BRITISH COLUMBIA REVIEW BOARD

IN THE MATTER OF PART XX.1 (Mental Disorder) OF THE CRIMINAL CODE R.S.C. 1985 c. C-46, as amended S.C. 2005 c. 22

REASONS FOR DISPOSITION
IN THE MATTER OF

JOHNATHAN ALLEN BROWN

HELD AT: Kelowna Law Courts
Kelowna, BC
11 September 2007

BEFORE:	**CHAIRPERSON:**	**B. Walter**
	MEMBERS:	**Dr. G. Laws, psychiatrist**
		L. Chow

APPEARANCES:
ACCUSED/PATIENT: Johnathan Allen Brown
ACCUSED/PATIENT COUNSEL: B. Loewen
HOSPITAL/CLINIC: R. Ververda Dr. K. Stevenson
ATTORNEY GENERAL: C. Forsyth

[1] CHAIRPERSON: On September 11th, 2007 the British Columbia Review Board convened an annual hearing to review the disposition of Johnathan Allen Brown who is now age 27. This is Mr. Brown's fifth hearing before the Review Board. He is the subject of a verdict of NCRMD given March 2nd, 2004.

[2] The index offences giving rise to that verdict occurred on June 28th, 2003. At that point Mr. Brown was observed smashing the windows of a neighbour's automobile and residence. Witnesses reported seeing Mr. Brown striking Mr. Carr, the victim's, vehicle with an axe and overheard the accused uttering threats to kill the victim. Apparently Mr. Brown was responding to auditory hallucinations wherein he was hearing a young female child's voice informing him that the victim was sexually assaulting her.

[3] On arrest it was learned by the accused's psychiatrist, Dr. Eamon, that Mr. Brown had apparently not been taking his prescribed antipsychotic medications for several weeks before the incident. The accused has a mental health history dating from his adolescence. Despite an assigned diagnosis of schizophrenia he had established a record of noncompliance with prescribed treatment which over time led to his readmissions to psychiatric wards.

[4] Although this index offence did not involve actual physical harm to another, Mr. Brown does have a minor criminal history consisting of an assault upon his mentally ill mother while he was a youth, of 17. That assault consisted of a slapping incident. It would certainly not qualify for consideration as seriously violent.

[5] In addition to the accused's diagnosis of schizophrenia, he is the subject of additional diagnoses of ADHD and learning disorders and presents with a lengthy history of behavioural problems. During 2003 the accused experienced a number of hospital admissions in Vernon. In addition to his history of noncompliance with medications and his preference for unconventional alternative healing strategies, he also has a lengthy history of cannabis and alcohol use. He has in more recent times added other substances, including crack cocaine, to his drug-using repertoire.

[6] It must be said that, although the accused has improved under consistent treatment since the index offence, he has never discontinued what has been characterized as his chronic use of marihuana.

[7] Shortly after his first Review Board hearing in April of 2004 the accused, due to complaints of side effects, began to refuse medications in May and June of 2004. It was the treatment team's strategy to escort him to the clinic to receive his periodic injections. His voluntary compliance and attendance remained somewhat dilatory. His treatment team continued to be of the view that the accused lacked insight into his illness and its treatment and considered him a somewhat high risk of relapse given his difficulties in complying fully with treatment expectations.

[8] In September of 2005, again due to the accused's noncompliance with his disposition as well as burgeoning signs of decompensation, the accused was admitted to FPH after being certified in Vernon. He was once again conditionally discharged following a mandatory hearing on October 31st, 2005.

[9] In May of 2006 the accused embarked on a cross-country journey as far as Quebec after being evicted from his mental health residence in Vernon. Prior to his departure, the accused had missed as many as three appointments scheduled for the administration of his injectible medications. He had consistently denied his illness, preferring to blame historic LSD use for his symptoms. His case manager indicated that the accused was bordering on delusional thinking throughout the year. In the spring of 2006 he had admitted to the weekly use of crack cocaine as well as alcohol and his chronic ingestion of marihuana continued unabated.

[10] Eventually, in August of 2006, the accused apparently began to experience an intensification of his symptoms. With his case manager's assistance he had himself admitted to hospital in Quebec. He was repatriated and admitted to the Forensic Psychiatric Hospital of British Columbia on August 4th, 2006. Once at FPH he reluctantly began to acknowledge that he may have a mental illness, although he remained free of any overt psychosis during that hospitalization.

[11] On the basis of his appropriate behaviour and absence of symptoms the accused was once again conditionally discharged as of a mandatory hearing on October 6th, 2006. The Review Board determined to continue its jurisdiction over the accused as a result of the accused's not only ongoing, but escalating, use of a variety of substances, some of which could be expected to precipitate an acute psychotic episode. The accused has in the past demonstrated that he can behave in an untoward and dangerous manner when severely psychotic.

[12] The current hearing is scheduled for the purpose of conducting an annual review of the accused's disposition. Case manager Ververda's evidence indicates that the accused left FPH and returned to Vernon on November 3rd, 2006. The discharge plan was that Mr. Brown would reside with his grandparents who remain supportive of him. However, that accommodation was short-lived; he left his grandparents' home after four days and secured his own independent accommodation where he quickly reconnected with his previous drug-using peer group.

[13] Not unexpectedly, Mr. Brown relapsed immediately to the use of alcohol, marihuana and cocaine. By the end of November the accused as much as admitted that his drug use, in particular his crack cocaine use, was "out of control". His case manager began to note some decompensation in the form of emerging psychotic themes in the accused's conversations.

[14] By December the accused's premises were taken over by a drug dealer to whom the accused was indebted. Wisely, the accused vacated the premises and temporarily lived with his mother in Vernon. Since January he has once again obtained alternate accommodation with an apparently supportive family. He managed to curtail or eliminate his use of cocaine but has continued to use marihuana as attested to by each of two subsequent urinalysis screens.

[15] Since January, and with his temporary residential instability having passed, the accused has been more stable and somewhat more compliant with respect to his treatment and reporting expectations. He appears slightly more insightful in terms of accepting his illness and endorses some benefit from medications, although he continues to complain of somatic side effects and over-medication. As he has in the past, he continues to endorse confidence in alternate psychological, philosophical and naturopathic interventions. Nevertheless, he is overall stable and not overtly psychotic. In an effort to learn more about the circumstances precipitating the index offence he has, in breach of his current disposition, made contact with at least two individuals that he is prohibited from contacting by virtue of paragraph 9 of his current disposition. Mr. Brown has obtained employment in the construction field which has also stabilized him and provided some structure and routine to his day.

[16] Mr. Brown's case manager agrees that under current circumstances Mr. Brown presents a low level of threat for violence. This would obviously increase if he were not in

receipt of his medications and were to relapse again to more destabilizing intoxicants or psychostimulants. Mr. Ververda also indicates that the accused's grandparents, with whom he enjoys a cordial relationship, remain supportive of the accused and he of them.

[17] The accused's supervising forensic psychiatrist, Dr. Stevenson, in effect adopts the case manager's chronology of events since the accused has returned to Vernon. Since that time Dr. Stevenson has seen the accused on eight occasions. He confirms that the accused has reported for the administration of his injectible meds and is currently demonstrating no symptoms of overt or florid psychosis; he is not actively delusional or hallucinating. Dr. Stevenson confirms that there have been no reports of violence or aggression involving the accused from the community.

[18] It is also Dr. Stevenson's expert opinion that the accused is somewhat more insightful and accepting of his illness, although he continues to aspire to pursuing alternative psychological and non-medical treatments. Mr. Brown also believes that his medications are at a too-high dosage and he continues to complain of side effects. Nevertheless, he presents as pleasant, cooperative, but could still be a significant threat should he once again become noncompliant.

[19] In that vein, and in support of the Board's continued jurisdiction over Mr. Brown, Dr. Stevenson adds that during his more than three-month unauthorized absence, in the summer of 2006, the accused would have, at least for part of that period, been under the effects of his last injection, at least until the middle of July. Dr. Stevenson reminds us that after one or two months, when he reported to a hospital in Quebec, the accused showed at least some incipient symptoms.

[20] Dr. Stevenson also wanted to correct findings of fact at paragraph 30 of the Board's reasons of October 6th, 2006, where a panel member, in dissent, commented on the accused's intramuscular injections of Modecate and its debilitating side effects. Dr. Stevenson pointed out that in fact Mr. Brown had been on that substance well before coming under the jurisdiction of the BC Review Board and while he was being treated by the so-called civil mental health system.

[21] Under questioning Dr. Stevenson clearly indicated that in his view the accused is unlikely to comply medically into the long-term future based, on his personal philosophies and views with respect to conventional psychiatric treatment. If the accused is not

medicated and relapses to full-blown psychosis, Dr. Stevenson believes that he could pose a significant threat to others.

[22] Dr. Stevenson was also somewhat concerned that the accused has in the past been less than fully disclosive of his symptoms and is reluctant to discuss their nature, believing that his personal psychological strategies and abilities have taught him to cope with and stop any signs of psychotic thinking before it exacerbates or before he loses control thereof. Dr. Stevenson does not believe that such strategies would suffice to maintain him in a mentally stable manner absent medication.

[23] The Review Board heard from Mr. Brown who told us, in his rather over-inclusive, verbose manner, that he works as a construction apprentice. He admits to his ongoing use of marihuana. He indicates that he will continue to receive his injectible meds, which he believes have benefits, in addition to the alternative remedies he wishes to pursue. He told us that he has plans for his life. If absolutely discharged he would continue to take his medications along with dietary supplements, would continue to see a doctor, and may implement plans to travel elsewhere in British Columbia or even abroad. He admitted that, despite their negative side effects, the psychiatric medications do maintain his stability, but he continues to believe that his symptoms at the time of the index offence were drug-induced.

[24] In assessing all of the evidence the Review Board had no hesitation in concluding that the accused's evidence lacks reliability. Perhaps due to his communication style or what may be at least low-level residual symptoms, the accused presents in a manner that is not just vague but over-inclusive, tangential, rambling and perhaps even deliberately evasive or avoidant.

[25] We must of course also assess and consider the historic evidence with respect to the accused's mental condition, any history of violence, as well as his current functioning and reintegration in assessing whether or not he continues to present a significant threat warranting our ongoing jurisdiction over him. We do conclude that, based on his presentation, his mental state may not be as stable as the disposition information would lead one to conclude. Certainly what Dr. Stevenson termed his low-grade symptoms were, in our view, markedly in evidence during this hearing.

[26] Nevertheless, Mr. Brown is not floridly psychotic. He is well known in his community and in the local service network in Vernon. Presumably a more precipitous

decompensation as a result of his relapse to intoxicants or as a result of his noncompliance with medication could be responded to by others in his environment.

[27] We disagree with his counsel's characterization of the *Winko* test or definition of significant threat, in particular the temporal dimension thereof. Yet this panel had some doubt that this accused, given his lengthy history of mental illness, coupled with a relatively innocuous history of violence, currently satisfies the *Winko* test. In other words, the evidence failed to persuade us that this accused is a reasonably foreseeable significant threat of serious physical or psychological harm of a criminal nature. Accordingly, and although we have absolutely no doubt of this man's illness and his need for ongoing treatment, we felt that in law at least he was entitled to be absolutely discharged.

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