COURT OF APPEAL FOR ONTARIO

CITATION: Reisher (Re) 2015 ONCA 929
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Laskin, Hourigan and Pardu JJ.A.

IN THE MATTER OF: JANET REISHER

AN APPEAL UNDER PART XX.1 OF THE *CODE*

Anita Szigeti, for the appellant

Katherine Stewart, for the respondent Crown

Gavin S. MacKenzie, for the respondent Person in Charge of the Centre for Addiction and Mental Health

Heard: August 25, 2015

On appeal against the disposition of the Ontario Review Board, dated October 31, 2014, with reasons reported at *Reisher (Re)*, [2014] O.R.B.D. No. 2814.

Laskin J.A.:

A. Introduction

[1] Janet Reisher appeals the Ontario Review Board's refusal to grant her an absolute discharge. The overriding question on this appeal is: Did the Board err in finding that Ms. Reisher remains a significant threat to the safety of the public?

[2] In 2002, Ms. Reisher was found not criminally responsible on account of mental disorder on charges of carrying a dangerous weapon and assault causing bodily harm. She attacked two strangers with a pocket knife, one after another, while being driven by paranoid delusions. From 2002 until November 2013, she was detained at the Centre for Addiction and Mental Health, often with privileges that allowed her to live outside the Hospital. In November 2013 the Board granted Ms. Reisher a conditional discharge.

[3] At her annual review hearing in October 2014, Ms. Reisher sought an absolute discharge. The Board refused to order one; instead, it ordered the continuation of her conditional discharge. Relying mainly on the evidence of Ms. Reisher's psychiatrist, Dr. Duff, the Board held, at para. 14:

> [T]he accused remains a significant risk to the safety of the public. … She has a lengthy history of noncompliance with medication while in the community. She has limited insight into her mental illness and the relationship between non-compliance with medication and aggression. She lacks a concrete plan for follow-up if absolutely discharged.

[4] Ms. Reisher makes two submissions on appeal. First, she submits that the Board erred in two ways in its application of the test for significant threat to public safety: it failed to consider whether Ms. Reisher could be supervised under the civil mental health system, and it wrongly focused on her historical non-compliance with medication, her limited insight into her mental illness, and her lack of a concrete plan, instead of asking whether she was likely to commit a serious criminal offence if absolutely discharged. Second, Ms. Reisher submits that the Board's finding that she remains a significant threat to public safety was unreasonable.

[5] If we were to agree with Ms. Reisher's first submission, she would be entitled to a new hearing. If we were to agree with her second submission, she would be entitled to an absolute discharge.

B. Background

(a) Personal circumstances

[6] Ms. Reisher was 44 years old at the time of the hearing before the Board. She was born in the Ukraine and came to Canada in 1991. She completed grade 11 and then spent six months at Seneca College, studying cosmetics and makeup artistry.

[7] For some time, Ms. Reisher has lived in her own apartment in a building on Bathurst Street in Toronto. Her rent is subsidized by Jewish Family and Child

Services. According to the Hospital report, she likes the building and the neighbourhood. Over the years, Ms. Reisher has had a variety of short-term jobs, including waitressing and cleaning private homes. In July 2014, she began to volunteer at the Bernard Betel Centre, answering the phone once a week for up to two hours.

[8] While under the Board's jurisdiction, Ms. Reisher has given birth to two daughters – the first in February 2009 and the second in September 2010. Ms. Reisher's mother takes care of the children, but Ms. Reisher visits them frequently.

[9] Ms. Reisher has no history of substance abuse and, apart from her index offences, has never been charged with a criminal offence.

(b) Psychiatric history and the index offences

[10] Ms. Reisher has been diagnosed with schizo-affective disorder – bipolar type. She has had a long and troubled psychiatric history.

[11] She began seeing a psychiatrist when she was 18. She was hospitalized in her early- to mid-twenties for depression and mania. Between 1996 and 2001, she was admitted to the North York General Hospital 13 times, both voluntarily and involuntarily.

[12] The index offences took place in October 2001. Ms. Reisher first threatened to kill a taxi driver, while waiving a four-inch pocket knife. She then

fled to a nearby apartment building. There, she knocked on the door of a unit occupied by a 92-year-old man whom she did not know. When he opened the door, she stabbed him twice in the chest and slashed his hand as he was trying to defend himself.

[13] After being found not criminally responsible, Ms. Reisher was detained at the Centre for Addiction and Mental Health. When exercising community living privileges, she often had to be readmitted to the Hospital. On one occasion, she assaulted a member of her treatment team. The following year, she assaulted her boyfriend's roommate; he refused to press charges.

[14] However, a major change occurred, beginning in May 2011. Since then, Ms. Reisher has lived continuously in the community, in her Bathurst Street apartment, and has had no major incident requiring her readmission to the Hospital. Nor has she engaged in any assaultive behaviour. Dr. Duff attributes this major change to a change in Ms. Reisher's medication, which I will discuss below.

(c) Ms. Reisher's failure to comply with her medication regime

[15] Ms. Reisher has a history of failing to take her required medication. Typically, she would fail to do so after she was released from or eloped from the Hospital. And, typically, her non-compliance would lead to a rapid deterioration in her mental health and to symptoms of paranoia.

[16] Beginning in March 2009, her medication regime was changed. She began taking a bi-weekly injectable anti-psychotic medication, which is administered at a clinic. She supplemented this long-lasting medication with daily oral tablets, which she took at home. Dr. Duff agreed that the injectable medication was a turning point in her treatment, as it allowed her to be maintained in the community without readmission to the Hospital.

[17] Nonetheless, even during the year leading up to her last Board hearing, at least twice Ms. Reisher did not take her oral tablets. And on both occasions she demonstrated symptoms of paranoia.

[18] In March 2014, Ms. Reisher told her nurse she was concerned about a male tenant living upstairs. She believed that the tenant was getting into her apartment at night, stealing things, and injecting her, and she believed she could hear him recording his own voice. In response, Ms. Reisher changed the locks to her apartment. Her paranoia disappeared when the male tenant moved out of the building. Shortly after this episode, a nurse found four oral tablets in Ms. Reisher's apartment that should not have been there. Ms. Reisher claimed they were "extras", but, as Dr. Duff explained, the Hospital nurses do not leave extra tablets.

[19] In July 2014, Ms. Reisher told her treatment team she was getting very little sleep because of a conflict with her on again, off again boyfriend Camillo.

She called him an “evil, bad man” and claimed that the Hospital was forcing her to have a relationship with him. A week after this incident, a nurse discovered eight “extra” tablets in her apartment.

(d) The Board’s 2013 Disposition

[20] At Ms. Reisher’s 2013 annual review, the Hospital sought a continuation of her detention order. The Board rejected the Hospital’s position and ordered a conditional discharge. The Board’s reasons, however, emphasized the importance of maintaining Ms. Reisher under its jurisdiction.

[21] The Board said that Ms. Reisher needed frequent monitoring to ensure that she was complying with her medication regime and that her mental state was stable. Absent a Board disposition, the risk of her failing to take her medication would be high, and, correspondingly, the risk of her violently reoffending would increase.

[22] Still, despite her need for a high level of supervision and her lack of insight into her mental illness, the Board concluded that Ms. Reisher’s risk to public safety could be managed under a conditional discharge. The Board noted that, if Ms. Reisher did not take her medication and if her mental condition then deteriorated, under a conditional discharge the Hospital could still respond rapidly in one of two ways: by securing her involuntary admission to a hospital under the *Mental Health Act*, R.S.O. 1990, c. M.7; or, as she had consented to a condition requiring that she accept the treatment recommended by her

psychiatrist, by returning her to the Centre for Addiction and Mental Health for breach of this condition. The Board concluded that "consistent compliance with medication is crucial to risk management of Ms. Reisher": *Reisher (Re)*, [2013] O.R.B.D. No. 3146, at para. 44.

(e) Ms. Reisher's lack of insight into her mental illness and her lack of a concrete plan

[23] As the Board observed in its 2013 disposition, Ms. Reisher continues to have limited insight into her mental illness. She claims that she does not get sick and refuses to acknowledge that she needs ongoing monitoring. When Dr. Duff asked her what she would do about taking her medication if she were granted an absolute discharge, she said she might go to a psychiatrist, or perhaps her family doctor, once a month.

C. Analysis

(i) Did the Board misapply the test for significant threat to public safety?

[24] If an NCR accused is not a significant threat to public safety, then, under the *Criminal Code*, R.S.C. 1985, c. C-46, the accused is entitled to an absolute discharge. In *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625, the Supreme Court of Canada discussed the meaning of a "significant threat to the safety of the public", at para. 57:

> [T]he threat posed must be more than speculative in nature; it must be supported by evidence. The threat must also be "significant", both in the sense that there

> must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A miniscule risk of a grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold. Finally, the conduct or activity creating the harm must be criminal in nature. [Citations omitted.]

[25] The Board can thus only maintain jurisdiction over an NCR accused if the person "poses a significant risk of committing a serious criminal offence": *Winko*, at para. 57.

[26] Ms. Reisher submits that the Board misapplied this test in two ways: first, by failing to consider whether she can be managed under the civil mental health system; and second, by failing to focus on the test from *Winko*, and instead focusing on her history of failing to take her medication, her lack of insight into her mental illness, and her lack of a concrete plan if absolutely discharged. For the reasons that follow, I do not agree with either branch of Ms. Reisher's submission.

(a) Did the Board err by failing to consider whether Ms. Reisher could be managed under the civil mental health system?

[27] Ms. Reisher submits that the terms of her conditional discharge could be replicated by a Community Treatment Order (CTO) under s. 33.1 of the *Mental Health Act*. She contends that the Board erred by failing to consider this option. In support of her submission she relies on this court's decision in *R. v. Stanley*, 2010 ONCA 324, 100 O.R. (3d) 81, where this court substituted an absolute

discharge for the conditional discharge ordered by the Board on the ground the appellant could be managed under a CTO.

[28] I do not accept Ms. Reisher's submission for four reasons. First, Ms. Reisher did not raise the possibility of a CTO before the Board. She led no evidence in support of CTO and she did not ask for one in her submissions. And it is the Board, not this court, that should consider whether Ms. Reisher can be managed under a CTO.

[29] Second, even though the possibility of a CTO was not expressly raised before the Board, I think it is safe to assume the Board implicitly rejected a CTO as an alternative to a conditional discharge. The Board is an expert tribunal and is well aware of the mechanisms under the *Mental Health Act*. Indeed, in its 2013 disposition, the Board averted to the possibility of involuntary admission to a hospital under the *Mental Health Act* as one way to manage Ms. Reisher's risk under a conditional discharge.

[30] Third, although, as counsel for the Hospital acknowledged, one could craft a CTO that closely replicates the terms of Ms. Reisher's conditional discharge, Ms. Reisher would have to consent to a CTO. The Board has no jurisdiction to order an absolute discharge and then to require that the accused enter into a CTO. The Hospital report and Dr. Duff's evidence before the Board show that Ms. Reisher is resistant to monitoring and to any form of compulsion. Thus, it is

unlikely she would consent to a CTO, and, even if she did, a CTO has to be renewed every six months, giving her periodic opportunities to opt out.

[31] Fourth, Ms. Reisher's psychiatric history weighs against the appropriateness of a CTO for her. When she misses only one or two doses of her required medication, she tends to decompensate very quickly. When she experiences symptoms of her illness, she can be returned to a secure treatment unit more quickly under the terms of a conditional discharge than under any of the *Mental Health Act* provisions.

[32] Ms. Reisher's situation differs from that of the appellant in *Stanley* in two important ways. First, Mr. Stanley had a track record of consistently complying with his medication regime for several years. Second, on his appeal, the Hospital led fresh evidence from Mr. Stanley's psychiatrist, who testified that he had issued a CTO for Mr. Stanley and that he was satisfied Mr. Stanley would adhere to its terms. On the basis of the fresh evidence, this court concluded that Mr. Stanley no longer posed a significant threat to the safety of the public and it thus ordered that he be discharged absolutely. This sort of evidence is lacking in the present case. Although recently Ms. Reisher has done much better in taking her medication, Dr. Duff remains concerned Ms. Reisher has only done so under Hospital supervision. And we have no evidence from Dr. Duff that Ms. Reisher would adhere to a CTO. Rather, the evidence suggests the contrary.

[33] I would not give effect to this ground of appeal.

(b) Did the Board err by failing to focus on the test from *Winko*?

[34] Ms. Reisher submits that, instead of focusing on whether she poses a significant risk to commit a serious criminal offence, the Board focused on her history of failing to comply with her medication regime, her limited insight into her mental illness, and her lack of a concrete plan if absolutely discharged. I do not agree with this submission.

[35] Ms. Reisher's history of non-compliance, her limited insight, and her lack of a concrete plan were all considerations that led the Board to conclude she remains a significant threat to public safety. In reaching this conclusion, the Board relied on the evidence of Dr. Duff, who testified about Ms. Reisher's limited insight and her potential to act violently if freed from Board supervision:

> I guess you can see in her -- in the history of the index offence in particular that she was, that it was violent, obviously serious, and, and, and, and, and so she's got the potential to act on delusions and to act in a very dramatic and violent way. She continues not to have full insight about that and as soon as she becomes paranoid, what insight she has is worse. There's, there's less insight; she gets angrier. And, and if she were not under the ORB I, I think that her -- it would become very difficult to follow her in a safe manner in, in the community. She'd be a challenge to, to, to care for in a safe way.
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> …
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> She's very defensive. I think, so without the oversight of, of, of the ORB I think that probably she would go back

> to being unstable the way she was before and now we know for sure that there is this potential for serious violence when she's ill. So I think there's that risk is always there.

[36] Dr. Duff also expressed concern about Ms. Reisher's lack of a concrete plan, a consideration that is relevant in assessing an accused's risk to public safety: see *Winko*, at para. 61. Dr. Duff testified:

> Well, I would be very concerned about what would happen if she had an absolute discharge. …if she had an absolute discharge what kind of follow up would she think was reasonable and, and that I thought she should have a team of, at least, of people who could come and visit her; an ACT team preferably. And she got very upset with that. So she does not think that she really needs any oversight. She doesn't really think she's at any risk of, of relapse.
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> …
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> So I, I would be very concerned about, about her ability to keep to -- to maintain the monitoring that she needs and to maintain the medication that she needs to stay well.

[37] In the light of this evidence from Ms. Reisher's psychiatrist, which the Board was justified in relying on, I see no error in its application of the test for significant threat to public safety. I would therefore not give effect to this ground of appeal.

(ii) Was the Board's finding unreasonable?

[38] A review board's finding that an NCR accused is a significant threat to public safety is entitled to deference on appeal. An appellate court asks not

whether the Board's finding was correct, but whether it was reasonable. Ms. Reisher submits that the Board's finding was unreasonable. I do not accept her submission.

[39] Although the Board's reasons are brief, they reasonably justify its finding that Ms. Reisher remained a significant threat to the safety of the public. The evidence of Dr. Duff, which I quoted earlier, supports the Board's finding.

[40] Ms. Reisher committed the index offences – serious and violent offences – when she experienced paranoid delusions after failing to take her medication. And Dr. Duff testified that her paranoia is "under the surface and could resurface fairly quickly". Yet Ms. Reisher continues to believe she is not at risk to act violently and she does not require any monitoring.

[41] Thus, while acknowledging that Ms. Reisher is more stable than she has been in the past, the Board was justifiably concerned that, without its supervision, Ms. Reisher was at risk of going off her medication, of decompensating, and of violent recidivism. The Board summed up its assessment of Ms. Reisher's risk as follows, at para. 15:

> Ms. Reisher must be commended, as the last two years have been the most stable under the jurisdiction of the ORB. However, she requires the treatment team to ensure that she is compliant with medication, and that she is not experiencing paranoia or acting out aggressively. Therefore, the Conditional Discharge remains the necessary and appropriate Disposition.

[42] On the evidence before it, the Board's conclusion was reasonable. I would not give effect to this ground of appeal.

D. Conclusion

[43] The Board did not misapply the test for significant threat to the safety of the public. Nor was its finding that Ms. Reisher remains a significant threat unreasonable. I would therefore dismiss her appeal.

Released: December 31, 2015 (JL)

"John Laskin J.A."
"I agree C.W. Hourigan J.A."
"I agree G. Pardu J.A."