CITATION: Thompson and Empowerment Council v. Ontario, 2013 ONSC 5392
COURT FILE: 05-CV-293285
DATE: 20130912

2013 ONSC 5392 (CanLII)

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KARLENE THOMPSON AND EMPOWERMENT COUNCIL, SYSTEMIC ADVOCATES IN ADDICTIONS AND MENTAL HEALTH Applicants	)	*Marshall Swadron and Mercedes Perez*, for the Applicants
– and –	)	
ATTORNEY GENERAL OF ONTARIO Respondent	)	*Rochelle Fox* and *Daniel Huffaker*, for the Respondent
	)	**HEARD:** May 8, 9 and 10, 2013

Constitutional Challenge to the Expanded Civil Committal Criteria and Community Treatment Orders added to the Ontario Mental Health Act in 2000

Decision of

Justice Edward Belobaba

2013 ONSC 5392 (CanLII)

TABLE OF CONTENTS

Paragraphs

I. Overview...1

II. Brian's Law

(1) The expanded civil commitment criteria...16
(2) The community treatment order provisions...26

III. The positions of the parties

(1) The applicants' position...35
(2) The respondent's position..38

IV. Karlene Thompson and Amy Ness

(1) Karlene Thompson...43
(2) Amy Ness..58

V. Analysis

(1) Section 7..71
(2) Vagueness..109
(3) Section 9..119
(4) Sections 10(a) and (b)...120
(5) Section 12...122
(6) Section 15(1)..124

VI. Conclusion...127

VII. Disposition..131

2013 ONSC 5392 (CanLII)

JUSTICE EDWARD BELOBABA:

I. Overview

[1] The applicants challenge the constitutionality of the expanded civil commitment criteria and community treatment provisions that were added in 2000 to the *Mental Health Act*[1] ("MHA") by the enactment of *Brian's Law.*[2]

[2] *Brian's Law* was passed in memory of Brian Smith, a well-known Ottawa radio broadcaster who was shot and killed in 1995 by an untreated schizophrenic named Jeffrey Arenburg. The killer said he heard voices emanating from broadcast towers that compelled him to randomly shoot and kill the radio broadcaster as he was walking to his car. The *Ottawa Citizen* reviewed the killer's history of encounters with the provincial mental health system and concluded in an editorial that:

> [A] combination of easier committal procedures and the availability of community treatment orders would have stopped Arenburg's tailspin. Brian would be alive and Arenburg would be living in peace in the community.

[3] At the inquest into Brian Smith's death, the jury recommended a comprehensive review of the province's mental health system and the introduction of community-based treatment programs. Several years later, the provincial legislature responded with Bill 68, "An Act in Memory of Brian Smith." In essence, *Brian's Law* did two things: one, it expanded the 1978 MHA criteria for psychiatric assessment and involuntary admission beyond simply 'danger to themselves or others' and added new concepts such as

---

[1] *Mental Health Act*, R.S.O. 1990, c. M.7, as amended by S.O. 2000, c.9.

[2] *Brian's Law (Mental Health Legislative Reform), 2000*, S.O. 2000, c.9 (Bill 68).

'substantial mental deterioration' unrelated to dangerousness; and two, it added a new regime of 'community treatment orders' ("CTOs").

[4] The applicants are Karlene Thompson, who was detained in a hospital as an involuntary patient[3] and treated in the community under CTOs, and the Empowerment Council, an organization advocating on behalf of clients of mental health and addiction services. The applicants say that the expanded criteria for psychiatric assessment and involuntary admission (ss. 15(1.1), 16(1.1) and 20(1.1) of the MHA, known as the Box "B" criteria) and the CTO provisions (ss. 33.1-33.9 of the MHA) are in breach of ss. 7, 9, 10(a) and (b), 12 and 15(1) of the *Charter of Rights and Freedoms*.[4] The respondent's position is that *Brian's Law* is constitutional and the application should be dismissed.

[5] Karlene Thompson left Canada in 2007 and has not returned. According to her CTO team leader, Ms. Thompson returned to her native Jamaica in order to avoid further psychiatric treatment. The Empowerment Council was granted standing as a public interest litigant in 2011.[5] I will continue to refer to "the applicants" although I recognize that the application is really being carried by the Empowerment Council.

[6] The key issue before me is legislative purpose. Was *Brian's Law* enacted solely for public safety reasons – that is, to provide broader institutional parameters for dealing with the seriously mentally ill who pose a danger to themselves or others? Or was it also enacted to provide an improved treatment regime for all seriously mentally ill persons? The applicants argue the former "single purpose"; the respondent the latter "dual purpose."

[7] If *Brian's Law* had been enacted solely or even primarily for public safety reasons, i.e. to deal with mentally ill persons that are prone to violence, I would likely have found the applicants' submissions to be persuasive. The studies show that there is no meaningful

---

[3]Most individuals detained under the MHA have been diagnosed with a psychotic illness. Approximately 70% of CTO subjects have been diagnosed with schizophrenia and the remaining 30% with schizoaffective disorder or bipolar disorder. Although the causes of schizophrenia and other psychotic illnesses remain unknown, the standard psychiatric treatment for psychotic conditions is antipsychotic (neuroleptic) medication.

[4] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11. The applicants also alleged breaches of s. 2 of the *Charter* but did not pursue this line of argument.

[5] *Thompson v. Attorney General of Ontario*, 2011 ONSC 2023, 161 O.R. (3d).

2013 ONSC 5392 (CanLII)

correlation between mental illness and violence.[6] Thus, the expansion of the civil committal criteria and the imposition of a new coercive community treatment regime and their potential application to all seriously mentally ill people (the vast majority of whom will never be a danger to themselves or others) would most likely have been unconstitutional. The law would have been too broad and the applicants would have been denied the principles of fundamental justice that are guaranteed by s. 7 of the *Charter*.

[8] But the purpose of *Brian's Law* was more than public safety. In my view, the purpose of the impugned amendments was two-fold: public safety *and* improved treatment of the mentally ill. This dual purpose is apparent not only on the face of the legislation but from a review of what was said in the legislature when the law was enacted.

[9] Given that the purpose of these MHA amendments is both public safety and improved treatment, it became more difficult for the applicants to show that the challenged amendments are overbroad and a violation of section 7 of the *Charter*. Or, indeed, that they are a violation of any of the other cited *Charter* provisions.

[10] The fact that the applicants can point to numerous controversies in the medical and scientific literature on a range of important topics that question the effectiveness of modern antipsychotic medications or the need for a coercive CTO regime is, to be sure, a matter of concern for policy-makers and legislators. But medical or scientific controversy alone, where the evidence is inconclusive, is not a determinative factor in a constitutional challenge of enacted legislation.

[11] Even if I thought that these controversies about the law's effectiveness merit review by the Minister of Health and Long-term Care (as I do), this would not affect my decision as a judge about the law's constitutional validity. A judge is not a roving royal commission. My judicial jurisdiction is (properly) limited to deciding whether the impugned legislation is in breach of the *Charter* and, to this end, I am obliged to apply the applicable legal principles as set out by our Court of Appeal and by the Supreme Court of Canada.

---

[6] According to the studies in the material before me, mental disorders – in sharp contrast to alcohol and drug abuse – account for a miniscule portion of violent incidents. The actual data show that the risk of homicide by schizophrenics is about three-tenths of one per cent.

2013 ONSC 5392 (CanLII)

[12] As already noted, I have found that *Brian's Law* has a dual purpose: public safety and improved treatment. I have further found that the applicants have not shown on the material before me and on the basis of the applicable legal principles that the law is overbroad or otherwise in breach of the *Charter*. The applicants have not established that the impugned amendments are unconstitutional.

[13] For the reasons that follow, the application is dismissed.

II. Brian's Law

[14] The Minister of Health and Long-Term Care introduced the first reading of *Brian's Law* in April 2000, by describing it as a "very important piece of legislation that will mean better treatment for people with serious mental illness and safer communities across our province."[7] The proposed amendments to the MHA focused mainly on two areas: expanded civil commitment criteria (ss. 15(1.1), 16(1.1), 20(1.1)) and a new regime of community treatment orders (ss. 33.1-33.9.)

[15] The new provisions added by *Brian's Law* are long and detailed. Rather than setting them out in full, I will summarize them, along with the companion provisions that are not being challenged, in order to provide some context.

(1)The expanded civil commitment criteria

Section 15: Application for a Psychiatric Assessment

[16] Section 15 of the MHA sets out the criteria by which a physician, within 7 days of seeing a person, may apply with a "Form 1" for a psychiatric assessment of that person. When a physician makes a Form 1 application, the application authorizes the person's detention in a psychiatric facility where he or she may be restrained, observed and examined for up to 72 hours. By requiring the assessment to be conducted in a psychiatric facility, s. 15 ensures that a "second opinion" is provided by a physician who is experienced in assessing and treating mental disorders. After the assessment, a decision is made that the person meets the criteria for involuntary admission and should be admitted, should be admitted on a voluntary status basis, or should not be admitted.

---

[7] Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 47A (25 April 2000) at 2369 (Hon. Elizabeth Witmer, Minister of Health and Long-Term Care).

2013 ONSC 5392 (CanLII)

[17] Section 15 contains two sets of criteria for psychiatric assessments. Section 15(1), enacted in 1978, and not being challenged herein, sets out what are known as the Box "A" criteria listed on Form 1. Generally speaking, s. 15(1) and Box A provide that a physician who (i) has reasonable cause to believe that the person was threatening or attempting to cause harm to himself/herself, was behaving violently towards another person or causing a person to fear bodily harm, or showing an inability to care for himself/herself, and (ii) is of the opinion that the person is apparently suffering from mental disorder which likely would result in (iii) serious bodily harm to the person, another person or serious physical impairment, may make an application for a psychiatric assessment. The constitutional validity of section 15(1) and Box A has been upheld by the Court of Appeal.[8]

[18] *Brian's Law* added s. 15(1.1) that expanded the civil commitment criteria. These criteria are known as the Box "B" criteria. Under Box B, the physician must have reasonable cause to believe that the person:

> (i) has previously received treatment for a mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or another, or substantial mental or physical deterioration, or serious physical impairment of the person; and
>
> (ii) has shown clinical improvement as a result of the past treatment.

[19] The examining physician must also be of the opinion that:

> (iii) the person is apparently suffering from the same or a similar mental disorder for which he or she previously received treatment;
>
> (iv) given the person's history of mental disorder and current mental or physical condition, he or she is likely to cause serious bodily harm to himself or herself or another person, or suffer substantial mental or physical deterioration or serious physical impairment; and

---

[8] *C.B. v. Sawadsky*, [2005] O.J. No. 3682 (S.C.J.) [*Sawadsky*], aff'd on other grounds (2006), 82 O.R. (3d) 661 (C.A.), leave to appeal to S.C.C. refused, [2006] S.C.C.A. no. 479.

2013 ONSC 5392 (CanLII)

> (v) is incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility, and the consent of his or her SDM has been obtained.

[20] A person detained for a psychiatric assessment under a Form 1 application, whether under the Box A or B criteria, must receive notice of the application (Form 42), which sets out the reasons for the detention and advises that the person has a right to retain and instruct counsel without delay.

Section 16: Justice of the Peace's Order for Psychiatric Examination

[21] Section 16 of the MHA provides that a justice of the peace may issue an order (Form 2) for the examination of a person by a physician where evidence provided under oath indicates that the person meets the criteria required under ss. 16(1) or (1.1). *Brian's Law* added s. 16(1.1) which generally mirrors the criteria in s. 15(1.1). The applicants are only challenging s. 16(1.1).

Section 20: Involuntary Admission

[22] Section 20 of the MHA provides when a person must be released from a psychiatric facility, admitted as a voluntary patient, or admitted as an involuntary patient. A physician who completes a certificate of involuntary admission (Form 3) cannot be the same physician who completed the application for psychiatric assessment (Form 1).

[23] Section 20 contains two sets of conditions for involuntary admission. Section 20(5), not impugned, requires involuntary admission or renewal where the physician is of the opinion that the person has a mental disorder that likely will result in serious bodily harm to the person or another or serious physical impairment of the person, and the person is not suitable for admission as an informal or voluntary patient.[9]

[24] Section 20(1.1), added by *Brian's Law*, provides that the physician, after examining the person, shall admit the person as an involuntary patient if he or she is of the opinion that all of the following criteria are met. The person,

[9] A voluntary patient must personally consent to admission to a psychiatric facility. An informal patient is admitted to a psychiatric facility with the consent of another person, *i.e.* an authorized guardian of the person, power of attorney, or in limited circumstances a substitute decision maker: see HCCA, s. 1 and MHA, s. 24.

2013 ONSC 5392 (CanLII)

(i) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or another, or substantial mental or physical deterioration, or serious physical impairment of the person;

(ii) has shown clinical improvement as a result of the past treatment;

(iii) is suffering from the same or a similar mental disorder for which he or she received treatment;

(iv) is likely to cause serious bodily harm to himself or herself or another person, or suffer substantial mental or physical deterioration or serious physical impairment;

(v) is incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility, and the consent of his or her SDM has been obtained; and

(vi) is not suitable for admission or continuation as an informal or voluntary patient.

2013 ONSC 5392 (CanLII)

[25] A person who is involuntarily admitted is entitled to notice (Form 30) of the authority and reason for the detention. The Form 30 informs the person that he/she has a right to ask the Consent and Capacity Board ("CCB") to review the involuntary admission and the right to retain and instruct counsel without delay. Attached to Form 30 must be the form to seek review (Form 16). Persons who are involuntarily admitted are also provided rights advice from a rights adviser[10] regarding legal options for reviewing their admission and assistance in completing the Form 16, if they wish, and finding legal counsel. The person, if found to be incapable with respect to treatment, may also seek review by the CCB of the finding of incapacity. Through rights advice, patients are made aware of the procedural protections respecting findings of incapacity and involuntary admission.

(2) The community treatment order provisions

[26] *Brian's Law* also added a new community treatment regime. Sections 33.1 to 33.9 of the MHA govern CTOs. The purpose of a CTO is set out in s. 33.1(3):

---

[10] Most psychiatric facilities have designated the Psychiatric Patient Advocate Office (the "PPAO"), an office of the Ministry of Health and Long-Term Care, to provide rights advice services free of charge to in-patients. The PPAO has also been designated to act as a rights adviser for persons in the community regarding CTOs.

> The purpose of a community treatment order is to provide a person who suffers from a serious mental disorder with a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility. Without limiting the generality of the foregoing, a purpose is to provide such a plan for a person who, as a result of his or her serious mental disorder, experiences this pattern: The person is admitted to a psychiatric facility where his or her condition is usually stabilized; after being released from the facility, the person often stops the treatment or care and supervision; the person's condition changes and, as a result, the person must be re-admitted to a psychiatric facility.

[27] To issue or renew a CTO all of the following conditions as set out in s. 33.1(4) must be met:

(i) the person, in the previous three year period, must have been a patient in a psychiatric facility on two or more separate occasions, or for a total of 30 days or more or been subject to a prior CTO;

(ii) the person or his or her SDM, the physician, and any other person involved in the person's treatment or care and supervision have developed a community treatment plan for the person;

(iii) within 72 hours before entering the community treatment plan, the physician has examined the person and is of the opinion that the person:

- is suffering from mental disorder such that he or she needs continuing treatment or care and continuing supervision while living in the community,
- the criteria for a psychiatric assessment in s. 15(1) or (1.1) must be present where the person is not currently a patient in a psychiatric facility,
- if the person does not receive continuing treatment or care and supervision while living in the community, he or she is likely, because of mental disorder, to cause serious bodily harm to him or herself or another or to suffer substantial mental or physical deterioration or serious physical impairment, and
- the person is able to comply with the community treatment plan in the CTO;

2013 ONSC 5392 (CanLII)

(iv) the treatment or care and supervision required under the CTO are available in the community;

(v) the physician has consulted with the persons proposed to be named in the community treatment plan;

(vi) the physician is satisfied that the person subject to the order and his or her SDM, if any, have consulted with a rights adviser and have been advised of their legal rights; and

(vii) the person or his or her SDM consent to the community treatment plan in accordance with the rules for consent under the *Health Care Consent Act.*

2013 ONSC 5392 (CanLII)

[28] A CTO must contain, *inter alia*, a description of the community treatment plan, and an undertaking by the person to attend appointments and to comply with the plan, or an undertaking by the person's SDM to use best efforts to ensure that the person complies with those obligations. A CTO lasts six months (unless terminated earlier) and may be renewed.

[29] Before a CTO is issued or renewed, the physician must provide notice (Form 49) and a copy of the plan. Form 49 advises of the right to consult a rights adviser before a CTO can be issued or renewed and that a rights adviser will contact them. Form 49 specifically provides that the person and the SDM each have the right to retain and instruct counsel about the proposed CTO before it is issued or renewed and at any time after.

[30] The rights adviser is required to promptly give rights advice to the person and the SDM about the requirements for the issuance or renewal of the CTO, the significance of such an order, and their legal options for review. The rights adviser also discusses whether the person wishes to apply to the CCB to review the finding of incapacity with respect to treatment. Through rights advice at the point of the notice of intention to issue a CTO, persons receiving the notice are made aware of the range of available legal options and the procedural protections respecting findings of incapacity, involuntary admission and CTOs. A physician who subsequently issues or renews a CTO must provide a copy of the CTO, including the community treatment plan, to the person, along with a notice that he or she has a right to a hearing before the CCB under s.39.1 of the MHA.

[31] Where the person subject to a CTO has failed to comply with his or her obligations under the CTO (s. 33.1(9)), the physician may issue an order for examination (Form 47). However, s. 33.3(2) of the MHA first requires the physician to have reasonable cause to believe that the person continues to meet the criteria for a CTO, and that reasonable efforts have been made to locate the person, inform the person (if capable or his or her SDM if

not capable) of the failure to comply with the community treatment plan and the possible consequences, inform the person or SDM that a Form 47 may be issued and of the possible consequences, and provide assistance to the person to comply with the terms of the order. An order for examination (Form 47) is not an application for a psychiatric assessment (Form 1), nor does it admit someone as an involuntary patient in a psychiatric hospital (Form 3).

2013 ONSC 5392 (CanLII)

[32] Four other provinces - Alberta, Newfoundland and Labrador, Nova Scotia and Saskatchewan – also have legislation that supports CTOs.[11] All of these provinces use the diversionary CTO model, as the person must meet the province's committal criteria, but, with the exception of Alberta, combine it with preventative elements by requiring that the person have a defined amount of past hospitalization to be eligible for a CTO.

[33] In Saskatchewan and Newfoundland and Labrador, the consent of the patient, or of anyone else, is not required for the CTO. In contrast, in Ontario, the community treatment plan must be consented to either by the person if capable or if incapable by an SDM.

[34] The Ministry of Health and Long-Term Care's CTO Information Record database shows that the number of CTOs issued annually between December 1, 2000 and March 31, 2011 reached a high of 1093 in 2008-2009 and then decreased to 656 in 2009-2010. The Ministry's information, based on aggregate data from the Common Data Set Mental Health (CDS-MH), is that the average amount of time between the date of an initial CTO and the expiry date of the individual's most recent renewal of the CTO is 1.9 years. In Toronto, 33% of CTOs are not renewed, 48% are renewed between 1 and 5 times, and 19% are renewed more than 6 times.

III. The position of the parties

(1) The applicants' position

[35] The applicants seek declarations, pursuant to subsection 52(1) of the *Constitution Act, 1982*, that the expanded committal criteria and the new community treatment order provisions of the MHA infringe sections 7, 9, 10, 12 and 15 of the *Charter*, are not saved

---

[11] *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s.24.3; *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c.42, s.47; *Mental Health Care and Treatment Act*, S.N.L. 2006, c.M-9.1, s.40; *Mental Health Act*, R.S.A. 2000, c.M-13, s. 9.1 – 9.6.

by section 1, and are thus of no force or effect. Specifically, the applicants challenge sections 15(1.1), 16(1.1) and 20(1.1) (the Box B criteria for involuntary detention) and sections 33.1 to 33.9 (the CTO provisions).

2013 ONSC 5392 (CanLII)

[36] The applicants argue that *Brian's Law* subjected a new class of persons, at no risk of causing serious bodily harm to themselves or others or serious physical impairment of their person, to involuntary psychiatric hospitalization. The impugned law also established CTOs to force psychiatric treatment in the community upon all who meet the expanded involuntary hospitalization criteria.

[37] The applicants say that the impugned legislation reinforces societal stereotypes that equate mental illness with dangerousness. It relies upon coercion in the delivery of mental health care in the absence of evidence that coercion is necessary. It employs means that are grossly disproportional to its goals of promoting mental health and public safety. In so doing it infringes or denies the rights and freedoms guaranteed by sections 2, 7, 9, 10, 12 and 15 of the *Charter*. These violations are not saved by section 1 of the *Charter*.

(2) The respondent's position

[38] The Attorney General of Ontario responds as follows. Public safety and the prevention of violence to the person with the serious mental illness and to those in the community is only one of several purposes of these provisions. The other purposes of the expanded assessment and committal criteria are: (i) to facilitate treatment, through assessment and hospitalization, for persons, incapable of consenting to treatment, with recurrent or on-going mental illness where past treatment for the illness has resulted in clinical improvement for the person ("revolving door patients"), and (ii) to prevent likely substantial mental or physical deterioration without treatment. The provisions seek to balance these objectives with the liberty and autonomy interests of incapable persons suffering from mental disorder. This balance is achieved through the criteria for assessment and committal and through various legislative procedural protections and the requirement of capable, informed and voluntary consent.

[39] The respondent goes on to argue that because these multiple objectives can be in tension, the provisions contain extensive procedural protections, such as mandatory access to rights advice prior to the issuance of a CTO; and requiring patient consent or, where the patient is incapable, consent of the SDM under the *Health Care Consent Act, 1996* ("HCCA").

[40] Moreover, says the respondent, the objectives outlined above are consistent with the HCCA's objectives, which are to provide a carefully balanced "response to the problem of accommodating the individual autonomy of the mentally ill person and the aim

of securing effective treatment for mentally ill people".[12] As the HCCA and the MHA are closely related legislation that "operate in tandem" as part of a coherent mental health scheme, the respondent submits that "the provisions of each statute must accordingly be read in the context of the other and consideration must be given to each statute's role in the overall scheme."[13]

2013 ONSC 5392 (CanLII)

[41] The respondent points out that Ontario courts have upheld the Box A assessment and involuntary admission provisions of the MHA and found no breaches of ss. 7, 8, 9, 10, 12 and 15 of the *Charter*.[14] The respondent says the same result should follow here and asks that the application be dismissed.

IV. Karlene Thompson and Amy Ness

[42] The applicants present the stories of two "survivors" of the *Brian's Law* amendments in support of their constitutional challenge: Karlene Thompson and Amy Ness. If the legislative purpose behind the Box B criteria and the CTO regime was only public safety, then this evidence would be particularly compelling. However, if a further legislative purpose was the improved treatment of the seriously mentally ill, then, frankly, this evidence is much less compelling.

(1) Karlene Thompson

[43] Karlene Thompson provided no affidavit evidence on this application. However, the parties have agreed that the record and transcripts giving rise to the May 19, 2005 decision of the CCB regarding Ms. Thompson may be relied upon in this application. In that hearing, Ms. Thompson gave evidence, was cross-examined by the lawyer for her attending psychiatrist and was further questioned by the Board. The Board also received evidence from Ms. Thompson's attending psychiatrist Dr. Peter Grant, Ms. Thompson's father and Ms. Thompson's CTO team leader. Upon the parties' agreement that the record

---

[12] *Bell ExpressVu Limited Partnership v. Rex*, 2002 SCC 42, [2002] 2 S.C.R. 559, at paras. 45-46.

[13] *Starson v. Swayze*, 2003 SCC 32, [2003] 1 S.C.R. 772, at paras. 9-11; *S.M.T. v. Abouelnasr*, 166 A.C.W.S. (3d) 569 (S.C.J.), at para. 57.

[14] *Sawadsky*, *supra* note 8, at para. 42; *Robertson v. Canada (A.G.)*, 2000 CarswellOnt 318 (S.C.J.); *Starnaman v. Penetanguishene Mental Health Centre*, [1994] O.J. No. 1958 (Gen. Div.) [*Starnaman*], aff'd (1995), 24 O.R. (3d) 701 (C.A.); *Chandrasena v. McDougald*, 17 A.C.W.S. (3d) 819.

before the Board could be used in the application, Ms. Thompson's appeal from the Board's decision was abandoned.

[44] Ms. Thompson is a university-educated, former school teacher who is 59 years of age. She has a psychiatric history dating back to 1973 including numerous psychiatric admissions and unwanted treatment with neuroleptic medication. She has been diagnosed with schizophrenia, paranoid type.

[45] Before December 2000, Ms. Thompson had been admitted to a psychiatric facility at least 13 times. Between hospital admissions (1990 to 2000) she did not function well in the community. She would be hospitalized and treated with antipsychotic medication with her SDM's consent. She would then stabilize and be discharged, only to later deteriorate and be re-admitted into hospital after failing to take antipsychotic medication.

[46] In December 2000, Ms. Thompson was brought to a hospital emergency room under a Form 2 order for examination. The discharge summary described Ms. Thompson, upon her arrival, as being "unable to adequately care for herself". She had been urinating and defecating into garbage bags and keeping them in her room, and would not touch anything that had touched the floor. She was not adequately dressed for winter. While fully oriented, she was obsessively counting her fingers and was mumbling to herself indicating that she might have been hearing voices. Ms. Thompson did not appear to be bothered by the overwhelming stench in her room. The discharge statement indicated that "her mental state [on admission] had deteriorated to the point that she was essentially non-functional": the same as at her previous psychiatric admission. Ms. Thompson was admitted pursuant to a Form 1, deemed to be incapable of consenting to treatment and managing her property, and then admitted involuntarily (Form 3). These findings were accepted by the CCB and the finding with respect to capacity was upheld by this court. [15] After her appeal was dismissed, Ms. Thompson was given antipsychotic medication.

[47] While in hospital "her hygiene improved and she became more organized in her functioning," and she was discharged from hospital in December 2001 on a CTO. The community treatment plan specified outpatient care with her psychiatrist, Dr. Grant; that her father act as her SDM; weekly meetings with the CTO Team at an agreeable time and place for assessment and ongoing clinical work and rehabilitation; and that Ms. Thompson take a prescribed neuroleptic every 2 weeks (decreased to 3 weeks at her request) with the dosage and frequency monitored and adjusted as indicated by her mental status and any

[15] *Thompson v. Grant*, [2001] O.J. No. 1778 (S.C.J.).

2013 ONSC 5392 (CanLII)

side effects. The antipsychotic medication was given by injection, as Ms. Thompson refused to take it orally, but she was not physically restrained for the injections.

[48] Ms. Thompson said that the major side effects she experienced while taking antipsychotic medication were excessive weight gain (nearly 50 pounds), over-sedation, excessive salivation, pain at her injection sites and pain in her legs. During her August 2004 CCB hearing, she testified that she still experienced side effects from the medication and was taking anti-side effect medication.

[49] After being discharged from hospital, the CTO Team found Ms. Thompson a place in a supportive housing program. Between December 2001 and December 2003, Ms. Thompson often failed to attend appointments for her antipsychotic injections medication, with Dr. Grant and sometimes with the CTO Team. While there were short periods of time during which Ms. Thompson did not receive antipsychotic medication and was relatively stable, in general, when she did not receive her outpatient antipsychotic medication injections, her mental state declined. For example, Ms. Thompson was repeatedly observed during those periods as being distracted, responding to internal stimuli (laughing and nodding to herself), engaging in obsessive-compulsive routines, thought blocking (trying to block sounds from her ears), being restless and anxious, and appearing disheveled with urine odor. In May 2003, Dr. Grant issued a Form 1 for psychiatric assessment and her CTO was subsequently renewed.

[50] By contrast, during the same period (December 2001 to December 2003), when Ms. Thompson was taking antipsychotic medication, she had appropriate and organized thought content, did not express hallucinations or delusions and engaged with the CTO Team. While not in complete remission, her psychotic symptoms were considerably reduced.

[51] In December 2003, Ms. Thompson's fourth CTO expired. She displayed some signs of mental deterioration (limited eye contact, being overly distracted, and counting her fingers.) However, given her refusal to receive antipsychotic medication injections and willingness to see the CTO Team every two weeks, it was decided to see how she functioned while not on a CTO but receiving case management services and living in supportive housing. She was offered antipsychotic medication which she rejected.

[52] Between January and August 2004, Ms. Thompson's mental state initially fluctuated and later consistently and substantially deteriorated. By June 2004, she had delusions that her roommate was smearing feces in the apartment and was spending hours at a time in the only washroom in her unit. This impacted the other residents. By July 2004, she consistently expressed paranoid beliefs that her roommate was trying to harm her, poison her food and drinks and was entering her locked bedroom with a key. She

2013 ONSC 5392 (CanLII)

began to lock herself in her room and did not eat because she feared poisoned food in the communal fridge. Despite receiving a fridge in her room, her fears of food tampering continued. By the end of July 2004, she was exhibiting obsessive behaviours (i.e. toe tapping, finger counting, and repeatedly stopping to spit out accumulated salvia). Her father, Dr. Grant, the CTO Team and the housing staff became very concerned about her deteriorating mental status and how her resulting behavior could lead to the loss of her housing or readmission to hospital.

[53] In July 2004, Dr. Grant assessed Ms. Thompson and issued a Form 49 (Notice of Intention to Issue a CTO) as she satisfied the Box B criteria. In his view she had already suffered substantial mental deterioration. Both Ms. Thompson and her SDM were given rights advice, and were later provided notice of the CTO's issuance (Form 46) and a Form 48 (CCB Application) to review the CTO. In September 2004, the CCB confirmed Ms. Thompson's incapacity to consent to treatment and the CTO, subject to an outstanding *Charter* challenge.[16] At the CCB Hearing, Dr. Grant testified that all aspects of the CTO "reversed the revolving door that was occurring prior to it". Ms. Thompson's CTO Team Leader also testified to the positive contribution that the CTO made to her ability to maintain some functioning in the community. Even though she did not consistently comply with the CTO's terms, because of the CTO she was hospitalized only once in two years.

[54] In November 2006, Karlene Thompson left Canada for Jamaica where she was admitted to a psychiatric hospital and underwent antipsychotic treatment. She returned to Toronto in April 2007, and underwent a psychiatric assessment. In May 2007, she was found incapable of consenting to psychiatric treatment and was involuntarily admitted. In May 2007, the CCB rescinded her involuntary admission, confirmed her incapacity to consent to antipsychotic medication, but found her capable of consenting to blood pressure medication. In August 2007, Ms. Thompson again left for Jamaica and has not returned.

[55] The applicants emphasize that at no point was Ms. Thompson ever a danger to herself or others and that after December 2000 all of her interactions with the mental health system were based on the Box B criteria and the CTO regime. The applicants also

---

[16] On May 19, 2005, following the Divisional Court's decision in *Ontario (Attorney General) v. Patient* (2005), 250 D.L.R. (4th) 697 (Div. Ct.), the CCB dismissed Ms. Thompson's *Charter* challenge for lack of jurisdiction. By then, Ms. Thompson's CTO had expired and was not renewed. On May 27, 2005, she appealed the CCB's decision to this court challenging the impugned MHA provisions. The appeal was not advanced within the HCCA time frames.

2013 ONSC 5392 (CanLII)

point out that, according to her father, there had never been a time when Ms. Thompson was stable, even when taking neuroleptic medication.

[56] During her last attendance before the CCB, Ms. Thompson explained to the Board that she could manage on her own without medication. She noted that all humans have frailties and that she was within the realm of normal. She said that she could not fit into the box or routine that everyone else wanted her to fit into.

[57] The Board nonetheless upheld both Dr. Grant's finding that Ms. Thompson was incapable in respect of treatment and the CTO. The CTO was upheld solely on the Box B grounds.

(2) Amy Ness

[58] Although not a party litigant, Amy Ness has provided the applicants with a supporting affidavit. Ms. Ness is 40 years of age, is also university-educated and self-identifies as a survivor of psychiatry. She was diagnosed with schizophrenia in 2002 and, as of July 2011, had been subject to a CTO for over two years.

[59] Ms. Ness was first diagnosed with schizophrenia in June 2002 when she was involuntarily admitted to the Centre for Addiction and Mental Health (CAMH) under the Box A criteria. At the time, Ms. Ness' symptoms included delusion of persecution, delusions of reference,[17] somatic delusions,[18] and ideas of reference.[19] According to CAMH records, at times, Ms. Ness appeared to be responding to internal stimuli. Ms. Ness believes that she has been unfairly diagnosed, and that her past mental deterioration has resulted from anger, stress, coffee addiction and previous treatment in psychiatric settings. The CCB has repeatedly found Ms. Ness incapable with respect to treatment and upheld her involuntary admissions.

[60] On each occasion that her CTO was issued or renewed, it was on the basis that she would otherwise suffer substantial mental deterioration. Ms. Ness described the CTO as

---

[17] A strongly held belief that random events, objects and behaviours of others have a particular and unusual significance to oneself.

[18] A fixed, false belief that one's bodily functioning, sensation or appearance is grossly abnormal.

[19] An incorrect interpretation of casual incidents and external events as having direct reference to oneself, which when sufficiently intense, constitute delusions.

2013 ONSC 5392 (CanLII)

contrary to her values and beliefs, depriving her of her liberty, autonomy and, in turn, her dignity.

[61] Ms. Ness has been administered several neuroleptic medications on the basis of her mother's consent as SDM. She has been physically restrained and has been held down and forcibly injected with medication. The first generation neuroleptic Modecate which was injected against her will every two weeks, rendered her barely able to speak or write and caused her to feel restlessness and constant pain such that minutes felt like hours. The second generation neuroleptic Risperidone caused painful constipation, difficulty sleeping and extreme restlessness. The second generation neuroleptic Olanzapine caused her to feel slow and sluggish, caused bowel problems and made her skin feel waxy. While it reduced bad feelings, it also eliminated feelings of pleasure and bliss. Ms. Ness was also fearful that the long-term administration of Olanzapine would cause her to develop diabetes, which, according to the applicants, is a well-known potential side effect of second generation neuroleptic drugs.

[62] During her psychiatric hospitalizations, Ms. Ness says she had observed insensitive nursing staff, patients screaming to be released from near-continuous seclusion, patients forcibly injected with medications against their will and even some subjected to unwanted electroshock therapy. She felt caught in a cycle of violence in which she had lashed out in reaction to or in an attempt to prevent psychiatric treatments. When told that she would not be released from hospital unless she agreed to be placed on a CTO, Ms. Ness acquiesced for fear of worse consequences if she remained in hospital.

[63] Ms. Ness considered the requirements of the CTO that she report regularly to her psychiatrist and her social worker to be punitive. If she failed to report, take her medications as prescribed or submit to blood and urine testing she was liable to be arrested. She was afraid of expressing her feelings or of disclosing any worsening of her mental health for fear of the consequences.

[64] Ms. Ness challenged her CTO before the CCB. She credited her wellness to housing, artistic expression, employment, meditation, yoga, talk therapy, supportive relationships and other supports in the community. She did not attribute her wellness to the daily low dose of Olanzapine that was forced upon her. The Board upheld the CTO, holding that Ms. Ness was incapable in respect of the community treatment plan (the administration of Olanzapine) and that the CTO criteria were met.

[65] In March 2009, Ms. Ness was placed on a CTO for the first time. Consent was provided by her SDM (her mother). As of the date of her affidavit (July 2011), she continued to be subject to a CTO. The CCB has upheld on review the issuance of Ms. Ness' CTOs and her incapacity to consent to treatment. In January 2012, this court also

2013 ONSC 5392 (CanLII)

upheld the issuance of Ms. Ness' September 17, 2010 CTO and the finding that she was incapable of consenting to treatment. Ms. Ness' community treatment plan includes monthly appointments with her psychiatrist, meeting with her case manager every three weeks, and orally taking a low dose of antipsychotic medication. Since being placed on a CTO, Ms. Ness has not been admitted to a psychiatric facility, either voluntarily or involuntarily. Ms. Ness has maintained her housing. She volunteers with community organizations, has a job, and takes yoga and acting classes. While she believes that the CTO is restrictive of her "liberty and autonomy" and is "an attack on [her] personal dignity," she prefers the CTO to involuntary hospitalization.

2013 ONSC 5392 (CanLII)

[66] In contrast, between June 2002 (Ms. Ness' first admission) and March 2009 (her first CTO), Ms. Ness had five admissions to a psychiatric facility. Ms. Ness' involuntary admissions were always based, in whole or in part, on Box A criteria.

[67] Before being placed on a CTO and in between her hospital admissions, Ms. Ness was generally non-compliant with psychiatric follow-up and taking antipsychotic medication. Leading up to each psychiatric admission, Ms. Ness would exhibit psychotic symptoms such as (i) increasing paranoid delusions fearing persecution from neighbours, strangers and family, including fears of poisoned food and medication; (ii) increasing agitation, anger, hostility, screaming and violence leading to altercations in her housing (when in shelter), in stores, in restaurants, on the street and with family members; (iii) somatic delusions focused on her bodily functions, particularly her bowels; (iv) delusions of reference and ideas of reference; (v) disorganized thinking; and (vi) responses to internal stimuli.

[68] The respondent disagrees with the applicants' statement that Ms. Ness "has never caused serious harm to herself or anyone else". The respondent points to the following: (i) in 2004, prior to Ms. Ness being placed on a CTO, a Form 1 was issued after Ms. Ness demonstrated violent and agitated behaviour; (ii) in 2007, while hospitalized Ms. Ness kicked her mother in the back and hit her repeatedly; (iii) in 2009, there were two incidents. In one incident, Ms. Ness grabbed a large kitchen knife and marched upstairs towards her mother after discovering a magazine about schizophrenia. In the other incident, Ms. Ness kicked and punched the emergency department psychiatrist.

V. Analysis

[69] As I have already noted, the applicants allege breaches of ss. 7, 9, 10(a) and (b), 12 and 15(1) of the *Charter*. The respondent points out that almost all of these claims are based on the s. 7 argument and acknowledges that, because of this, if an infringement is found, it likely cannot be justified under s.1.

[70] I will consider each of these constitutional challenges in turn. However, I think it can fairly be said at the outset that the applicants' strongest argument is s. 7 and overbreadth. That is, if the purpose of *Brian's Law* (the expanded civil commitment criteria and new community treatment regime) was only public safety and was aimed solely or even primarily at mentally ill persons who are a danger to themselves or others, then the impugned amendments were most likely broader than necessary because they extended to people who, while mentally ill, posed no danger to themselves or others.

(1) Section 7

[71] Section 7 of the *Charter* provides that "[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice". The s.7 analysis involves two distinct steps. First, the claimant must demonstrate that there has been a deprivation of the right to life, liberty or security of the person. Secondly, the claimant must demonstrate that the deprivation is not in accordance with a principle of fundamental justice.[20]

[72] Here the respondent concedes that ss. 15(1.1) (psychiatric assessment) and 16(1.1) (psychiatric assessment pursuant to an order of justice of the peace) implicate the liberty interest, and that the liberty and security of the person are engaged where a person is involuntarily admitted to a psychiatric facility pursuant to s. 20(1.1). The respondent also concedes that the CTO provisions implicate the liberty interest of an *incapable* person whose SDM provided consent where the person does follow the community treatment plan. Indeed, the Supreme Court has held that "liberty" is engaged where state compulsions or prohibitions affect important and fundamental life choices.[21] The respondent agrees that this would include compliance with a community treatment plan.

[73] However, the respondent does not concede that the CTO provisions engage the liberty interest of a *capable* person who has consented to a community treatment plan as

---

[20] *Centre for Addiction and Mental Health v. Ontario*, 2012 ONCA 342, 111 O.R. (3d) 359, at para. 32; *Bedford v. Canada (A.G.)*, 2012 ONCA 186, 109 O.R. (3d) 1, at paras. 88-89 [*Bedford*], leave to appeal to S.C.C. granted, [2012] S.C.C.A. No. 159); *Canadian Foundation for Children, Youth and the Law v. Canada (A.G.)*, 2004 SCC 4, [2004] 1 SCR 76, at para. 3 [*Canadian Foundation*]; *Winnipeg Child and Family Services v. K.L.W.*, 2000 SCC 48, [2000] 2 SCR 519, at para. 70.

[21] *Blencoe v. British Columbia (HRC)*, 2000 SCC 44, [2000] 2 S.C.R. 307, at para. 49; *Bedford*, *supra* note 20, at paras. 93-94.

2013 ONSC 5392 (CanLII)

there is no effect on fundamental life choices or personal autonomy.[22] Although I tend to agree with the respondent on this last point, given the outcome herein, I do not have to resolve this issue.

2013 ONSC 5392 (CanLII)

[74] For the purposes of the analysis that follows, I will assume that liberty and/or security interests have been infringed by both the Box B and the CTO amendments. The first step of the s. 7 analysis has been completed. The next step requires the court to determine if these infringements or deprivations are in accord with the principles of fundamental justice. The onus of proving this is on the applicant.[23]

[75] Over the last two decades, the Supreme Court has set out three principles of fundamental justice that arguably apply herein: legislation cannot be overbroad; it cannot be arbitrary and it cannot be grossly disproportionate to the state interest that the legislation seeks to protect. More specifically:

(i) A law is overbroad if it is broader than necessary to accomplish its purpose;[24]

(ii) A law is arbitrary if it bears no relation to, or is inconsistent with, the objective that lies behind the legislation;[25]

(iii) The doctrine of disproportionality requires the court to determine whether the law pursues a legitimate state interest, and if so, whether the law is grossly disproportionate to the state interest.[26] A law will be grossly disproportionate when

---

[22] In *Ontario (Attorney General) v. Patient* (2005), 250 D.L.R. (4th) 697 (Div. Ct.), at para. 41 the Divisional Court described the participation of persons in a CTO as "voluntary" as opposed to the involuntary admission of patients under the MHA.

[23] *R. v. Malmo-Levine*, 2003 SCC 74, [2003] 3 S.C.R. 571, at paras. 78, 133, 143 [*Malmo-Levine*].

[24] *R. v. Heywood*, [1994] 3 S.C.R. 761 [*Heywood*].

[25] *Chaoulli v. Quebec (A.G.)*, 2005 SCC 35, 254 D.L.R. (4th) 577.

[26] *Malmo-Levine*, *supra* note 23, at para. 143.

> its impact on the s. 7 interests is so extreme that its benefits are not worth its costs.[27]

[76] With each of these doctrines, the court must determine the legislative objective and then scrutinize the policy instrument enacted as the means to achieve that objective.[28]

[77] I therefore begin the analysis by determining the objective or purpose of *Brian's Law*. Was it solely or primarily public safety? Or did it have a dual purpose, namely public safety and medical treatment? The applicants urge the former; the respondent the latter.

[78] I can understand the applicants' argument. After all, the title of the impugned law is *Brian's Law*. It was obviously named in honour of an individual who died violently at the hands of a person who was clearly mentally ill, and much of what was said by the Minister and her Parliamentary Assistant when the law was being debated seems to suggest that the law's primary purpose was to reduce similar incidents of violence by people who were mentally ill. Consider the following excerpts from the legislative debates as the Minister of Health and Long-Term Care and her Parliamentary Assistant discussed the purpose of *Brian's Law*:

> At the inquest into Brian's death, the jury recommended a comprehensive review of Ontario's mental health legislation and the introduction of community treatment programs to ensure that people with serious mental illness who pose a danger to themselves or others get the treatment they need. Today we are introducing legislation to fulfill those recommendations that have been echoed too many times in too many inquests since 1995.[29]
>
> To ensure that people with serious mental illness who pose a danger to themselves or others get the treatment they need.[30]

---

[27] Hamish Stewart, *Fundamental Justice: Section 7 of the Canadian Charter of Rights and Freedoms* (Toronto: Irwin Law, 2012) at 154.

[28] See Peter W. Hogg, *The Brilliant Career of Section 7 of the Charter*, (2012) 58 S.C.L.R. 195 at 209.

[29] Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 47A (25 April 2000) at 2369 (Hon. Elizabeth Witmer, Minister of Health and Long-Term Care).

[30] *Ibid.*

2013 ONSC 5392 (CanLII)

> That's why our government is introducing this bill… it is important to save lives and prevent these kinds of tragedies from occurring in the future … we want to make sure that those people who pose a danger to themselves and to others get the kind of treatment they really need and really should have.[31]

2013 ONSC 5392 (CanLII)

[79] Even though legislative debates are now permissible sources for review, [32] it is not enough to point to selected excerpts from the legislative debates and draw conclusions about overall legislative purpose. In determining the purpose of a impugned law, the court should first examine the legislation on its face. Here, two things become immediately apparent. One, the Box B provisions, i.e. the sub-parts of s. 15(1.1), go well beyond public safety and explicitly concern themselves with treatment issues. And two, the impugned CTO regime begins with an explicit purpose clause that is obviously about treatment.

[80] First, the Box B criteria. The new provisions allow for the committal of an individual that falls within the following criteria:

> (i) she has previously received treatment for a mental disorder that when not treated is of a nature or quality that will likely result in substantial mental or physical deterioration or serious physical impairment;
>
> (ii) she has shown clinical improvement as a result of the treatment;
>
> (iii) she is now suffering from that same disorder and is likely to suffer substantial mental or physical deterioration or serious physical impairment;
>
> (iv) she is incapable of providing her consent within the meaning of the HCCA; and
>
> (v) the consent of her SDM has been obtained.

---

[31] Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 66B (5 June 2000) at 3434 (Hon. Doug Galt).

[32] Although extrinsic material such as *Hansard* was at one time considered inadmissible to determine legislative purpose, it is now well accepted that legislative history and parliamentary debates can be considered and can play "a limited role" in the interpretation of legislation. See *Rizzo & Rizzo Shoes Ltd. (Re)*, [1998] 1 S.C.R. 27, at para 35, Iacobucci J., writing for the Court: "Although the frailties of *Hansard* evidence are many, this Court has recognized that it can play a limited role in the interpretation of legislation."

[81] These criteria strongly suggest that the Box B provisions are not just about public safety but also about providing improved treatment for seriously mentally ill individuals – hence the statutory focus on previous treatment, clinical improvement, substantial mental deterioration, inability to consent and the consent of the SDM.

2013 ONSC 5392 (CanLII)

[82] Next, the CTO regime. As I have already noted, s. 33.1(3) provides an explicit purpose clause:

> The purpose of a community treatment order is to provide a person who suffers from a serious mental disorder with a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility. Without limiting the generality of the foregoing, a purpose is to provide such a plan for a person who, as a result of his or her serious mental disorder, experiences this pattern: The person is admitted to a psychiatric facility where his or her condition is usually stabilized; after being released from the facility, the person often stops the treatment or care and supervision; the person's condition changes and, as a result, the person must be re-admitted to a psychiatric facility.

[83] In my view, the purpose of the new CTO regime could not be clearer. The legislative objective is to provide a community-based treatment plan for "revolving door" patients that fall within the prescribed criteria.

[84] The fact that *Brian's Law* has a dual purpose, public safety *and* improved treatment, is also evident when one reviews the legislative debates. One finds numerous examples of the Minister and her Parliamentary Assistant talking not only about public safety but also, and equally, about improved treatment:

> I rise in the House to introduce a very important piece of legislation that will mean better treatment for people with serious mental illness and safer communities across our province.[33]
>
> People suffering from mental illness can find it affects their ability to hold down a job, to manage the daily tasks in life that we come by so easily. Many end up homeless, with little or no support or treatment. We're proposing the

[33] Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 47A (25 April 2000) at 2369 (Hon. Elizabeth Witmer, Minister of Health and Long-Term Care).

> necessary changes to Ontario's mental health legislation, legislation that has stood in the way of families, police and social workers for years.[34]
>
> A major step that provides the legislative framework for a continuum of care from institutional to community-based living … by expanding the current committal criteria so as to allow the chronically mentally ill, their families and their designated health professionals to intervene at an earlier stage in the committal process.[35]
>
> While we were developing this bill, we tried really hard to recognize that we're not dealing with strictly a violence issue. We're trying to deal with a number of issues that the mentally ill suffer from: victimization, suicide and violence. We're trying to do it in a very balanced way so that we have an opportunity to provide a continuum of care from the psychiatric facility to the community but also have that opportunity to protect society and protect the patient's right to treatment and protect the patient's rights.[36]
>
> The [CTOs] are set in place for the seriously mentally ill in order to permit appropriate treatment in the community as a less restrictive alternative to hospitalization, as proposed by psychiatrists or a physician.[37]
>
> [Brian's Law] will protect public safety, but also ensure that there is the appropriate care and treatment provided for those who suffer from serious mental illness.[38]

[85] In sum, not only do I find that the applicants have failed to show that the sole and primary purpose of the Box B and CTO amendments was public safety, I find (based on

---

[34] Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 66B (5 June 2000) at 3432 (Hon. Doug Galt).

[35] *Ibid.* at 3429-3430.

[36] Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 67A (6 June 2000) at 3475 (Hon. Brad Clark).

[37] Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 66B (5 June 2000) at 3430 (Hon. Doug Galt).

[38] Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 67A (6 June 2000) at 3476 (Hon. Elizabeth Witmer, Minister of Health and Long-Term Care).

2013 ONSC 5392 (CanLII)

the face of the legislation and the legislative debates) that *Brian's Law* had a dual purpose, public safety *and* treatment.

[86] Having found that one of the two purposes was the improved treatment of the mentally ill, it becomes difficult it not impossible for the applicants to show that the Box B and/or CTO provisions are broader than necessary to accomplish the treatment objective. The most the applicants can do, and they do in a careful and compelling fashion, is to try to show that the actual treatment regime, based as it is on modern psychiatry and its controversial use of antipsychotic medication, does not actually result in the effective treatment of the mentally ill individuals that come within the broad reach of this law. The applicants and their distinguished experts argue the ineffectiveness of antipsychotic (or neuroleptic) medications[39] and question the need for a coercive CTO regime.[40] They point to numerous studies that strongly support their position.

[87] When I say "numerous studies," I am understating the volume of material that was placed before me. The applicants and their experts have carefully documented their submissions by referring to an array of empirical research, both Canadian and international. They also take full advantage of the findings of the two internal studies that were commissioned by the Ministry of Health and Long-Term Care. Both the Dreezer Report[41] and the Malatest Report[42] set out troubling findings about the CTO regime and together underscore, at least, the need for further review.

[88] The respondent, in turn, puts forward its own distinguished expert, a psychiatrist with extensive institutional and community treatment experience who speaks authoritatively about the overall effectiveness of antipsychotic medications and the new

---

[39] The applicants point to studies that show that neuroleptic medications are often unsuccessful in treating, among other things, the core delusions or hallucinations that are a diagnostic feature of schizophrenia and other psychotic illnesses.

[40] The applicants point to studies that question the need for a CTO regime that is based on coercion and support their submission that "assertive community treatment teams" and other forms of comprehensive (non-coercive) case management in the community are more effective.

[41] Dreezer & Dreezer Inc., *Report on the Legislated Review of Community Treatment Orders Required under Section 33.9 of the Mental Health Act* (December 2005).

[42] R.A. Malatest & Associates Ltd., *The Legislated Review of Community Treatment Orders: Final Report*, (May 23, 2012).

2013 ONSC 5392 (CanLII)

CTO regime and refers to Canadian and international studies that he and others have conducted that appear to support the respondent's position.

[89] The most I can conclude from these conflicting submissions is that there is considerable disagreement in the mental health professional community and the relevant scientific literature about the effectiveness of modern psychiatric practices in the treatment of serious mental illness, especially the habitual use of antipsychotic/neuroleptic medications. There is also a significant disagreement about the efficacy of a community treatment regime that is based on coercion.

[90] The outcome of the competing analyses is troubling but inconclusive. The only conclusions that can be fairly drawn from the conflicting empirical studies that are contained in the record before me are (1) the applicants have presented a compelling case that the impugned amendments enacted by *Brian's Law* may not be working as intended and may be causing more harm than good; and (2) the Minister of Health and Long-Term Care would be well advised to consider a comprehensive review of the impact and effectiveness of both the Box B provisions and the CTO regime.

[91] But neither of these conclusions can support a finding of overbreadth, arbitrariness or gross disproportionality. Indeed, the case law is clear that where the evidence is inconclusive and the efficaciousness of a legislative remedy is difficult to measure, it is for the legislature and not the courts, to decide upon the appropriate course of action. Here is how the Court of Appeal put it in *Cochrane*:[43]

> [W]here the risk of harm or the efficaciousness of Parliament's remedy is difficult or impossible to measure scientifically it is for the legislature, not the courts, to decide upon the appropriate course of action, provided there is evidence of a "reasoned apprehension of harm". It was not the role of the application judge to make detailed factual findings as that would lead to "micromanagement of Parliament's agenda". Her task was rather to apply the "relevant constitutional control"; namely, "the general principle that the parliamentary response must not be grossly disproportionate to the state interest sought to be protected": see *Malmo-Levine*, at para. 133.

[92] In this case, the relevant constitutional control, and the easiest constitutional lever that the applicants can pull, is s. 7 and overbreadth. The fact that there is disagreement amongst the experts and in the mental health literature about the effectiveness of the

[43] *Cochrane v Ontario (Attorney General)*, 2008 ONCA 718, 92 O.R. (3d) 321, at paras. 26-29 [*Cochrane*].

2013 ONSC 5392 (CanLII)

treatment plans that are currently in use should be enough to prompt a governmental review but not enough for a finding of unconstitutionality under s. 7 of the *Charter*.

[93] Let me explain this in a bit more detail.

The legislation is not overbroad

[94] The applicants mischaracterize the impugned Box B provisions as relying on a "stereotypical assumption that all incapable people with mental illness are implicitly at future risk of serious harm to self or others". The evidence shows there is a segment of persons with mental illness who respond to treatment while in hospital but who repeatedly stop taking medication after discharge, relapse and experience substantial mental and physical deterioration, and are readmitted to hospital. Ms. Thompson`s and Ms. Ness' histories demonstrate this pattern. The Box B provisions are applied by trained medical professionals to the specific group described above on an individualized basis. The Box B provisions are not demonstrably overbroad.

[95] Nor are the CTO provisions. The purpose of the CTO provisions is to provide a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility. The CTO provisions, as outlined above, contain strict parameters for their application, stringent procedural protections in terms of review and rights advice, and a requirement of consent. The community treatment plan which underlies the CTO is individualized and tailored to the person's circumstances. CTOs only apply to a class of individuals who suffer from a serious mental disorder and who, as a result of their serious mental disorder, have exhibited a pattern of recurrent hospitalizations that feature stabilization followed by discharge, discontinuation of treatment, relapse and readmission. As with the expanded committal and assessment provisions, the CTO provisions are not available for persons experiencing their first psychotic episode. The requirement of a minimum number of recent hospitalizations or cumulate days in hospital is consistent with the objective of reducing the tendency of persons to cycle in and out of hospital because of non-adherence to treatment when discharged from hospital.

[96] The CTO provisions do not permit involuntary psychiatric assessment based solely on non-compliance with the community treatment plan or withdrawal of consent by the SDM. There is a process requiring the clinician to try to meet with the person and the SDM, discuss the non-compliance and attempt to assist the person to be compliant. Only if that process does not succeed, can the physician issue an order for examination (Form 47), which is not a Form 1 or a Form 3. Forms 1 and 3 may be issued only where their applicable criteria (ss. 15 or 20) are met.

2013 ONSC 5392 (CanLII)

[97] While there is conflicting data, some of the studies indicate that CTOs bring stability to the lives of many individuals. Like any therapeutic intervention, they may not work for all individuals. However, there is research that demonstrates that persons placed on CTOs are significantly less likely to be the victims of violence, have significantly reduced hospitalizations and violent behaviour, and have increased follow-up with clinical services. While some people can be treated in the community voluntarily without a CTO, others do not appreciate that they have a mental illness and they refuse to take treatment or follow-up with mental health services when discharged from hospital. The respondent points to one study that found that voluntary outpatient services alone did not reduce violence; rather it is only voluntary outpatient services combined with a CTO which increases medication adherence, reduces substance use, and significantly reduces incidence of violent behaviour. The data is, to be sure, conflicting. However, I agree with the respondent that government does not have to wait for definitive social science conclusions to make social policy.

The legislation is not arbitrary

[98] As already noted, the purposes of the impugned Box B psychiatric assessment and involuntary admission provisions are to: (i) facilitate treatment, through assessment and hospitalization, for persons, incapable of consenting to treatment, with recurrent or on-going mental illness where past treatment for the illness has resulted in clinical improvement for the person, (ii) prevent the likely substantial mental or physical deterioration in such patients that would arise without treatment, and (iii) protect public safety and prevent violence to the person with the serious mental illness and to those in the community. It cannot be reasonably said that the impugned provisions bear no relation to, or are inconsistent with, these purposes.

[99] There is some evidence that demonstrates that the Box B criteria facilitate faster treatment for persons with recurrent or on-going mental illness where past treatment has resulted in clinical improvement and where substantial mental or physical deterioration would likely arise without treatment. Without the Box B criteria, physicians would have to wait until the person deteriorated to the point of serious bodily harm (to himself or another) to assess and hospitalize. As the respondent's expert explained, the "major problem" with this approach is that many of these individuals would not remain under continuing medical supervision and as a result, a physician would not be "able to step in and commit the person" just at the point where he or she became a danger to themselves or others. The expert also suggested that use of the Box B criteria minimizes prolonged delays in receiving needed treatment, thus increasing the prospects for a better long-term outcome.

2013 ONSC 5392 (CanLII)

2013 ONSC 5392 (CanLII)

[100] As for the CTO regime, the procedural and substantive protections provided to persons subject to CTOs cannot be described as arbitrary. The CTO provisions set out strict criteria as to when a CTO may be issued. They require consent to the community treatment plan from the person subject to the CTO if capable or SDM if incapable; prior notice of the intention to issue or renew a CTO (Form 49); specific notice in Form 49 of the right to consult a rights adviser prior to the issuance or renewal of the CTO, and the right to retain and instruct counsel prior to the issuance or renewal of the CTO and after; provision of rights advice prior to the issuance or renewal of the CTO which includes advice about all legal options; provision of a copy of the CTO (Form 45) including the community treatment plan; expiration of CTOs after 6 months unless renewed or terminated early; the right to apply to the CCB to review whether the criteria for a CTO is met; automatic review by the CCB when a CTO is renewed for a second time, and upon every second renewal thereafter; and appeal to the Superior Court of Justice.

[101] These are not arbitrary statutory provisions.

The legislation is not grossly disproportionate

[102] The respondent agrees that antipsychotic medication is the standard treatment for persons diagnosed with a psychotic illness but points to the evidence that shows that for many people antipsychotic drugs: (i) reduce the intensity of symptoms (allowing other treatment interventions to be effective), particularly the core hallucinations and delusions that are a diagnostic feature of schizophrenia and other psychotic illnesses, (ii) shorten the exacerbations of illness allowing people to reach and sustain psychosocial milestones, (iii) reduce the risk of relapse, and (iv) reduce the risk of suicide. There is evidence in the record that antipsychotic drugs have made it possible to successfully treat large numbers of patients with schizophrenia and other psychotic illnesses, which permits discharge from institutional care.

[103] There is evidence in the record that without antipsychotic medication Ms. Thompson`s mental state fluctuated and then, after she consistently failed to take her medication, she substantially deteriorated. By contrast, with antipsychotic medication, her mental state demonstrated appropriate and organized thought content, she did not express any hallucinations or delusions, and she was engaged with the CTO Team.

[104] Since being placed on a CTO, Ms. Ness has not been hospitalized; she is volunteering in the community; she has a job; and she is involved in the arts. While Ms. Ness attributes her success to social and protective factors (change in lifestyle, yoga, having a home and work, and overall improved health) the CCB found it was likely that the CTO and medication were providing some benefit to her which allowed her to explore these other activities that also supported her wellness.

[105] There is evidence in the record that CTOs significantly increase the contact that persons on a CTO have with mental health services. Patients who have been on a CTO have increased rates of follow up with mental health services even after the CTO expires. There is evidence in the record that CTOs do not drive people away from mental health services; they ensure that people who do not recognize the need for service stay connected. With developing insight, most individuals on CTOs continue to follow-up even when their CTO ends. There is also evidence suggesting that CTOs reduce victimization and that sustained use of CTOs reduces hospitalization, violence, arrest and homelessness.

[106] One should also acknowledge the statutory safeguards to ensure the consent of the patient or his or her SDM; the rights advice that is provided and the manner in which persons subject to CTOs are notified of their rights to retain and instruct counsel and to seek review. By providing advance notice through s. 33.1(8) and Form 49 (and confirmation of same through Form 50), not only do the CTO provisions inform individuals and their SDMs as soon as possible that they have a right (and will be given access) to rights advice and a right to retain and instruct counsel before a CTO is issued and after its issuance (Form 45), but it also allows the provision of timely rights advice about the individual's legal options. This includes advice about the potential alternatives to a CTO (e.g. involuntary admission or continuing involuntary admission) and the ability to seek review of any findings that are the prerequisites for a CTO, such as findings of incapacity to consent to treatment or involuntary admission.

[107] The evidence with respect to Ms. Thompson and Ms. Ness indicates that they were able to seek review of their CTOs after the Form 45 (CTO) was issued. They also challenged findings of incapacity with respect to treatment that if overturned by the CCB would have rendered their CTOs invalid under the case law, as they would not have consented to treatment under their community treatment plans.[44]

[108] In short, on the evidence before me, the applicants have failed to establish that the Box B and CTO provisions are grossly disproportionate to the state's legitimate interest in providing treatment for the mentally ill. I am not persuaded that the impact on the s. 7 interests is so extreme that the benefits of these provisions are not worth their costs. Given the disagreements about the law's "effectiveness" there is good reason for the government

---

[44] *Starnaman*, *supra* note 14, at paras. 44-54 (Gen. Div.).

2013 ONSC 5392 (CanLII)

to review both the Box B and the CTO provisions but, as I have already noted, this is nowhere near enough for a finding of gross disproportionality.

(2) Vagueness

[109] Vagueness is related to overbreadth. As Cory J. explained in *Heywood*: "Overbreadth and vagueness are related in that both are the result of a lack of sufficient precision by a legislature in the means used to accomplish an objective."[45]

[110] A law is unconstitutionally vague if it does not provide an adequate basis for legal debate and analysis or "is not intelligible". To avoid vagueness, laws must give a "sufficient indication as to how decisions are to be reached, such as factors to be considered or determinative elements".[46]

[111] The applicants argue that in sections 15(1.1), 16.(1.1) and 20(1.1) of the MHA, the criteria for involuntary admission include a physician's opinion that the patient is likely to suffer "substantial mental deterioration" and that the patient has shown "clinical improvement" as a result of previous treatment. The criterion of "clinical improvement," say the applicants, offers no guidance as to what constitutes an "improvement".

[112] The applicants also submit that the term "substantial mental deterioration" is unduly vague. They argue that this provision has been interpreted in different ways by the CCB. Interpretations have ranged from equating "substantial" with "considerable, consequential, ample, significant, sizeable"[47] to any worsening of a psychotic illness.[48]

[113] In my view, the impugned phrases, "substantial mental deterioration" or "clinical improvement" are not unconstitutionally vague. Laws are not vague simply because they are subject to interpretation. Legal criteria "may be difficult to apply in some cases, but that is not the same as vagueness and does not result in arbitrary or unfair decision-

---

[45] *Heywood*, *supra* note 24, at para. 50

[46] *Canadian Foundation*, *supra* note 20, at para. 15, citing *Canada v. Pharmaceutical Society (Nova Scotia)*, [1992] 2 S.C.R. 606, at para. 70.

[47] *Re C.P.*, 2003 CanLII 15613 (Ont. C.C.B.) [*Re C.P.*].

[48] *Re D.M.*, 2004 CanLII 30951 (Ont. C.C.B.).

2013 ONSC 5392 (CanLII)

making".[49] It is only "where a court has embarked upon the interpretative process, but has concluded that interpretation is not possible" that a law will be declared unconstitutionally vague.[50] A law will not be struck down as being vague simply because reasonable people might disagree as to its application to particular facts.[51]

2013 ONSC 5392 (CanLII)

[114] One must remember that Canadian law is replete with legal concepts that are subject to interpretation but not impossible to interpret: such as "reasonable foreseeability" (in tort law), "the best interests of the child" (in family law) and "substantial completion" (in construction law). And, there are dozens of other examples.

[115] I am satisfied on the evidence before me that psychiatrists, as specialists in the treatment of mental disorders, are especially familiar with the phenomenon of mental deterioration. They view the term "substantial mental deterioration" to mean not just a trivial change in symptoms and/or functioning, but rather a significant increase in symptoms and/or a significant decline in functioning (e.g. difficulty in being able to go to work and hold a job, or completing basic activities such as feeding or hygiene).

[116] The impugned provisions have been applied by Ontario courts in an intelligible manner in previous cases. In *T.S. v. O'Dea*, this court adopted the CCB's interpretation in *Re (C.P.)* of the word "substantial" in s. 20(1.1)(d) of the MHA, so that the degree of mental or physical deterioration a person is likely to suffer must be "considerable, consequential, ample, significant, sizeable".[52]

[117] No court has concluded that the phrases "substantial mental deterioration" or "clinical improvement" are so vague that they are impossible to interpret. Indeed, a Manitoba court has rejected the argument that mental health legislation which allows for involuntary admission on the basis of "substantial mental deterioration" is unconstitutionally vague.[53] And, a Wisconsin court found that the involuntary civil

---

[49] *Ontario v. Canadian Pacific Ltd*., [1995] 2 S.C.R. 1031, at 1069-1072 and 1090-1091; *Canadian Foundation*, *supra* note 20, at paras. 15-16; and *Cochrane*, *supra* note 43,at paras. 37-39 (C.A.)

[50] *Ontario v. Canadian Pacific Ltd.*, *ibid.*, at para. 79.

[51] *Cochrane*, *supra* note 43, at para. 43.

[52] *T.S. v. O'Dea* (2004), 127 A.C.W.S. (3d) 1238 (S.C.J.), at paras. 29-34; *Re C.P.*, *supra* note 47; *Van Es v. Dunn*, 2011 ONSC 950, [2011] O.J. No. 768 (S.C.J.); see also *Re (K.L.)*, [2005] O.C.C.B.D. No. 196.

[53] *Bobbie v. Health Sciences Centre* (1988), 56 Man. R. (2d) 208 (Man. Q.B.).

commitment standard of "severe mental, emotional or physical harm" was not unconstitutionally vague, overbroad or a violation of equal protection.[54]

[118] In sum, none of the arguments advanced under s. 7 of the Charter – overbreadth, arbitrariness, gross proportionality or vagueness – succeed.

(3) Section 9

[119] Section 9 of the *Charter* provides that everyone has the right not to be arbitrarily detained or imprisoned. The Supreme Court has held that a detention will be arbitrary where it is based on a discretionary authority that is not governed by any criteria – either express or implied.[55] Psychiatric assessment and involuntary detention under ss. 15(1.1), 16(1.1) and 20(1.1) amount to a detention for the purposes of s. 9. However, the impugned provisions do not violate s. 9 because they are not arbitrary. I agree with the respondent that the structured discretion to require a person to undergo a psychiatric assessment (s. 15(1.1) and 16(1.1)), to involuntary admit a person under s. 20(1.1), or to issue a CTO under s. 33.1(4) are the antithesis of arbitrariness.

(4) Sections 10(a) and (b)

[120] The applicants say that the Box B and CTO provisions infringe ss. 10(a) (right to be informed promptly of the reasons for arrest or detention) and 10(b) (right to retain and instruct counsel). The applicants did not press this point and frankly, I do not understand this submission. The impugned provisions are replete with "rights" notifications and procedural safeguards.

[121] In my view, the applicants have failed to establish that the provision of rights advice and the notification of the right to retain and instruct counsel statutorily required by the MHA in respect of both the Box B and CTO amendments is (somehow) a violation of s. 10 of the *Charter*.

(5) Section 12

[122] Section 12 of the *Charter* provides that everyone has the right not to be subjected

---

[54] *In re the Commitment of Dennis H., State of Wisconsin v. Dennis H.*, 2002 WI 104, 255 Wis. 2d 359, at paras. 14-18, 24-29, 33-34, 44-45.

[55] *R. v. Hufsky*, [1988] 1 SCR 621 at 633.

2013 ONSC 5392 (CanLII)

to any "cruel and unusual treatment or punishment". In order to engage s. 12 the applicants must show that the Box B criteria and the CTO provisions (1) involve some treatment or punishment by the state, and (2) that such treatment is "cruel and unusual."

2013 ONSC 5392 (CanLII)

[123] Even if what is authorized by the Box B criteria or the CTO provisions constitutes "treatment" within the meaning of s. 12, the test for whether it is cruel and unusual is similar to the fundamental justice analysis under s. 7: the treatment imposed must be so grossly disproportionate and so excessive as to "outrage standards of decency".[56] The applicants have provided no evidence that the expanded involuntary committal procedures or the new community treatment regime outrage standards of decency. Given the (admittedly disputed) evidence as to the beneficial effects associated with treatment for serious mental illness, and the effectiveness of CTOs, it cannot be said that these provisions constitute cruel and unusual punishment.

(6) Section 15(1)

[124] Section 15(1) of the *Charter* guarantees equality before the law and the equal protection and benefit of the law "without discrimination based on race, national or ethnic origin, colour, religion, sex, age or *mental* or physical disability." There is no dispute that mental disorder corresponds to an enumerated ground and that persons with mental disorders have historically been subject to stereotyping.

[125] However, in my view, the impugned provisions do not discriminate on the basis of mental disability. Neither the Box B criteria nor the CTO provisions are based on *presumed* group or personal characteristics. They require an individualized consideration of each person's clinical history, current mental and physical status, and the likelihood of serious bodily harm to him/herself or others or substantial mental or physical deterioration of each particular patient. The experiences of both Ms. Thompson and Ms. Ness, as described earlier, demonstrate that the impugned provisions correspond to their individual needs and circumstances.

[126] There is no violation of s. 15(1).

VI. Conclusion

---

[56] *Canadian Foundation*, *supra* note 20, at para. 49; *Malmo-Levine*, *supra* note 23, at paras. 159-160.

2013 ONSC 5392 (CanLII)

[127] *Brian's Law* had a dual purpose: public safety and improved treatment of persons suffering from serious mental illness. The applicants have not established that the Box B or CTO provisions are overbroad, vague, arbitrary or grossly disproportionate to a legitimate state interest, and thus in violation of s. 7 of the *Charter*. Nor have they established any breaches of ss. 9, 10, 12 or 15 of the *Charter*.

[128] The applicants have, however, established a compelling case for a governmental review of the impact and effectiveness of the Box B and CTO provisions. Hopefully, this will come to pass in the not too distant future.

[129] Involuntary civil commitment and forced psychiatric treatment will always be enormously difficult issues for modern governments. Incarcerating people who have committed no crime and forcing them to take medication that may have devastating side-effects tests the legitimacy of coercive psychiatry, the justifiable limits of state intervention and the meaning of individual freedom.

[130] The most that I can do as a judge (I am not a one-man royal commission) is determine if the impugned legislation, even where there is disagreement about its effectiveness, crosses into a constitutional danger zone. I am of course concerned about the extent of the disagreement over the Box B and CTO provisions, but I am obliged to conclude as a matter of law that these impugned provisions are not unconstitutional.

VII. Disposition

[131] The application is dismissed.

[132] Given this decision, the respondent's motion to strike certain paragraphs from the affidavits of Professors Reaume and Cohen on various grounds (hearsay, argument and relevant expertise) is rendered moot. Also, my decision in this matter would have been the same regardless of the outcome of the respondent's motion to strike.

[133] No costs were sought and none are awarded.

[134] I am obliged to counsel on both sides for their assistance and for the quality of their advocacy.

____

Belobaba J.

Released: September 12, 2013

2013 ONSC 5392 (CanLII)

CITATION: Thompson and Empowerment Council v. Ontario, 2013 ONSC 5392
COURT FILE: 05-CV-293285
DATE: 20130912

2013 ONSC 5392 (CanLII)

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KARLENE THOMPSON AND EMPOWERMENT COUNCIL, SYSTEMIC ADVOCATES IN ADDICTIONS AND MENTAL HEALTH

Applicant

– and –

ATTORNEY GENERAL OF ONTARIO

Respondent

REASONS FOR JUDGMENT

BELOBABA J.

Released: September 12, 2013