CITATION: Thompson v. Attorney General of Ontario, 2011 ONSC 2023
COURT FILE NO.: 05-CV-293285PD2
DATE: 20110401

SUPERIOR COURT OF JUSTICE - ONTARIO

RE: Karlene Thompson and Empowerment Council, Systemic Advocates in Addictions and Mental Health, Applicants

AND:

Attorney General of Ontario, Respondent

BEFORE: D. M. Brown J.

COUNSEL: S. Hanley, for the moving party, Respondent

M. Swadron and M. Perez, for the responding parties, Applicants

HEARD: November 9, 2010

REASONS FOR DECISION

I. Motion to dismiss *Charter* application as moot or for lack of a proper applicant

[1] In July, 2005 the applicants commenced an application seeking to declare sections of the *Mental Health Act*, R.S.O. 1990, c. M.7, as amended, of no force and effect by reason of their violation of certain sections of the *Canadian Charter of Rights and Freedoms*. The respondent, the Attorney General of Ontario ("AGO"), moves to dismiss the application as moot or lacking an applicant with proper standing or, in the alternative, for orders striking out portions of affidavits filed in support of the application.

[2] For the reasons set out below, I dismiss the motion, on terms.

II. The history of this proceeding

[3] At various times during her life Karlene Thompson had been found incapable of consenting to medical treatment, admitted to a psychiatric facility as an involuntary patient and made subject to community treatment orders. The immediate events leading to this application go back to August 16, 2004, when Dr. Peter Grant issued a Form 45 community treatment order for Ms. Thompson. She applied to the consent and Capacity Board ("CCB") to review the community treatment Order ("CTO") and raised a constitutional challenge to the legislative

authority for such orders. In September, 2004 the CCB confirmed the CTO, but deferred dealing with the Charter challenge pending the release of the Divisional Court's decision in the *Jane Patient* case.[1] In that case the Divisional Court held that the CCB lacked the jurisdiction to decide constitutional challenges to legislation. Subsequently, in May, 2005 the CCB dismissed Ms. Thompson's *Charter* challenge to the *MHA* on the basis that it lacked jurisdiction to deal with it.

[4] By that time Ms. Thompson's CTO had expired and was not renewed. Nonetheless, on May 27, 2005 she appealed the CCB's decision to this Court. In her notice of appeal she sought the following relief pursuant to section 52 of the *Constitution Act, 1982*:

> A declaration that the expanded criteria for Form 1 applications for psychiatric assessment in subsection 15(1.1) and the community treatment order provisions in sections 33.1 through 33.8 of the *Mental Health Act*, R.S.O. 1990, c. M.7, as amended by S.O. 2000, c. 9 (the "*MHA*") are of no force and effect.

[5] Five weeks after filing her appeal from the CCB decision Ms. Thompson started this application, together with her co-applicant, Empowerment Council, Systemic Advocates in Addictions and Mental Health (the "Council"). The Council was created in 2002 to provide a voice for psychiatric patients of the Centre for Addiction and Mental Health ("CAMH"). It is a member-run body which receives funding from CAMH. It was formally incorporated in May, 2003 and advocates at a systemic level on behalf of addiction and mental health clients. In this application the applicants seek the following declaratory relief in respect of provisions of the *Mental Health Act*:

(i) A declaration that the expanded criteria for applications for psychiatric assessment in s. 15(1.1) and for involuntary admission to hospital in s. 20(1.1) of the *MHA* are of no force and effect;

(ii) A declaration that the CTO provisions in ss. 33.1 through 33.8 of the *MHA* are of no force and effect.

The applicants allege that the provisions of the *MHA* in issue infringed rights guaranteed under ss. 2, 7, 8, 9, 10, 12 and 15 of the *Charter* and that such infringements are not justifiable under section 1 of the *Charter*.

[6] On November 9, 2009, Ms. Thompson abandoned her appeal to this Court from the decision of the CCB. She did so because in November, 2006 she had returned to Jamaica, the country of her birth. There she was detained at a psychiatric hospital where she underwent antipsychotic treatment. Ms. Thompson returned to Toronto in April, 2007, and underwent a psychiatric assessment. In May, 2007 she was found incapable of consenting to psychiatric

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[1] *Ontario (Attorney General) v. Jane Patient* (2005), 250 D.L.R. (4th) 697 (Ont. Div. Ct.).

treatment and was admitted to the North York General Hospital as an involuntary patient. Later that month the CCB rescinded her involuntary admission, confirmed her incapacity to consent to antipsychotic medication, but found Mr. Thompson capable of consenting to treatment with blood pressure medication.

[7] In August, 2007, Ms. Thompson went back to Jamaica and she has not returned to Canada.

[8] The applicants have acted in a desultory fashion to move this proceeding along. Supporting affidavits were filed in August, 2006 (Geoffrey Reaume), January, 2007 (David Cohen) and March, 2009 (Jennifer Chambers). The Council delivered its application record in April, 2009. In June, 2009 the AGO gave notice that it intended to bring this motion to dismiss the application. That prompted the remaining applicant, the Council, to file three additional affidavits focused on the issue of its standing.

III. Positions of the parties

[9] The AGO submits that with Ms. Thompson's departure from Canada the application now is moot and no proper basis exists for this Court to exercise its discretion to hear a moot case or to grant the applicant Council public interest standing to proceed alone with the application. In the alternative, the AGO submits that in the event the Council is permitted to proceed with the application, certain portions of the supporting affidavits of Professors Reaume and Cohen should be struck out as containing inadmissible evidence.

[10] The Council argues that although the application is moot as against Ms. Thompson, it possesses the interest and standing to proceed with its constitutional challenge to the provisions of the *MHA* because this application provides the only practical and effective method by which that legislation can be subjected to judicial review.

IV. The applicable legal principles

A. The discretion to hear a moot case

[11] In *Philips v. Nova Scotia (Commission of Inquiry into the Westray Mine Tragedy)*[2] the Supreme Court of Canada reviewed the principles of mootness applicable in cases which raise constitutional issues:

> This Court has said on numerous occasions that it should not decide issues of law that are not necessary to a resolution of an appeal. This is particularly true with respect to constitutional issues and the principle applies with even greater emphasis in

[2] [1995] 2 S.C.R. 99, paras. 6, 9 and 12.

> circumstances in which the foundation upon which the proceedings were launched has ceased to exist.
>
> …
>
> The policy which dictates restraint in constitutional cases is sound. It is based on the realization that unnecessary constitutional pronouncements may prejudice future cases, the implications of which have not been foreseen. Early in this century, Viscount Haldane in John Deere Plow Co. v. Wharton, [1915] A.C. 330, at p. 339, stated that the abstract logical definition of the scope of constitutional provisions is not only "impracticable, but is certain, if attempted, to cause embarrassment and possible injustice in future cases".
>
> …
>
> This practice applies, a fortiori, when the substratum on which the case was based ceases to exist. The court is then required to opine on a hypothetical situation and not a real controversy. This engages the doctrine of mootness pursuant to which the court will decline to exercise its discretion to rule on moot questions unless, inter alia, there is a pressing issue which will be evasive of review…

[12] Notwithstanding statements of this kind by the Supreme Court of Canada, Professor Hogg has written that: "The Court has a discretion to decide a moot case, and, at least in constitutional cases, usually exercises the discretion in favour of deciding the case."[3] He continued:

> I have footnoted below a number of constitutional cases which were moot by the time they reached the Supreme Court of Canada, but which were decided nevertheless. In these cases, the Court was obviously persuaded that (1) there was a serious legal question to be decided, and (2) the question, despite its mootness, would be properly argued on both sides. Where both these factors are present, the Court will usually exercise its discretion to decide a moot case.[4]

B. Public interest standing

[13] I accept as an accurate statement of the legal principles regarding public interest standing the following passage from the decision of Himel J. in *Bedford v. Canada (Attorney General)*:[5]

> [58] Unlike private standing, public interest standing may be granted by the court at its discretion, provided certain requirements are met. The requirements for a discretionary grant of public interest standing to challenge the validity of legislation were

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[3] Peter Hogg, *Constitutional Law of Canada, Fifth Edition* (Toronto: Carswell, 2009), §59.3(c)
[4] *Ibid*.
[5] (2010), 102 O.R. (3d) 321 (S.C.J.)

recognized by the Supreme Court in a trilogy of cases: *Thorson v. Canada (Attorney General)*, [1975] 1 S.C.R. 138, [1974] S.C.J. No. 45; *Nova Scotia (Board of Censors) v. McNeil*, [1976] 2 S.C.R. 265, [1975] S.C.J. No. 77; *Canada (Minister of Justice) v. Borowski*, [1981] 2 S.C.R. 575, [1981] S.C.J. No. 103. Public interest standing was reviewed several years later by the Supreme Court in *Canadian Council of Churches v. Canada (Minister of Employment and Immigration)*, [1992] 1 S.C.R. 236, [1992] S.C.J. No. 5. The Supreme Court wrote, at para. 37, that the court must be satisfied of the following criteria before it will exercise its discretion in favour of an applicant:

> (a) there is a serious issue raised as to the validity of the legislation in question;
>
> (b) the applicant must be directly affected by the legislation or have a genuine interest in its validity; and,
>
> (c) there is no other reasonable and effective way this issue could be brought before the court.

[59] The proper approach to these criteria was discussed in the case of *Corp. of the Canadian Civil Liberties Assn. v. Canada (Attorney General)* (1998), 40 O.R. (3d) 489, [1998] O.J. No. 2856 (C.A.), where the Ontario Court of Appeal said, at para. 18:

> . . . the criteria should not be considered as mere technical requirements to be applied in a mechanistic fashion. They have been extracted from various judicial responses to concerns arising out of any proposed extension of the scope of public interest standing. In order to understand and to apply these criteria properly these underlying concerns should be kept in mind.

[14] The underlying (and related) concerns to which the Court of Appeal referred in *CCLA v. Canada (Attorney General)* include: (i) the concern about the allocation of scarce judicial resources and the need to screen out the mere busybody; (ii) the concern that when determining issues the courts should have the benefit of the contending points of view of those most directly affected by them; (iii) the requirement that no other reasonable and effective manner exists in which the issue may be brought before a court; and (iv) a concern about the sufficiency of the evidence in the absence of a person directly affected by the impugned legislation.[6]

V. Analysis

[15] In the present case the issues raised in the notice of application obviously are moot as against Ms. Thompson – she has returned to Jamaica and has no intention of returning to Canada. The real issue is whether the Council can demonstrate, in the absence of Mr. Thompson as a co-applicant, that this Court should exercise its discretion to grant it public interest standing. Let me turn then to consider the criteria for granting public interest standing, assessed in light of the underlying concerns expressed in the jurisprudence about expanding the scope of standing.

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[6] *CCLA v. Canada (A.G.)* (1998), 161 D.L.R. (4th) 225 (Ont. C.A.), paras. 19 to 30.

A. Does the application raise a serious legal question?

[16] The AGO acknowledges that the threshold for establishing that a proceeding raises a serious issue to be tried is a low one: does a reasonable cause of action exist?[7] Notwithstanding this low threshold, the AGO submits that it is plain and obvious that the Council's allegations of constitutional invalidity cannot succeed. To examine this issue I propose first to summarize the challenged provisions of the *MHA*, identify the allegations of constitutional infirmity advanced by the Council, and then consider the jurisprudence concerning the constitutionality of provision of mental health legislation.

A.1 The legislative provisions challenged by the applicant

[17] The Council seeks to challenge the constitutional validity of amendments made to the *MHA* in 2000 by Bill 68, known as *Brian's Law*, which expanded the grounds upon which a person may be held for psychiatric assessment or admitted involuntarily to a hospital, as well as the provisions introducing CTOs.

Expansion of grounds for assessment: Form 1, Box B criteria

[18] Section 15 of the *MHA* sets down the criteria by which a physician may apply for a psychiatric assessment of a person. The prescribed form for such an application is known as a Form 1. If a physician makes a Form 1 application, the application serves as sufficient authority for seven days to take the subject of the application in custody to a psychiatric facility forthwith and to detain the subject person "in a psychiatric facility and to restrain, observe and examine him or her in the facility for not more than 72 hours": *MHA*, s. 15(5).

[19] Prior to the 2000 amendments the criteria for such an application were the "Box A" criteria listed on a Form 1 which involved, broadly speaking, a conclusion by the examining physician that reasonable cause existed to believe that the person was threatening or attempting to cause harm to himself or towards another person and that the person was suffering from a mental disorder which likely would result in bodily harm to himself or another.[8]

[20] Bill 68 expanded the criteria for an application for a psychiatric assessment, and those criteria are shown on Form 1 in "Box B", hence their colloquial name of "Box B criteria". Those expanded criteria are contained in section 15(1.1) of the *MHA* which provides as follows:

> 15. (1.1) Where a physician examines a person and has reasonable cause to believe that the person,
>
> > (a) 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

[7] *Ibid.*, para. 82.
[8] *MHA*, s. 15(1).

> result in serious bodily harm to the person or to another person *or substantial mental or physical deterioration of the person or serious physical impairment of the person*; and
>
> (b) has shown clinical improvement as a result of the treatment,
>
> and if in addition the physician is of the opinion that the person,
>
> (c) is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;
>
> (d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or *is likely to suffer substantial mental or physical deterioration or serious physical impairment*; and
>
> (e) 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 substitute decision-maker has been obtained*,
>
> the physician may make application in the prescribed form for a psychiatric assessment of the person. (emphasis added)

[21] The Box B amendments permit an application for assessment where a person previously has received treatment for a mental disorder of certain kinds and presently is suffering from the same mental disorder. Of significance for purposes of this motion is that section 15(1.1) expands the ambit of mental disorders to include ones which are of a nature or quality that likely will result in "substantial mental or physical deterioration of the person or serious physical impairment of the person" – i.e. mental disorders which are not limited to those which might result in serious bodily harm to the person or another. Also of significance is the requirement that a physician cannot make a Box B application unless the person is incapable of consenting to treatment and *"the consent of his or her substitute-decision maker has been obtained*".

[22] The *MHA* defines a "substitute decision-maker" as one authorized under the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Schedule A, to give or refuse consent to a treatment on behalf of the patient if the patient is incapable with respect to the treatment under the *HCCA*. Part II of the *HCCA* contains an extensive framework governing substitute decision-makers, including identifying who may act as a substitute decision-maker (*HCCA*, s. 20) and the principles which a substitute decision-maker must follow when giving or refusing consent to a treatment on behalf of an incapable person (*HCCA*, s. 21). Foremost amongst those principles is that consent must be given or refused in accordance with a prior known capable wish of the person.

[23] A person detained for assessment under a Form 1 application is entitled to notice of the application. The notice must indicate that the person has the right to retain and instruct counsel without delay: *MHA*, s. 38.1. However, the *MHA* does not afford a person subject to a Form 1 application access to a rights advisor, nor does it offer a right of appeal to the CCB from the application.

Expansion of grounds for detention: *MHA*, s. 20

[24] Section 20 of the *MHA* prescribes the duties of a physician who has examined a person pursuant to a Form 1 assessment. Section 20(1) specifies when a person must be released from a psychiatric facility, admitted as a voluntary patient, or admitted as an involuntary patient. Certificates for involuntary admission initially run for no more than two weeks (Form 3), but may be renewed (Form 4).

[25] Again, at issue on this application are the provisions of section 20 of the *MHA* which expand the criteria for involuntary admission from beyond the likelihood of serious bodily harm to the patient or another, to the likelihood of suffering substantial mental or physical deterioration or serious physical impairment. Those expanded criteria are found in section 20(1.1) of the *MHA* which reads:

> 20. (1.1) The attending physician shall complete a certificate of involuntary admission or a certificate of renewal if, after examining the patient, he or she is of the opinion that the patient,
>
> > (a) 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 to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person;
> >
> > (b) has shown clinical improvement as a result of the treatment;
> >
> > (c) is suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;
> >
> > (d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment;
> >
> > (e) has been found 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 substitute decision-maker has been obtained; and
> >
> > (f) is not suitable for admission or continuation as an informal or voluntary patient.

[26] As with the case of the expanded criteria in section 15(1.1), those in section 20(1.1) require a finding that the person is incapable of consenting to treatment and the consent of his or her substitute decision-maker has been obtained.

[27] The *MHA* requires that where a physician completes a certificate of involuntary admission, or renewal, he must promptly give the patient written notice advising of the rights to retain counsel and to seek a hearing before the CCB. The physician must also notify a rights

adviser who, in turn, must meet with the patient and explain, *inter alia*, the right to have the certificate reviewed by the CCB. If requested, the rights adviser must assist the patient in making an application to the CCB and in obtaining legal services. [9]

[28] The patient may apply to the CCB "to inquire into whether or not the prerequisites set out in this Act for admission or continuation as an involuntary patient are met."[10] The CCB must begin the hearing within seven days after receipt of the application and render its decision within one day after the day the hearing ends.[11]

Community treatment orders

[29] The amendments to the *MHA* enacted in 2000 introduced the concept of community treatment orders, or CTOs. The purpose of a CTO is described in section 33.1(3) of the *MHA*:

> 33.1 (3) 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.

[30] Section 33.1(4) of the *MHA* sets out the criteria which must be met in order for a physician to issue or renew a CTO:

> 33.1 (4) A physician may issue or renew a community treatment order under this section if,
>
> (a) during the previous three-year period, the person,
>
> (i) has been a patient in a psychiatric facility on two or more separate occasions or for a cumulative period of 30 days or more during that three-year period, or
>
> (ii) has been the subject of a previous community treatment order under this section;
>
> (b) the person or his or her substitute decision-maker, the physician who is considering issuing or renewing the community treatment order and any other

[9] *MHA*, s.38(1)-(3), and (9).
[10] *MHA*, s. 39(1).
[11] *HCCA*, s. 75(2)(3)

health practitioner or person involved in the person's treatment or care and supervision have developed a community treatment plan for the person;

(c) within the 72-hour period before entering into the community treatment plan, the physician has examined the person and is of the opinion, based on the examination and any other relevant facts communicated to the physician, that,

(i) 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,

(ii) the person meets the criteria for the completion of an application for psychiatric assessment under subsection 15 (1) or (1.1) where the person is not currently a patient in a psychiatric facility,

(iii) if the person does not receive continuing treatment or care and continuing supervision while living in the community, he or she is likely, because of mental disorder, to cause serious bodily harm to himself or herself or to another person or to suffer substantial mental or physical deterioration of the person or serious physical impairment of the person,

(iv) the person is able to comply with the community treatment plan contained in the community treatment order, and

(v) the treatment or care and supervision required under the terms of the community treatment order are available in the community;

(d) the physician has consulted with the health practitioners or other persons proposed to be named in the community treatment plan;

(e) subject to subsection (5), the physician is satisfied that the person subject to the order and his or her substitute decision-maker, if any, have consulted with a rights adviser and have been advised of their legal rights; and

(f) the person or his or her substitute decision-maker consents to the community treatment plan in accordance with the rules for consent under the *Health Care Consent Act, 1996*.

[31] Again, one requirement for making a CTO is the consent of the person or his substitute decision-maker. A person under consideration for a CTO must be informed of his right to retain and instruct counsel.[12] A CTO runs for six months and may be renewed.[13]

[32] The *MHA* imposes certain obligations on a person subject to a CTO, most importantly that the person attend scheduled appointments with the physician who issued the order and

[12] *MHA*, s. 33.1(8).
[13] *Ibid*., s. 33.1(11).

comply with the community treatment plan described in the CTO.[14] If a physician has reasonable cause to believe the person has failed to comply with those obligations, the physician may issue an order for the examination of the person.[15] Such an order authorizes a police officer to detain the patient and take him to the physician who issued the order for examination.[16]

[33] If a person subject to a CTO, or his substitute decision-maker, withdraws his consent to the order, the physician must review the person's condition "to determine if the person is able to continue to live in the community without being subject to the order".[17] To do so the physician may issue an order compelling the person to attend for an examination.

[34] The *MHA* provides that a person subject to a CTO may apply to the CCB for an inquiry into whether the criteria for issuing or renewing a CTO are met. Such an application may be made each time a CTO is issued or renewed. On the second renewal of a CTO the *MHA* requires an automatic review by the CCB.[18]

A.2 The Council's allegations of constitutional infirmity

[35] The Council advances two constitutional challenges to the expanded grounds for assessment and involuntary admission: (i) the phrase "substantial mental or physical deterioration" is vague and overly broad; and (ii) the expansion of the criteria to include those who are not likely to harm themselves or others infringes sections 2, 7, 9, 12 and 15 of the *Charter*.

[36] Its challenges to the CTO legislative scheme draws on the same sections of the *Charter* and attacks both procedural and substantive aspects of the CTO regime, including:

(i) The possibility of involuntary detention as the result of non-compliance with the treatment plan or the withdrawal of consent without any evidence of likely risk of harm to the patient or others;

(ii) The vagueness of the requirement for the community treatment plan to contain "any conditions relating to the treatment or care and supervision of the person";

(iii) The absence of requirements mandating the delivery of rights advice after the CTO has issued;

(iv) The absence of any demonstration that appropriate continuing treatment and care is available in the community when the order is made; and,

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[14] *Ibid*., s. 33.1(9).
[15] *Ibid*., s. 33.3(1).
[16] *Ibid*., s. 33.3(3) and (4).
[17] MHA, s. 33.4(2).
[18] MHA, s. 39.1.

(v) The over-reach of the regime by including all persons who suffer from a serious mental disorder, not just those who might fit the description of a "revolving door patient".

[37] The AGO makes two responses to the Council's challenges. First, it points out that the expanded assessment and involuntary admission provisions apply only where a person apparently is, or has been found, incapable and the consent of that person's substitute decision-maker has been obtained or, in the case of the CTO regime, the person or his substitute decision-maker has consented. Second, the AGO submits that the case law has upheld Ontario's capacity and substitute decision-making laws which authorize the use of reasonable restraint to give effect to a substitute decision-maker's consent.

A.3 The jurisprudence

[38] I do not propose to review the jurisprudence concerning Ontario's mental health and capacity law at any length. In its 1991 decision in *Fleming v. Reid*,[19] the Court of Appeal signaled the need for appropriate procedural safeguards when legislative provisions seek to impose treatment on a person. In that case the Court held that it was contrary to the principles of fundamental justice to force a patient to take anti-psychotic drugs in his best interests without providing the patient, or the patient's substitute, any opportunity to argue that it is not the patients best interests, but rather his competent wishes, which should govern the course of the patient's psychiatric treatment.[20]

[39] In a 1995 decision, *Starnaman v. Penetanguishene Mental Health Centre*, the Court of Appeal held that the pre-*Brian's Law* involuntary assessment and admission provisions in sections 15 and 20 of the *MHA* did not infringe sections 7 or 12 of the *Charter*.[21]

[40] Finally, in a more recent decision, *S.M.T. v. Abouelnasr*,[22] this Court dismissed a constitutional challenge to the provisions of the *MHA* and *HCCA* permitting the injection under restraint of anti-psychotic drugs for the purpose of treating incapable persons. In so finding Lack, J., after referring to *Fleming v. Reid*, wrote:

> In that case the Court of Appeal made clear that forcible treatment of an incapable person is permissible provided the principles of fundamental justice are complied with by allowing the person or the substitute to argue capable wishes should govern. The Health Care Consent Act meets this requirement by setting out in sections 20 to 22 rules to guide substitute decision makers in making decisions. These rules include that the person's prior wishes will govern when known and that decisions are to be based on the person's best interests when prior capable wishes are not known. The process for determining

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[19] (1991), 4 O.R. (3d) 74 (C.A.).
[20] *Ibid*., p. 94.
[21] (1995), 24 O.R. (3d) 701 (C.A.), pp. 705-6.
[22] 2008 CanLII 14550 (ON S.C.).

whether a person lacks capacity provides for a full hearing before the Consent and Capacity Board, the right to request the Board to appoint a particular representative to give or refuse consent on a person's behalf, and the right of appeal from the Board's decision to the Superior Court. In short, the substantive and procedural safeguards in the Health Care Consent Act exceed the minimal constitutional protections required by the principles of fundamental justice.

I agree with counsel for the Attorney General of Ontario that Fleming v. Reid is a complete answer to the appellant's argument that the Health Care Consent Act infringes section 7 of the *Charter.*

The provisions which authorize the administration of treatment without personal consent where the person is incapable and a substitute decision maker provides consent are not ambiguous or vague. They are not arbitrary. They plainly further the purpose of the Health Care Consent Act of promoting the autonomy of capable persons to consent to or refuse treatment and protecting the welfare of persons who would benefit from treatment, but who are incapable of giving consent.

A.4 Conclusion

[41] The threshold the Council must meet at this stage of the analysis is quite low. Although the provisions of the *MHA* which the Council seeks to challenge include requirements that either the consent of the patient (in the case of a CTO) or the consent of an incapable patient's substitute decision-maker (in the case of an application for assessment or involuntary admission) must be obtained before orders compelling the detention or compulsion of the patient can be made, the operation of those provisions touches upon the important issue of the liberty interests of persons, and the constitutionality of those provisions has not been reviewed by this Court. Judges of this Court and the Court of Appeal have commented on the difficult issues which surround any consideration of the mental health legislative regime.[23] Accordingly, I conclude that it is not plain and obvious that the Council will not succeed on its application, so I move on to the second consideration concerning public interest standing.

B. Does the Council have a genuine interest in the resolution of the legal issue?

[42] For purposes of the motion the AGO did not dispute that the Council had a genuine interest in the legal rights of mental health patients. The record showed that the Council has had extensive experience in that area. The AGO advanced two reasons why the Council had not established that it had a genuine interest in the resolution of the issues raised by this application: (i) its delay in prosecuting this application; and, (ii) its failure to adduce any evidence from Ms.

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[23] *C.B. v. Sawadsky* (2006), 82 O.R. (3d) 661 (C.A.), para. 32; *Robertson v. Canada (Attorney General),* 2000 CarswellOnt 318 (S.C.J.), para. 52.

Thompson or others who had been subject to orders made under the impugned sections of the *MHA,* thereby resulting in a lack of adjudicative facts before the Court.

B.2 Delay

[43] This application was commenced in July, 2005. The applicants did not complete their application record until April, 2009, almost four years later. Ms. Chambers, a representative of the Council, explained that the organization is small and relies on her ability to devote time to the application in order to move it along. From 2005 until 2009 she had to spend much of her time caring for a terminally ill partner. On cross-examination Ms. Chambers also testified that the Council was pre-occupied dealing with some other issues during the past few years. While I am not impressed by the second explanation that the Council, in effect, had better things to do for the past few years than proceed with this application, I do not regard its delay as determinative. It has now completed its record and it has counsel. Given that the application involves a challenge to the constitutionality of legislation, in the circumstances of this case I do not see much prejudice to the AGO from the delay. Certainly the imposition of a timetable on future steps in the application can ensure that the Council prosecutes it with diligence.

B.2 Lack of adjudicative facts

[44] Of greater concern is the lack of adjudicative facts in the Council's application record.

[45] Ms. Thompson did not file an affidavit in support of this application. The absence of an affidavit from an applicant is unusual. The notice of application indicated that Ms. Thompson would be filing an affidavit, but her departure from Canada obviously intervened.

[46] That said, the application record does include the record of appeal for Ms. Thompson's appeal to the CCB from the August 16, 2004 CTO made against her. The application record also contains the transcripts of the two day hearing before the CCB in August, 2004 which includes the evidence Ms. Thompson gave before the CCB, as well as her cross-examination by the physician's counsel and her questioning by members of the CCB. A review of the evidence she gave reveals that it touches upon the effect on her of the treatment plan and the administration of medication.

[47] The applicants also filed affidavits from two academics in support of their application. Geoffrey Reaume teaches in the Critical Disability Studies program at the Faculty of Health, York University, as well as at the School of Disability Studies, Ryerson University. His 2006 affidavit contains a strong historical dimension, no doubt reflecting his academic interest in the history of mental health institutions in Ontario. It did not contain evidence about the impact or effect of the 2000 amendments made to the *Mental Health Act*, but may provide some historical context.

[48] David Cohen teaches at the College of Health and Urban Affairs, Florida International University in Miami, Florida. He previously taught at the University of Montreal. His 2007 affidavit also does not contain evidence about the impact or effect of the 2000 amendments to the

Mental Health Act, but he does deal with the effect of neuroleptic drug therapies and discusses some of the literature about community treatment programs in other jurisdictions.

[49] Counsel for the AGO submitted that the applicants' challenge focuses on the effect of the impugned provisions of the *MHA* on a person and therefore it would be unfair to allow this application to proceed without some evidence adduced by a person who had been subjected to an order under a questioned section and without the opportunity of the AGO to cross-examine that person.

[50] Those are legitimate points to raise. To the first I would note that the unique temporal aspects of the legislation in question pose practical challenges to the collection of evidence to support a *Charter* challenge to the statute. Assessment orders last for 72 hours; involuntary admission orders run for 14 days, with an opportunity for renewal; and, CTOs last six months, again subject to renew. The short duration of those orders present practical problems for bringing a challenge to the legislation authorizing those orders – a person may well be free and clear of an order before the steps can be taken to bring an application in this court to challenge the relevant statutory provisions. That also means that the best evidence of the effect of an order may well be the evidence given by a patient at a CCB hearing which, by statute, must be held quickly after the making of an order.

[51] I do not view it as my task, on a motion questioning the standing of an applicant to bring a proceeding, to rule on the admissibility of evidence. That is a job for the judge hearing the application on its merits. However, I must consider the sufficiency of the evidence filed in support of the application as part of the process of ascertaining whether the Council qualifies for public interest standing. The transcript of Ms. Thompson's evidence before the CCB provides some evidence of the effect of the CTO on her. For purposes of this motion, I conclude that the applicant has put forward some evidence which, if admitted by the applications judge, could provide some adjudicative facts in support of the challenge to the constitutionality of the legislation.

[52] I take counsel's point that the AGO was not able to cross-examine Ms. Thompson on her evidence before the CCB. She did undergo some cross-examination by physician's counsel, as well as questioning by the Board. It may not have been on the same issues as the AGO would consider relevant for this proceeding. In the specific circumstances of this case I do not regard the inability of the AGO to cross-examine Ms. Thompson as a sufficient reason to deny public interest standing to the Council. Such an inability may well affect the weight the applications judge will be prepared to give to Ms. Thompson's evidence, if admitted, but that is a matter for consideration at the hearing on the merits.

[53] In sum, I conclude that the applicants have put forward some evidence which, if admitted, would constitute adjudicative facts for consideration by the applications judge. Further, notwithstanding the delays in proceeding with its application, I am satisfied that the Council intends to pursue the matter with reasonable dispatch.

C. Does any other reasonable and effective manner exist by which the question may be brought before the Court?

[54] Turning to the third criteria, whether any other reasonable and effective manner exists by which the question can be brought before the Court, it is worth recalling the following remarks by the Court of Appeal in *CCLA v. Canada (Attorney General)*:

> In *Canadian Council of Churches v. Canada*, [1992] 1 S.C.R. 236, the court reviewed the approaches to standing taken in the United Kingdom, Australia and the United States and concluded that each of these jurisdictions has taken a more restrictive approach than have the courts in Canada. The court then reviewed the criteria established by the earlier quartet of cases and posed the question whether the current test for public interest standing should be extended. While the court maintained the criteria set out in the earlier cases, it clearly opted for a restrictive approach in their application. Cory J., in writing for the court, stated as follows (at pp. 252-53):
>
> > The increasing recognition of the importance of public rights in our society confirms the need to extend the right to standing from the private law tradition which limited party status to those who possessed a private interest. In addition some extension of standing beyond the traditional parties accords with the provisions of the Constitution Act, 1982. However, I would stress that the recognition of the need to grant public interest standing in some circumstances does not amount to a blanket approval to grant standing to all who wish to litigate an issue. It is essential that a balance be struck between ensuring access to the courts and preserving judicial resources. It would be disastrous if the courts were allowed to become hopelessly overburdened as a result of the unnecessary proliferation of marginal or redundant suits brought by well-meaning organizations pursuing their own particular cases certain in the knowledge that their cause is all important. It would be detrimental, if not devastating, to our system of justice and unfair to private litigants.
> >
> > The whole purpose of granting status is to prevent the immunization of legislation or public acts from any challenge. The granting of public interest standing is not required when, on a balance of probabilities, it can be shown that the measure will be subject to attack by a private litigant. The principles for granting public standing set forth by this Court need not and should not be expanded. The decision whether to grant status is a discretionary one with all that that designation implies. Thus undeserving applications may be refused. Nonetheless, when exercising the discretion the applicable principles should be interpreted in a liberal and generous manner. [Emphasis added in original][24]

[24] *CCLA v. Canada (Attorney General), supra*., para. 21.

[55] In the present case I conclude that if public interest standing is not granted to the Council, then a very real risk exists that the provisions of the *MHA* at issue in this application may be immunized from any future challenge. I reach this conclusion for several reasons.

[56] First, although the AGO points to the large number of applications brought before the CCB to review CTOs as evidence of the facility of challenging the legislative provisions, as a result of the decision of the Divisional Court in the *Jane Patient* case the CCB lacks the jurisdiction to determine *Charter* challenges to CTOs. The result of the *Jane Patient* case has found its way into Part V of the *HCCA* which sets out the jurisdiction of the CCB. Section 70.1(1) of the *HCCA* now provides that: "The Board shall not inquire into or make a decision concerning the constitutional validity of a provision of an Act or a regulation." Accordingly, the statutory rights granted by the *MHA* to seek CCB review of involuntary admissions and the continuation of CTOs provides no meaningful opportunity to challenge before the CCB the constitutionality of provisions of the *MHA* because that tribunal lacks the jurisdiction to engage in such a review.

[57] Does the right of appeal to this Court from a decision of the CCB given by section 80(1) of the *HCCA* provide an effective, alternative means by which constitutional challenges to the assessment, involuntary admission and CTO provisions of the *MHA* could be made? In its factum the AGO noted that in the *Jane Patient* case the Divisional Court found that the Superior Court of Justice "provides a more appropriate, efficient and timely forum for the determination of *Charter* claims" than the CCB.[25] In that portion of its reasons the Divisional Court recited and adopted a passage from the factum of the AGO before it in that case. If that view of the efficacy and expediency of the appeal process to this Court from orders of the CCB accurately reflected the state of affairs back in 2005 when the *Jane Patient* case was decided, it certainly does not describe with any semblance of accuracy the present-day ability of this Court to deal expeditiously with appeals from the CCB.

[58] Last year I commented extensively on the practical difficulties facing patients who seek to exercise their right of appeal from decisions of the CCB to this Court. In January, 2010, I wrote, in *Bon Hillier v. Milojevic*:

> ...Although section 80 of the *HCCA* provides a person found incapable with a statutory right of appeal from the CCB and directs our court to "fix for the hearing of the appeal the earliest possible date that is compatible with its just disposition", experience has shown that without legal representation the person's appeal may flounder and stall, sometimes for a significant period of time…
>
> In order for Mr. Bon Hillier's right to appeal pursuant to sections 20.2 of the *SDA* and 80 of the *HCCA* to possess meaning, his position must be placed before the court in a cogent, intelligible and persuasive manner, and in a timely fashion. If Mr. Bon Hillier

[25] *Jane Patient, supra*., para. 54.

> had sought to initiate an action or application in this court, as a party under disability the *Rules of Civil Procedure* would not permit him to do so without representation by a litigation guardian who could advance his positions in an effective way, or instruct counsel to do so. But the *Rules* do not apply the concept of litigation guardian to Mr. Bon Hillier's statutory appeal, and under the provisions of the *HCCA* he is basically left to fend for himself. I find it difficult to understand how the Legislature could purport to give a person found incapable a meaningful right of appeal without, in appropriate circumstances, ensuring that the person declared incapable had access to legal representation. Without proper legal representation, that statutory right of appeal is illusory.
>
> Nevertheless, the Legislature has not established a mechanism to provide counsel for persons found incapable on appeals from the CCB…[26]

[59] Last October, in my decision in *Cavalier v. Ramshaw*, I re-iterated the difficulties faced by appellants from decisions of the CCB:

> Let me restate why *amicus* are necessary in many appeals from decisions of the CCB to this Court. Many appellant patients are not able to retain counsel and they are unable, by reason of their mental illness, to take the steps necessary to perfect their appeals, specifically the preparation of factums. If this Court is to discharge the duty imposed upon it by the Legislature to "fix for the hearing of the appeal the earliest date that is compatible with its just disposition", then the Court must be able to appoint qualified *amicus*. The primary role of such *amicus* is to help the court understand the legal and factual issues raised by the appellant/patient. *Amicus* provide such assistance to the court by filing a factum and presenting oral argument. Of course, it is always open to the appellant/patient to file a factum and make oral argument, but in most cases they do not because they are unable to do so or, if they make oral argument, it often has no bearing on the issues that the Court must consider on the appeal.[27]

[60] By the time I had stepped down last October as Administrative Judge for the Toronto Region Estates List an effective system to make available *amicus curiae* in appropriate cases involving appeals from the CCB to this Court still was not in operation. I therefore do not accept the submission by the AGO that appeals to this Court from decisions of the CCB offer a reasonable and effective way to challenge the constitutionality of those sections of the *MHA* dealing with assessments, involuntary admissions and CTOs. The AGO's submission displays an utter lack of understanding of the "reality on the ground" facing patient-appellants from CCB decisions.

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[26] 2010 ONSC 435, paras. 18 to 20.
[27] 2010 ONSC 5402, para. 21.

[61] The reality on the ground is that the orders made under the provisions of the *MHA* impugned in this application are of short duration. The 72-hour limit on detention to examine under a section 15 assessment order means that it is next to impossible for a person subject to such an order to challenge it before it expires. Involuntary admission orders and CTOs also are of short duration – 14 days and six months, respectively. Given the time it takes to proceed to a hearing before the CCB and then to appeal to this Court for a review of such orders, most will have expired before this Court can hear the appeals. Mootness would be a chronic problem plaguing such appeals. Layer on top of that the inability of most appellant-patients to secure counsel, largely due to the lack of, or the uncertainty surrounding the receipt of, timely Legal Aid, to assist them in putting together an appeal to this Court involving sophisticated *Charter* challenges, and one is left with a situation where, for all intents and purposes, the impugned provisions of the *MHA* would be immunized from judicial review.

[62] The application which the Council seeks to pursue has its own "litigation warts". The Council has delayed in moving it along and, no doubt, arguments will be made before the applications judge about how much weight to give to the evidence filed by the Council in support of its application. On the other side of the ledger, the Council is represented by counsel quite experienced in the field of mental health law and the preparation of the application has, at last, been completed. Notwithstanding its "litigation warts", I conclude that the present application most likely represents the only reasonable and effective means by which to subject to judicial review the impugned provisions of the *MHA*.[28]

D. Conclusion on public interest standing

[63] Consequently, although the issues in this application are moot as regards Ms. Thompson, I have considered the factors identified by the jurisprudence in considering whether to grant public interest standing and the concerns underlying those factors, including the allocation of scarce judicial resources, the need to have the benefit of contending points of view of those most directly affected by the issues, the need to have adjudicative facts available for consideration by the Court, and whether another reasonable and effective manner exists by which the issues may be brought before a court. Having done so, I have no hesitation in concluding that I should exercise my discretion in favour of granting the Council public interest standing to pursue this application.

[64] I do so, however, on terms. First, this application must proceed with more dispatch. I intend to impose a timetable for the completion of all remaining pre-hearing steps. I will give the parties three (3) weeks to attempt to agree upon such a timetable. If by April 20, 2011, they are unable to do so, then counsel shall schedule a 9:30 appointment before me on the Commercial List, where I am presently sitting, in order to settle a timetable. That appointment must be booked for either April 21 or 22, or May 2, 3 or 4, 2011.

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[28] I reach that conclusion without relying on any of the evidence contained in the affidavits of Ms. Szigeti and Ms. McDermott filed by the Council in opposition to this motion.

[65] Second, I impose further requirements on the expert evidence filed by the Council, to which I now turn.

VII. Motion to strike out portions of affidavits on main application

[66] On this motion the AGO sought alternative relief: if I did not dismiss the application, then the AGO requested that I strike out portions of the affidavits of Jennifer Chambers, Geoffrey Reaume and David Cohen filed in support of the application. The AGO submitted that certain portions of those affidavits consisted of legal argument, irrelevant and/or inflammatory statements, speculation, expert medical opinion that the deponents are not qualified to provide and opinion on matters that are commonplace or for which they have no special skill.

[67] Applications are designed to proceed in a summary fashion. In my view the court should not encourage parties to engage in pre-hearing motions on applications, otherwise the summary nature of that proceeding will be compromised. As to the proper time to raise objections to the content of affidavits filed in support of an application, I adopt as a correct statement of the law the following passage from *The Law of Civil Procedure* recently published by Justice Paul Perell and former Justice John Morden:

> The general rule is that it is for the court that hears the motion to determine whether material should be struck from an affidavit, and a pre-emptive motion should be brought only in the clearest cases.[29]

[68] With respect to any complaint that the content of an affidavit filed by an expert is improper, the applications judge is best positioned to discharge the court's gatekeeper function regarding expert evidence. So, too, on issues of relevancy and fact vs. argument, the applications judge will possess the best and most comprehensive perspective from which to rule on such disputes. Consequently, I dismiss this portion of the AGO's motion as premature, but without prejudice to the right of the AGO to raise its concerns with the applications judge.

[69] I do impose one term on the Council regarding the two expert witness affidavits filed from Professors Reaume and Cohen. Those affidavits were sworn in 2006 and 2007. In 2010 the *Rules of Civil Procedure* were amended to impose new requirements on expert witnesses. Those requirements now apply to this proceeding. Accordingly, I require the applicant to deliver, within 120 days of the date of this order:

(i) Supplementary affidavits from each of Professor Reaume and Cohen which contain the information specified by Rule 53.03(2.1) 3, 4 and 5;[30] and,

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[29] Perell and Morden, *The Law of Civil Procedure in Ontario, First Edition* (Toronto: LexisNexis, 2010), p. 560.

[30] 53.03(2.1) A report provided for the purposes of subrule (1) or (2) shall contain the following information:
…

(ii) An acknowledgement of expert's duty (Form 53) signed by each of Professor Reaume and Cohen.

[70] The duty of the expert to the court articulate in Rule 4.1 applies to experts who testify in all proceedings, whether actions or applications. Although the content disclosure requirements for expert reports set out in Rule 53.03(2.1) speak in terms of expert reports for use at trial, those requirements apply with equal force to expert opinions contained in affidavits filed in support of applications. Expert evidence must meet the same disclosure and admissibility requirements whether it finds expression in a report prepared for trial or an affidavit in support of an application or motion. Expert evidence filed in a proceeding in which issues concerning the constitutionality of legislation or state action are raised must also conform to such disclosure and duty of impartiality requirements.

VIII. Summary

[71] For these reasons, I dismiss the motion of the AGO, but on the terms set out above.

IX. Costs

[72] I would encourage the parties to attempt to settle the costs of this motion. If they cannot, the Council may serve and file with my office (c/o Judges' Administration, 361 University Avenue) written cost submissions, together with a Bill of Costs, by Friday, April 15, 2011. The AGO may serve and file with my office responding written cost submissions by Friday, April 29, 2011. Such responding cost submissions must include a Bill of Costs setting out the costs which that party would have claimed on a full, substantial, and partial indemnity basis. If a party opposing a cost request fails to file its own Bill of Costs, as I have directed, I may take that failure into account when considering the objections made by the party to the costs sought by the other party.[31] The costs submissions shall not exceed three pages in length, excluding the Bill of Costs.

[73] I wish to thank all counsel for the high quality of their written and oral submissions. They were of great assistance.

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3. The instructions provided to the expert in relation to the proceeding;
4. The nature of the opinion being sought and each issue in the proceeding to which the opinion relates.
5. The expert's opinion respecting each issue and, where there is a range of opinions given, a summary of the range and the reasons for the expert's own opinion within that range.

[31] *Frazer v. Haukioja* (2010), 101 O.R. (3d) 528 (C.A.), para. 73.

D. M. Brown J.

Date: April 1, 2011