas period and when out of hospital on passes, S.J.L. cut her arms requiring stitches and then again ingested acetaminophen requiring hospitalization. In early January 2009 when back at the Waterford Hospital, S.J.L. agreed to take Epival, a medication used as a mood stabilizer. She was at that time certified under the *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1, which certification was upheld in late January 2009 by the Review Board mandated by the *Act*. Arrangements were made in February 2009 for S.J.L. to be seen by Dr. Blaise Aguirre, who is, as I understand it, considered to have special expertise in the treatment of adolescents with psychiatric illnesses. He uses a form of treatment known as Dialectical Behaviour Therapy ("DBT") when treating adolescents with Borderline Personality Disorder. He assessed S.J.L. but found her not ready to be transferred to his clinic in Boston. This was due to his perception that S.J.L. lacked any motivation to help herself or to engage in any form of therapy.

[20] After this, there was a period of time that S.J.L. was taking her Epival and there were no self-harming incidents. As a result, she began getting passes, increasing in duration, and she was subsequently discharged to the care of her mother at the end of March 2009.

[21] The following day after that discharge, S.J.L. returned to the hospital having once again ingested an overdose of Epival and acetaminophen. As well, a needle was found in her chest wall at the time of her admission. A few days later she swallowed bottle caps. At about this time, she refused to take the Epival prescribed to her due what she claimed were side effects related to feeling sleepy and weight gain. In April 2009, she was found with a string around her neck and she also swallowed a blade from an eyebrow pencil sharpener. In May 2009, S.J.L. swallowed a pin and in June she was found with a ligature around her neck.

[22] It was also in June 2009 that I understand that an "Ethics Panel" at the Waterford Hospital stated that the hospital staff felt that the "standard of care was not being met" for S.J.L. It was felt that S.J.L.'s continued isolation in the Waterford Hospital was detrimental to her well-being. The Ethics Panel also stated that the health care team treating S.J.L. were of the opinion that "this patient cannot give consent to treatment and that a substitute decision-maker is required." (See report of Dr. Michel Silberfeld at page 6.) This occurred just prior to the sixteenth birthday of S.J.L., which birthday was on June 12, 2009.

[23] It appears that passes were subsequently reinstated to permit S.J.L. to leave the Waterford Hospital for short durations. During these passes in June 2009, S.J.L. came back to hospital having swallowed a blade and after taking an overdose of cold products. On another pass, she swallowed the blade portion of a steak knife requiring surgical removal. In early July 2009, S.J.L. left the Janeway Hospital contrary to medical advice related to her recovery from surgery and refused to return to the Waterford Hospital. Two days after leaving, she again swallowed a knife that was removed by an endoscopy procedure. A few days after, she attempted to swallow gauge dressing. Shortly after this, again all in July, she swallowed a steak knife and tweezers which required further surgical removal. She was then subsequently certified again under the *Mental Health Care and Treatment*

*Act*. After this, she continued to refuse to take any medications and on August 21, 2009, after being decertified and while out of the hospital on a two-hour pass, once again swallowed a knife.

[24] It was apparently in September 2009 that possible out-of-province treatment was once again discussed with S.J.L. but she refused to agree to this. The issue of treatment using DBT in Boston was again raised as well as family therapy. Again, no progress was made on either suggestion due to resistance on the part of S.J.L. In late September 2009, while away from the Waterford Hospital on a pass, S.J.L. had a further acetaminophen overdose. In October 2009 she swallowed a knife, scissors and part of a compass. After treatment for the physical effects of this, S.J.L. was discharged as she did not agree to stay in the hospital and at that time it was felt that she was not certifiable. She was discharged on November 18, 2009. On the following day she had to be readmitted for the surgical removal of a knife. After treatment for this, she was once again discharged but later readmitted the following day after swallowing a butter knife.

[25] It was after that, when it was concluded by two psychiatrists that S.J.L. was not certifiable and she wanted to leave the hospital, the mother of S.J.L. made the present application to the Court to prevent her discharge.

[26] S.J.L. remains detained at the Waterford Hospital under continuous 24-hour supervision at this time pursuant to this Court's order. There has been one incident reported of attempted self-harm since which involved S.J.L. swallowing a small safety pin she apparently found in the sweater given to her as a gift over the Christmas period. No surgery or other removal techniques were needed to deal with this.

[27] In total, from Dr. St. John's report, there have been three times when S.J.L. has been certified under the *Mental Health Care and Treatment Act* by two psychiatrists, the last occasion being on July 29, 2009 until August 20, 2009. There have been six occasions when she has been certified on one signature. On

November 30, 2009 and December 2, 2009, S.J.L. was found to not meet the criteria required for certification under the *Act*.

[28] It should be pointed out that from mid-2009 onward S.J.L. has had significant supervision while in the hospital to ensure her safety.

[29] It is also apparent that the parents of S.J.L., particularly the mother, have on occasion disagreed with treatment suggestions made for S.J.L. In fact, based upon the comments made by counsel for the mother, it seems clear that the mother has little, if any, trust in the ability of psychiatrists or other health care providers with Eastern Health to treat her daughter. As well, it seems that S.J.L. feels that she can and does manipulate or influence her mother's actions with regard to seeking support to refuse treatment.

[30] I have reviewed what I understand to be the medical and psychiatric history here in some detail as it is clearly relevant to providing a context for the present issue to be determined by me. It is, to say the least, a sad and troubling state of affairs.

**THE LAW**

**a) Competency**

[31] The age of majority in this Province is 19 (*Age of Majority Act*, S.N.L. 1995, c. A-4.2, section 2). Adults are presumed to be competent to make decisions regarding the course of their own medical and psychiatric treatment. This presumption can only be rebutted by evidence of incompetency. When competency is in question, an adult person can make any decision regarding treatment, notwithstanding that it may vary from the opinion of a health care provider and/or may result in significant deterioration of a person's health and

perhaps even likely lead to death of the person (see **Re Strong** (1993), 107 Nfld. & P.E.I.R. 350 (Nfld. S.C.(T.D.)); **Starson v. Swayze**, [2003] 1 S.C.R. 722; **Malette v. Shulman** (1990), 72 O.R. (2d) 417 (C.A.); **Fleming v. Reid** (1991), 4 O.R. (3d) 74 (C.A.); **Rodriquez v. British Columbia (Attorney General)**, [1993] 3 S.C.R. 519; and **A.C. v. Manitoba (Director of Child and Family Services)**, [2009] S.C.J. No. 30).

[32] In this Province, by way of legislation, including the *Advance Health Care Directives Act*, S.N.L. 1995, c. A-4.1 (section 7), the *Child, Youth and Family Services Act*, S.N.L. 1998, c. C-12.1, and the *Neglected Adults Welfare Act*, R.S.N.L. 1990, c. N-3, a person who attains the age of 16 is presumed competent to consent to their own medical treatment. This legislation is subject to the common law recognition of the "mature minor" doctrine. This doctrine recognizes that persons under the age of 16 who are found to be "mature minors" are able to make their own health care decisions. Such persons have the right to make such decisions based upon their level of maturity. The scrutinizing of that maturity is said to increase in accordance with the severity of potential consequences of the treatment or refusal to accept treatment (see **A.C. v. Manitoba (Director of Child and Family Services**, **C.(J.S.) v. Wren** (1986), 76 A.R. 45 (C.A.), and **Re A.Y.** (1993), 111 Nfld. & P.E.I.R. 91 (Nfld. U.F.C.)).

[33] The ability to make such decisions recognizes the significance given to a person's fundamental right to autonomous decision-making in connection with their own physical and mental health. It is only where it is established on a balance of probabilities that a person presumed to be competent is incompetent that the Court may exercise its common law *parens patrie* jurisdiction to interfere with a treatment decision or to impose a treatment option. The right to exercise this *parens patrie* authority in this Province is well established in such cases a **Re Strong**, **Re Jane Doe (Guardian ad litem),** 2005 NLTD 72, and **Eastern Regional Integrated Health Authority v. B.A.H.**, 2007 NLTD 30.

[34] In this case, by legislation S.J.L. is not a person who has reached the age of majority although she is presumed competent to make her own health care

decisions. As stated above, this presumption is rebuttable by proof of incompetency on a balance of probabilities.

[35] The legal test for determining competency or capacity is set out in **Starson v. Swayze** at paragraph 78 as follows:

> Capacity involves two criteria. First, a person must be able to understand the information that is relevant to making a treatment decision. This requires the cognitive ability to process, retain and understand the relevant information. … Second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. This requires the patient to be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof.

[36] As held by Green, J. (as he then was) in **Re Strong** at paragraph 24, "… it is only where a person clearly cannot in fact exercise her rights to make autonomous decisions regarding consent to medical treatment that a court should even consider exercising the *parens patriae* jurisdiction to make such decisions …" for the person involved.

[37] It is to be recognized that a competency assessment is both task and time specific. It must be based on an individualized assessment of the person's actions and what they say about their choices. Merely because others may see the decision of the person as not being reasonable does not mean the person is incompetent. Such is obviously in recognition of the autonomy and right of a person to make their own health care decisions. It is also clear that the mere existence of a mental illness or condition does not mean that the person cannot meet the requirements of the legal competency test.

[38] With regard to the first component of the test of competency stated above, the cognitive ability to process and retain relevant information must be present in determining whether a person understands information relevant to making a treatment decision. The person need not understand technical descriptions of their

illness or issues, nor does the person have to agree with the specific diagnosis made of that condition but must be capable of recognizing that he or she is affected by an illness or condition.

[39] For the second component of the test – being able to appreciate the reasonably foreseeable consequences of the treatment decision or lack of one, the person must have the ability to appreciate the consequences of the decision to be made. The person does not have to actually appreciate these consequences.

[40] I accept the description of the distinction between the concepts of "understanding" and "appreciating" as required in the **Starson** set out in an article titled "Determination of Competence", written by Kathleen Cranley Glass and Michel Silberfeld in S. Gauthier's *Clinical Diagnosis and Management of Alzheimer's Disease* (London, England: Martin Dunitz, 1996) at pages 349 and 350. This has been submitted to me as a reference by Mr. Day. There it is stated as follows:

> Understanding the decision will include being able to identify the decisional options the person is facing. After the options are elicited from the person, missing options should be suggested. Does the person recognize them? Do they seem pertinent? Why is one option preferred? Are the risks and benefits of the preferred option acknowledged? The acknowledgement of any risks and benefits should relate to the impact on the person's life. What is the subjective view of risk? Is the risk voluntarily assumed? Preferences for a decisional option are personal statements which may reflect important beliefs. What is important is often an indication of values which are held and "stand for the person". Religious and cultural values can become clear when individuals are faced with challenging situations which force them to focus on what is important to them. It is wise to remember that values often are altered by challenging circumstances. This may mean that an assessment of competence takes place in the midst of the decision-making process. If there is no time pressure, allowance should be made for the process of coming to a choice by extending the assessment over a number of interviews.
>
> Appreciating the consequences of the preferred decisional option is the most difficult task to assess, for which the least guidance is available. It is helpful for the assessment if the person can recognize his or her own limitations in

> making the decision at hand. The consequences are appreciated with reference to the person's life history and aspirations. They are connected to value statements. However, the person is expected to go beyond a simple statement of wishes. Some anticipation of the future, and the ability to consider events which have not occurred or may not occur, are necessary. Furthermore, in order to demonstrate appreciation of the implications of a choice, persons may need the ability to apply reflective thought (higher order intentions) to restrain themselves from impulsiveness, and to avoid certain biases which may inhibit their appreciation.

[41] In saying this, I also accept what was stated by McLachlin, C.J. in **Starson** at paragraph 15 where she points out the following:

> While the difference between ability to understand and appreciate and actual understanding or appreciation is easily stated, it may be less easy to apply in practice. Capacity is an abstract concept. The primary means of ascertaining capacity or ability, in any context, is to look at what an individual in fact says and does. …

[42] McLachlin, C.J. goes on to indicate that the first part of the test requires that a person is capable of intellectually processing the information related to the treatment decision to be made including information about the proposed treatment as well as what the impact of the treatment will be. The person must be able to acknowledge their symptoms but need not have to agree with any diagnosis made.

[43] As to the second component of the test – appreciation of foreseeable consequences of a treatment decision or lack of decision, McLachlin, C.J. characterizes this as being "more stringent than a mere understanding test, since it includes both a cognitive and an affective component". The person must not only be able to understand the relevant information but also must "appreciate the reasonably foreseeable consequences of a decision or lack of decision". Appreciation requires an ability to weigh and evaluate the foreseeable consequences of accepting or refusing treatment. She goes on to refer to what she found were three "common clinical indicators" to be used as a useful framework of assessing the required level of appreciation. These are as follows:

i) whether the person is able to acknowledge the fact that the condition for which treatment is recommended may affect him or her;

ii) whether the person is able to assess how the proposed treatment and alternatives, including no treatment, could affect his or her life or quality of life; and

iii) whether the person's choice is not substantially based on a delusional belief.

Again, it is to be recognized that agreement with the proposed treatment is not a requirement to establish the required level of appreciation. A person having the necessary capacity has the right to make what may seem to be foolish decisions with regard to their own health and well-being.

[44] While McLachlin, C.J. was not part of the majority in the **Starson** case, it seems clear that she was not in disagreement with the majority opinion with regard to the competency test to be applied. Rather, she disagreed with the majority judges in the application of that test with regard to Professor Starson. As a result, her comments regarding the test for competence are very helpful in any assessment to be made.

**b) Best Interests Standard**

[45] It is with all of this in mind that I must proceed to assess the evidence before me as to the competency of S.J.L. Before doing so, however, due to her age and level of maturity, I find it necessary to refer to what I consider is another aspect of the decision that I must make in this case, that being the application of the best interests standard. It is my opinion that the best interests standard should have application, where the treatment decision is related to the preserving of life of a person who is not legislatively recognized as an "adult". I am of the opinion that the best interests standard must be applied in line with the level of maturity had by the individual involved as well as the independence of their judgment. My reason for concluding that this is a proper consideration is based upon the rationale used by the Supreme Court of Canada's majority decision in **A.C. v. Manitoba (Director of Child and Family Services)**.

[46] In that case, Abella, J., for the majority of the court, found that, in accordance with the *Child and Family Services Act*, C.C.S.M. c. C80, applicable child protection legislation in place in Manitoba that stipulated that a court could authorize medical treatment for a person under 16 years of age considered in that person's best interests, such a consideration was not an unconstitutional one. The caveat to this is that the best interests standard must be applied in a manner that takes into increasingly serious account the young person's views the greater the child's level of maturity. This is an analysis that is best analogized with a "sliding scale" type of approach. While this reasoning was applied with regard to a person under of the age of 16, I find that the same reasoning is applicable to those over the age of 16 up to the time the person reaches the age of majority and is recognized by law as an adult.

[47] At paragraphs 81 and 82 in the **A.C. v. Manitoba (Director of Child and Family Services)** case, Abella, J. states:

> The general purpose of the "best interests" standard is to provide courts with a focus and perspective through which to act on behalf of those who are vulnerable. In contrast, competent adults are assumed to be "the best arbiter[s] of [their] own moral destiny" (Giles R. Scofield, "Is the Medical Ethicist an 'Expert'?" (1994), 3(1) *Bioethics Bulletin* 1, at p. 2), and so are entitled to independently assess and determine their own best interests, regardless of whether others would agree when evaluating the choice from an objective standpoint.
>
> The application of an objective "best interests" standard to infants and very young children is uncontroversial. Mature adolescents, on the other hand, have strong claims to autonomy, but these claims exist in tension with a protective duty on the part of the state that is also justified.
>
> [my emphasis]

[48] At paragraph 86 of her decision, Abella, J. goes on to state the following for situations where medical treatment is necessary to protect the life or health of a young person and where consent is not forthcoming:

> Where a young person comes before the court under s. 25 of the *Child and Family Services Act*, on the other hand, it means that child protective services

> have concluded that medical treatment is necessary to protect his or her life or health, and either the child or the child's parents have refused to consent. In this very limited class of cases, it is the ineffability inherent in the concept of "maturity" that justifies the state's retaining an overarching power to determine whether allowing the child to exercise his or her autonomy in a given situation actually accords with his or her best interests. The degree of scrutiny will inevitably be most intense in cases where a treatment decision is likely to seriously endanger a child's life or health.

[49] She goes on at paragraph 87 to hold that:

> The more a court is satisfied that a child is capable of making a mature, independent decision on his or her own behalf, the greater the weight that will be given to his or her views when a court is exercising its discretion under s. 25(8). In some cases, courts will inevitably be so convinced of a child's maturity that the principles of welfare and autonomy will collapse altogether and the child's wishes will become the controlling factor. If, after a careful and sophisticated analysis of the young person's ability to exercise mature, independent judgment, the court is persuaded that the necessary level of maturity exists, it seems to me necessarily to follow that the adolescent's views ought to be respected. Such an approach clarifies that in the context of medical treatment, young people under 16 should be permitted to attempt to demonstrate that their views about a particular medical treatment decision reflect a sufficient degree of independence of thought and maturity.

[50] Finally, at paragraphs 95 and 96 Abella, J. concludes as follows:

> In those most serious of cases, where a refusal of treatment carries a significant risk of death or permanent physical or mental impairment, a careful and comprehensive evaluation of the maturity of the adolescent will necessarily have to be undertaken to determine whether his or her decision is a genuinely independent one, reflecting a real understanding and appreciation of the decision and its potential consequences.
>
> As all of this demonstrates, the evolutionary and contextual character of maturity makes it difficult to define, let alone definitively identify. Yet the right of mature adolescents not to be unfairly deprived of their medical decision-making autonomy means that the assessment must be undertaken with respect and rigour. The following factors may be of assistance:

> - What is the nature, purpose and utility of the recommended medical treatment? What are the risks and benefits?
>
> - Does the adolescent demonstrate the intellectual capacity and sophistication to understand the information relevant to making the decision and to appreciate the potential consequences?
>
> - Is there reason to believe that the adolescent's views are stable and a true reflection of his or her core values and beliefs?
>
> - What is the potential impact of the adolescent's lifestyle, family relationships and broader social affiliations on his or her ability to exercise independent judgment?
>
> - Are there any existing emotional or psychiatric vulnerabilities?
>
> - Does the adolescent's illness or condition have an impact on his or her decision-making ability?
>
> - Is there any relevant information from adults who know the adolescent, like teachers or doctors?
>
> This list is not intended to represent a formulaic approach. Its objective is to assist courts in assessing the extent to which a child's wishes reflect true, stable and independent choices.
>
> [my emphasis]

[51] In **A.C. v. Manitoba (Director of Child and Family Services)**, notwithstanding the presumed competency of the individual involved, the majority of the Court allowed for a sliding scale application of the best interests standard. A person who is aged 16 and has not yet reached the age of majority is in no different a position than a person found to a "mature minor" under 16 years of age in my view. Neither have attained the age of majority notwithstanding a recognition of competency either by statute or common law. As the approach to be applied takes into account differing levels of maturity, I see no issue in accepting that the best interests standard is to be applied for individuals who, at law, are not recognized as being an "adult". The Court's authority to protect the vulnerable using its *parens patriae* jurisdiction accords with this approach for this class of persons.

[52] As a result, where the presumed competency of a young person who is under the age of majority is not rebutted, the Court in the exercise of its *parens patriae* jurisdiction should go further and consider the young person's level of maturity in determining whether it will force treatment in the face of the right of autonomous decision-making given to such a person. In other words, unlike adults, the best interests standard remains a consideration but must be applied in accordance with the maturity of the young person. The more the young person is found to be mature in his or her thinking process and in life, the greater regard that must be given to that person's choice. To me, the application of the best interests standard in the manner described accords with societal values and, as well, constitutional standards.

[53] Therefore, should I find that there has been a failure to rebut the presumption of competency for S.J.L. on a balance of probabilities, I must still have regard to the best interests standard using the approach set out above.

**EVIDENCE PRESENTED:**

[54] The evidence led at the hearing before me with regard to the legal competency of S.J.L. to make her own health care decisions came, for the most part, from five medical professionals. The Applicant also submitted an affidavit along with her application that forms part of the record before me and she has also testified in response to the affidavit filed by S.J.L. Neither party wished to cross-examine S.J.L. on her affidavit and agreed to the filing of this affidavit for my consideration of its contents. As agreed by counsel, I also met with S.J.L. for some 30 minutes at the Waterford Hospital. I have previously informed counsel, on the record, of the general content of my discussion with S.J.L. at that meeting as well as some of my impressions of her. I am well aware of the fact that my meeting with S.J.L. was brief and that any reliance I place on my impression of her from that meeting must be made with due caution.

**a) Expert Evidence**

[55] With regard to the testimony of the medical professionals, Dr. Silberfeld and Dr. Nurse were appointed by my order to conduct an assessment of the legal competency of S.J.L. At the same time, I posed two questions for their consideration as were set out earlier in this decision (see paragraph 7 above). Both psychiatrists conducted what were characterized as being "formal" assessments. As well, Dr. Kim St. John, who as previously indicated was the treating psychiatrist for S.J.L. for over one year up to the end of November 2009, also testified and provided a report that is relevant to the issue of S.J.L.'s competency in my opinion. Dr. St. John's assessment of this issue was characterized as being an "informal" one. Dr. David Day, a treating psychologist for S.J.L. for approximately one year, was also asked to prepare a report regarding her legal competency. His assessment was said to be a "formal assessment". Finally, Dr. Ronald Fraser, a psychiatrist retained by Eastern Health to review the treatment of S.J.L., also gave what he testified was a "philosophical" assessment of the legal competency of S.J.L.

[56] Dr. Silberfeld and Dr. Nurse, together with the psychologist, Dr. Day, all concluded that S.J.L. did not meet the legal criteria for competency to make decisions about her health care and treatment or to manage her future ongoing health care and treatment. All three indicated that S.J.L. did not meet either of the two components necessary for legal competency in the **Starson** test (although this is less clear to me with regard to Dr. Day's testimony).

[57] Dr. St. John testified that she believes that S.J.L. is legally competent to make her own health care decisions based upon her experience in dealing with S.J.L. over the past year. Dr. Fraser's testimony, as related to S.J.L.'s health care treatment review, concluded what he acknowledged was a philosophical view of her legal competency. He had not reviewed the vast majority of the medical chart of S.J.L. or her school records and spent little time interviewing her. While it is true that he depended significantly on information from the treatment team members in conducting his review, his expertise in the area of Borderline Personality Disorder makes his evidence relevant for consideration, at least to some degree. Saying this, I also accept that he did not conduct what I believe would be a

"formal" or "informal" assessment of the legal competency of S.J.L. to make her own health care decisions.

[58] Based upon what has been presented before me, I have little before me to suggest that S.J.L. does not suffer from Borderline Personality Disorder. This has been the main diagnosis for S.J.L. made by a number of psychiatrists who have either treated or have had occasion to assess her. I am aware that Dr. Nurse suggests that S.J.L. may have an Axis I diagnosis of depression but the documentation and reports that I have seen, or have been referred to in the evidence, apparently do not indicate agreement with that formal diagnosis.

[59] In describing Borderline Personality Disorder, Dr. St. John in her report dated December 14, 2009, stated as follows:

> Borderline Personality Disorder is a personality style characterized by unstable emotions, mood, behaviour, relationships and self-image. It occurs in 1 – 2% of the general population, which is approximately the same prevalence as Bipolar Disorder. It is felt to be twice as prevalent in women as men. The incident in inpatient population has been reported to be as high as 14 – 20%. There is an increased risk of developing Borderline Personality Disorder if there is a family history of the same. It is estimated that 69 – 80% of patients with this disorder attempted suicide, with a higher percentage engaging in non-suicidal, self-injurious behaviour. Despite treatment with best practices, the completed suicide rate is approximately 10%.
>
> The diagnosis of Borderline Personality Disorder has historically been viewed as difficult to treat, and even untreatable. More recently, it is recognized that various forms of psychotherapy can bring about changes and behaviour. Recent articles indicate that general psychiatric care, supportive psychotherapy, dialectic behaviour therapy and transference-focused psychotherapy all show positive impact on maladaptive behaviours and health care usage. Dialectic behaviour therapy often reported to be the best in this population, has its research based in specialized centres with patients who are committed to therapy.
>
> The role of medication in Borderline Personality Disorder is predominantly in the treatment of co-occurring diagnoses such as anxiety and depression. The evidence of drug treatment is poor at best. A number of medications have been tried due to the severity of symptomatology of this

> disorder. There is some evidence that mood stabilizers may be useful. Additionally, medications such as fluoxetine have been reported to decrease impulsivity, however, there is no drug treatment specifically for Borderline Personality Disorder.
>
> Hospitalization is recommended only for acute stabilization and is felt to lead to deterioration in most patients. Long-term hospitalization has not been shown to decrease suicidal or non-suicidal, self-injurious behaviours.

[60] More specifically, with regard to S.J.L.'s symptoms, Dr. St. John stated in her report at page 9 as follows:

> The diagnosis of Borderline Personality Disorder in [S.J.L.] has been based on: a pattern of unstable and intense interpersonal relationships characterized by idealization and devaluation (all good, all bad); frantic attempts to avoid real or imagined abandonment; impulsivity including a history of binging and purging (eating disordered behaviour), as well as substance use; an unstable sense of self; recurrent suicidal behaviours, both threats and gestures; chronic feelings of emptiness, and transient stress related paranoia. In fact, [S.J.L.] becomes non-communicative when extremely anxious.

[61] In assessing the expert evidence I have heard, it is clear to me that the diagnosis of a mental disorder, particularly a major personality disorder, as well as determining effective treatment options for such disorders is anything but "a perfect science". One of the psychiatrists in fact alluded to such an assessment as being like "a poker game".

[62] As well, it must be recognized here by me that Dr. Silberfeld, Dr. Nurse and Dr. Fraser each were called to assess S.J.L.'s circumstances on a time-limited basis. While not in any manner reflecting on their level of professionalism or expertise, there must be a recognition that the assessments may be limited to some degree by the fact that S.J.L. historically is a shy and anxious person who does not engage well in new situations. As Dr. St. John and Dr. Day were part of her treatment team, I am satisfied that there was some rapport built up between themselves and S.J.L. over time that gives their assessment such advantage. Some emphasis was placed on the fact that S.J.L. responded many times to questions of both Dr.

Silberfeld and Dr. Nurse by saying "I don't know". I am not satisfied, based upon what is before me, that these words actually were meant in such a fashion as to automatically permit a conclusion that S.J.L. truly did not know the answer to the question being asked or did not have the intellectual capacity to respond.

[63] As well, also to be considered is the affidavit filed by a member of the nursing staff at the Waterford Hospital after Dr. Silberfeld's meeting with S.J.L. where she later reported that S.J.L. indicated that she had intentionally mislead Dr. Silberfeld in certain answers she gave to him.

[64] One other significant fact that causes me concern relates to the report and evidence of Dr. Day. Initially when he presented his report regarding S.J.L, I found that there to be a surprising level of personal commentary and antagonism with staff members and members of S.J.L.'s treatment team. To say the least, this causes me much concern that the opinions being offered by Dr. Day are tainted to some degree and perhaps lack the required level of objectivity expected of a person providing expert testimony. As a result, the initial report was not admitted into evidence but a further report that he produced was. While satisfied that Dr. Day's testimony and second report are relevant to my decision here, what transpired with regard to this cannot be totally disregarded in any consideration of the weight to be his evidence.

[65] All of this must be considered in my weighing of the conclusions reached by each of the doctors who testified.

**b) S.J.L.'s Affidavit**

[66] As stated earlier, it was only after the testimony was completed at the hearing and upon my visiting with S.J.L. at the Waterford Hospital that she expressed any interest in taking part in these court proceedings. It was at that time that I appointed Ms. Sullivan to represent S.J.L.

[67] Based upon what I have been told, I am satisfied that Ms. Sullivan has met with S.J.L. on a number of occasions and reviewed the reports and some of the testimony of each of the medical professionals with her. Thereafter based upon what S.J.L. told her, Ms. Sullivan prepared an affidavit on behalf of S.J.L. Ms. Sullivan then met with S.J.L., reviewed the affidavit in detail and, upon being satisfied that it communicated what S.J.L. wanted to say, had her sign it.

[68] That affidavit contains some 61 paragraphs. As stated earlier, counsel advised that they did not wish to cross-examine S.J.L. on it and were prepared to allow it to be filed for my consideration. Some additional evidence was called to allow Ms. Sullivan the opportunity to ask questions to Dr. Fraser. As well, Dr. Nurse and the Applicant testified specifically in response to the affidavit S.J.L. had signed.

[69] S.J.L. refers in her affidavit to certain parts of the reports filed and testimony heard from the medical professionals. As well, she states that she understands the nature of this application made by her mother and the possible consequences of my finding her legally incompetent to make her own health care decisions. She goes on to state that she believes that she is capable of and, in fact, understands information given to her by her doctors regarding treatment. She goes on to state "I think I am able to appreciate the consequences of my refusal of treatment." She also acknowledges being diagnosed with Borderline Personality Disorder but says that she does not think that she has any mental disorder although she agrees that she has some of the symptoms of Borderline Personality Disorder, including impulsivity, poor judgment and mood swings.

[70] Of all of the reports filed, S.J.L. indicates that Dr. Fraser's description of her best applies in that she acknowledges she has poor judgment, she does not subscribe to social norms, and that it is not considered normal to swallow things that might kill her.

[71] With regard to her self-harming behaviour, S.J.L. states that not all of what has occurred has been the result of impulse. In fact, she says that on most

occasions she makes a conscious choice to harm herself. She does acknowledge that sometimes she feels she cannot resist the urge to self-harm. She also states that while she is not consumed with thoughts of harming herself, she does think about this "a lot".

[72] S.J.L. expresses awareness of the possibility of death as a result of her self-harming behaviors, especially by swallowing objects due to the concern of Dr. Price, a surgeon, that further surgeries are dangerous for her due to the present amount of scar tissue in existence as a result of prior surgeries. She does say that when swallowing, she does think about the nature of the object involved and whether it can be removed by "scope or if I will need surgery". She goes on to say that "most times" she has a reason for engaging in self-harm but chooses not to disclose the reasons to her health care providers.

[73] S.J.L.'s states that some reasons for refusing to take part in therapy or to accept medication are that if she makes a conscious decision to harm herself she cannot "understand how her doctor can treat a decision" and that the medications she has taken have not "had any impact on me whatsoever". She is also concerned about weight gain as a side effect of medication as well as how the drugs affect her thought processes.

[74] With regard to behaviour therapy in Boston, S.J.L. acknowledges Dr. St. John having explained this to her but states that she is shy and anxious and is not interested participating in such therapy outside of the St. John's area. She also does not want to participate in family therapy as she does not want to discuss her behaviors with family members.

[75] She acknowledges limited insight into some of the reasons she harms herself and that she, on her own, has never sought medical treatment. She says that she can stop her self-harming behaviors herself when she decides to do this. She agrees with Dr. Nurse's statement that she has "surrendered my ability to survive" and that she does "not have the ability to make any long lasting commitments towards preserving her own life".

[76] Finally, S.J.L. feels that she understands information related to Borderline Personality Disorder and while not specifically knowing what the treatment options are, she is not interested in taking any medications or involving herself in "talk therapy".

[77] It has been suggested by counsel for the Applicant that the affidavit submitted by Ms. Sullivan is "tainted" by the wording chosen by Ms. Sullivan in that the words and comments made are not those within the intellectual capacity of S.J.L. In fact, the mother testified that many of the phrases used were beyond the cognitive level of S.J.L. or were not in her vocabulary. I have considered this argument and evidence and find myself unable to accept that the affidavit in any way misrepresents the views of S.J.L. Having spoken to S.J.L. myself, I am unable to conclude that she could not relay her views to Ms. Sullivan. As well, as acknowledged by Ms. Sullivan, while the affidavit is not a verbatim account of what S.J.L. said, it is an accurate reflection of the position being taken by S.J.L. I would also point out that in the affidavit of the Applicant filed with her application to this Court, the mother acknowledges seeing the contents of a computer journal of S.J.L. in November 2009 and relates there what is stated in that journal. If one looks at the content reported by the Applicant, whether written by S.J.L. or not, there is a clear suggestion that S.J.L.'s cognitive understanding of her position is far more comprehensive than what the Applicant is suggesting in her evidence. While the words used by Ms. Sullivan in drafting the affidavit of S.J.L. may not all be seen by the mother as words that S.J.L. would normally use, I am completely satisfied that the affidavit accurately reflects what S.J.L. has to say.

[78] I am satisfied therefore that the contents of S.J.L.'s affidavit are clearly an expression of her views and are deserving of careful consideration in any legal competency analysis that I must make.

## MY CONCLUSIONS

### a) Competency

[79] As described earlier, the legal test adopted from the **Starson** case for competency involves a consideration of two components – the person's ability to understand information relevant to making a treatment decision and the ability to appreciate reasonably foreseeable consequences of a decision or lack of a decision. I will now assess each of these components as they relate to S.J.L. Before doing so, however, it is important once again to recognize that psychiatry is not an exact or perfect science and, by extension, even health care professionals acknowledge some uncertainty with regard to diagnosis, treatment options and prognosis. Based on what I have been given here, this is of particular note where the suggested diagnosis involves a serious personality disorder. Thus, in determining S.J.L.'s level of understanding and appreciation this reality is of some import in assessing her level of understanding and appreciation in the context of her competency to deal with such a condition.

#### i) Ability to Understand Information Relevant to a Treatment Decision

[80] The ability to understand information relevant to making a treatment decision requires cognitive ability to process, retain and understand the relevant information provided by S.J.L.'s treating medical professionals to her. Being able to identify decisional options is of relevance here. As well, even without agreement as to the particular diagnosis of her condition, S.J.L. must be able to recognize the possibility that she is affected by a mental condition.

[81] Considering everything that has been placed before me, I am not satisfied that the evidence presented regarding S.J.L. rebuts her presumed competence to make health care decisions with regard to this first component.

[82] I am satisfied that S.J.L. has sufficient cognitive capacity to understand relevant information given to her to enable her to make her treatment decisions. I am satisfied that with her education level, her assessed average intelligence (as disclosed by previous psychological testing) as well as her comments made to her health care providers and to this Court that she possesses sufficient ability to recall and process information given to her by her health care providers related to her condition and possible treatment options. It seems clear to me that S.J.L. is not out of touch with reality in her thinking and has the ability to understand information provided to her concerning her condition. While she does not agree that she has Borderline Personality Disorder, or any other mental disorder for that matter, I find that she recognizes that she has certain symptoms of Borderline Personality Disorder. She is able to link her present health circumstances with the manifestations of her condition. I am also satisfied that she recognizes what she is doing, including times when she attempts to seriously harm herself either as a result of urge or impulse or when she consciously acts. She has an appropriate understanding of possible treatment options open to her and has the ability to understand possible risks and side effects. The references in the reports and testimony of Dr. St. John and Dr. Day provide assistance in making this finding that she has this ability to understand the relevant information given to her about her condition and the treatment options suggested to her. The fact that she will not accept treatment does not mean she does not have the ability to understand she may have a condition and possible treatment options.

[83] In so concluding, I find myself in disagreement with the conclusions of Dr. Nurse and Dr. Silberfeld and perhaps Dr. Day. In this regard, while expert evidence was deemed necessary in this case based upon the issue to be determined, it is to be recognized that there is some disagreement among the medical professionals who testified with regard to this component. Obviously I am not able to readily discount any of the expert testimony but nor am I permitted to abdicate my fact-finding role to experts.

[84] As well, in this case there is ample evidence before me that reasonably supports the assertion that due to S.J.L.'s shyness and anxious nature, a full and accurate assessment, "formal" or "informal", was, at the least, difficult to complete. While Dr. Nurse had occasion to speak to the contents of S.J.L.'s affidavit, I am

not satisfied that his additional comments support a finding that she does not, at present, have the ability to understand relevant information provided to her related to her condition or possible treatment options.

[85] In so concluding, I am not saying that the reports or evidence provided by Dr. Silberfeld and Dr. Nurse was a result of any improper or negligent conduct on their part. To the contrary, I found both assessments to be very professional. In the limited time available to meet with S.J.L., notwithstanding a thorough review of her medical chart and other information, S.J.L. did little to engage meaningfully with either doctor. This appears to be partly a result of choice on her part and, as well, due to her shy and anxious nature.

[86] As a result, I find that S.J.L.'s presumed competence to make her own health care decisions has not been rebutted with regard to the first component of the competency test set out in **Starson**.

ii) Appreciation of Reasonable Foreseeable Consequences

[87] The second component of the **Starson** test is that S.J.L. must have the ability to apply the information given to her and to weigh the reasonably foreseeable consequences of her treatment decision or lack of one. Here, S.J.L. must be capable of recognizing that she is affected by the manifestations of a condition, even if she disagrees with the diagnosis, and she must be able to appreciate the consequences of a decision or lack of a decision regarding her health care needs. It does not have to be shown that she does actually appreciate the consequences for her to be found competent, only that she has the ability to appreciate the consequences.

[88] Here, while I have found that S.J.L. has the ability to understand relevant information related to her condition as well as potential treatment options based upon her level of intelligence, awareness and cognitive functioning, I am unable to

conclude that S.J.L. has the ability to appreciate the consequences of her decision or lack thereof. I am left with some doubt that S.J.L. is able to appreciate the full extent of the decision being made. While she talks about recognizing the potential impact of her self-harming behaviors and appears to know that death could be the result, she admits that she is, on at least some occasions, unable to control the urge to self-harm. To me, the lack of ability to control her urges is a manifestation of the condition that she suffers from.

[89] I see her circumstances as being different from a person who, for instance, is an alcoholic and who is unable to control the urge to drink. For S.J.L., I find that at present she does not appear to have the ability to appreciate the possible benefits of treatment. Her lack of motivation to involve herself in treatment is a result of the manifestation of her condition, not a conscious and controllable choice. She appears to conclude that treatment will not be beneficial as she believes herself to be in control of her actions. Yet, as stated earlier, S.J.L. has clearly indicated that she is unable, at least on some occasions, to control the urges that she feels. Unfortunately, S.J.L. is unable to take steps to prevent her from self-harming on an increasingly serious basis. In other words, her mental disorder prevents S.J.L. from having the ability to appreciate the reasonably foreseeable consequences of her decision to accept treatment or not. On this point I find myself in full agreement with both Dr. Nurse and Dr. Silberfeld and the psychologist, Dr. Day. Unlike the circumstances in the **Starson** case, the mental condition S.J.L. is suffering from is contributing to her refusal to accept any treatment at present.

[90] With regard to a lack of ability to appreciate possible benefits of treatment, I recognize that the medical professionals I have heard from all appear to be guarded, at best, about any future prognosis for S.J.L. While relevant for consideration, where a person is found unable to appropriately weigh treatment options, a finding of competency cannot be the result on the basis that there is uncertainty with regard to the results of possible treatment. Here, S.J.L.'s safety is clearly at risk by her behaviors and some attempt is justified to attempt to deal with those behaviors. What type of treatment is required is a matter that I will refer to shortly.

[91] As a result of my assessment of the second component of the **Starson** test, I conclude that the evidence presented rebuts, on a balance of probabilities, that S.J.L. has the ability to appreciate the reasonably foreseeable consequences of treatment or lack of treatment. She does not presently have the ability to appropriately weigh her possible treatment options.

iii) Best Interests

[92] A consideration of best interests here will have two aspects. First of all, as I indicated earlier in reference to the law, I am satisfied that even if I were to have found S.J.L. met the legal competency test set out in **Starson**, consideration of the best interests standard based on her level of maturity on a sliding scale as referred to earlier would still be necessary here. Clearly in this case a decision by S.J.L. to refuse to seek treatment for her mental condition would likely result in further increasingly serious self-harming acts. I am satisfied that death or serious bodily harm would result, either intentionally or accidentally. The evidence I have heard, including what S.J.L. has said, supports this.

[93] At the present time, I have concerns about whether S.J.L. has reached a sufficient level of maturity that would permit her to make her own health care decisions. While she is just over16 years of age, of average intelligence and able, at least to some degree, to make decisions regarding herself, I must recognize that she has hardly experienced life in the past two years in the same manner as other persons her age. For almost that full period she has resided in an institutional setting separated from family and friends. She has not been involved in a regular school program and has had no involvement in recreational and social activities normally experienced by others of her age. While maturity cannot be measured on any one of these factors, cumulatively speaking I have concerns about how all of this has impacted her present level of maturity. While possessing some level of maturity, I am satisfied that what S.J.L. has experienced will be a limiting factor in her ability to appropriately consider her treatment options and to make health care decisions.

[94] Any exercise of the Court's *parens patriae* jurisdiction is based upon the principle of protecting the vulnerable. Here, notwithstanding the recognition of the presumption of competence and the right to autonomous decision-making, even if legally competent, I would have exercised my *parens patriae* authority to intervene with regard to her decision-making related to S.J.L.'s future health care. In doing so I would have relied upon the sliding scale approach set out in **A.C. v. Manitoba (Director of Child and Family Services)** referred to earlier. A person's level of maturity, while admittedly a factor in consideration of the required level of understanding and appreciation in the **Starson** test, is to be assessed over and above this in circumstances such as those that S.J.L. finds herself in.

[95] The second aspect of the best interests principle is related to how the Court will exercise its *parens patriae* jurisdiction in this case. A finding of a lack of legal competence, or the lack of the necessary maturity as just discussed, puts the Court in a position where I have the authority and jurisdiction to intervene to protect the well-being of S.J.L. In doing so, I am mindful of what was said in **Re Eve**, [1986] 2 S.C.R. 388, by LaForest, J. at paragraph 77:

> Though the scope or sphere of operation of the parens patriae jurisdiction may be unlimited, it by no means follows that the discretion to exercise it is unlimited. It must be exercised in accordance with its underlying principle. Simply put, the discretion is to do what is necessary for the protection of the person for whose benefit it is exercised … The discretion is to be exercised for the benefit of that person, not for that of others. It is a discretion, too, that must at all times be exercised with great caution, a caution that must be redoubled as the seriousness of the matter increases. …

[96] With regard to the exercise of that discretion, the comments of Green, J. in **Re Strong** at paragraph 29 and 30 are of importance.

> In deciding that the discretion should be exercised, the question arises as to how the decision should be embodied in a formal order. Should the court, by order, actually purport to consent on behalf of the mentally disabled person (and direct a court official to execute the appropriate written consents) or should the court merely approve

> treatment as being appropriate and authorize another (perhaps the applicant or guardian if any) to give the requisite consent. In the latter situation, a residual decision-making discretion will be given to someone other than the Court.
>
> After some reflection, I have concluded that the Court itself should purport to give the consent. This follows, I believe, from the nature of the *parens patriae* jurisdiction. In **Re G**., MacDonald, C.J.T.D. stated at p. 241: "The *parens patriae* jurisdiction is founded on the necessity of acting for the protection of those who cannot care for themselves" and in **Re Eve**, LaForest, J. said at p. 286: "The Crown has an inherent jurisdiction to do what is for the benefit of the incompetent". If the Court in exercising its jurisdiction is to act for the protection of the incompetent and to do what is for her benefit, then it should be the court that actually makes the determination by order.

[97] At this time, based upon what is before me, I have some concern that S.J.L.'s continued detention in a hospital setting is or will be in her best interests. The evidence given of the negative impact of hospitalization for people suffering from Borderline Personality Disorders seems well accepted in the psychiatric field. While perhaps necessary to stabilize a patient, continual hospitalization is seen as counter-productive in the treatment of such a condition. I know that there is a suggestion of some form of supervised community placement that has been under consideration. As well, out of province treatment programs have been discussed. The use of medications is also of some concern here although the benefits for S.J.L. are perhaps questionable. Another obvious consideration, as has been pointed out by counsel for S.J.L., is that unless S.J.L. is motivated to participate in treatment programs, there likely would be negligible progress with regard to her future mental health.

[98] While it has been suggested by some counsel here that I should order S.J.L. detained up to the time that she is 17 years 6 months old, I am not satisfied at the present time that doing so, based upon what is presently before me, would be in her best interests. As a result, I am prepared to order at this time that she continue to be detained on the present order for a further period of 14 days from the release of these reasons. In 14 days this matter will be reconvened before me to allow counsel to present available and viable treatment options for S.J.L. I am asking each of them to explore what is available and what would be an appropriate treatment plan option. I will then have to assess, as best as I can, those treatment options to determine exactly how to exercise the discretion given to me and to

frame an order related to S.J.L.'s future care. As well, I would like to have addressed at that time the required duration of any order that I might make and the timing of any review.

[99] I am also asking the parties to recommend an appropriate substitute decision-maker for S.J.L. related to her future care.

[100] At this time, I am not convinced that this matter should proceed with the mother being named as the legal guardian of S.J.L. for the purpose of consenting to her future medical treatment. I say this notwithstanding that I fully accept that the mother clearly loves her daughter and wants what is best for her. As well, I mean to cast no negative aspersion at all concerning the mother's actions in this case. My concerns here regarding appointing S.J.L.'s mother as her substitute decision-maker are related to what I see as a need to preserve her relationship with S.J.L., which I am convinced is in S.J.L.'s best interests, and her ability to be fully objective in pursuing treatment for S.J.L.

[101] With regard to her relationship with S.J.L., this is already strained based upon the view of S.J.L. that her mother is not acting in accordance with her wishes. S.J.L. appears to have few relationships with others and it would not, in my opinion, be in S.J.L.'s best interests to erode further what has been a close relationship with her mother. S.J.L. definitely needs her mother if her mental health is to improve. The same can be said for her whole family.

[102] As to the mother's ability to make objective decisions, there is some evidence to suggest a level of tension and conflict exist as between the mother and S.J.L.'s health care providers. While this tension appears not to be one-sided and is understandable to some degree, at present I am not satisfied that it would be in the best interests of S.J.L. to appoint her mother as her substitute decision-maker in these circumstances. There is also the possible issue of S.J.L.'s apparent ability to influence her mother that must also be factored in here. Clear thinking and a healthy dose of objectivity is required in my view to deal with the very difficult treatment challenges facing S.J.L. While I am certainly prepared to carefully

consider the views of the mother with regard to treatment and placement for S.J.L. as I believe that they are extremely relevant, as was done in **Re Strong**, the Court will for now assess the appropriate treatment options for S.J.L. to determine the nature of the order to be made.

[103] Saying this, I remain prepared to be convinced that it would be in S.J.L.'s best interests to have the Applicant act as her substitute decision-maker in the future.

**CONCLUSION**

[104] I have no doubt that S.J.L. will become aware of this decision and its reasons. I want to stress to her that in making this decision I am not saying that she does not possess intelligence or that all of her decisions should not be respected. The word "incompetency" has a strong meaning for S.J.L. She made this clear to me when I met with her. However, while I am satisfied that S.J.L. is intelligent and that it is important to respect her decisions, unfortunately right now her mental condition is such that I am satisfied that she is unable to be fully capable of making decisions to deal with her treatment that best will assist her. In saying this, I want S.J.L. to know that she will be permitted to have some input into any future order to be made regarding her treatment. However, death is not a desirable or necessary result of the condition she suffers from. Help is out there for her and it is my hope that she will benefit from what is made available to her.

[105] This matter will now be called on a date arranged within the next week in order to discuss how we proceed from here based upon the extension of the present order for a further period of 14 days. The matter will then be called in 14 days from the release of these reasons at a time to be arranged by the Deputy Registrar.

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**RICHARD D. LEBLANC**
Justice