



# The Mentally Ill: How They Became Enmeshed in the Criminal Justice System and How We Might Get Them Out<sup>i</sup>

Prepared by the Hon. Mr. Justice Richard D. Schneider

For the Research and Statistics Division

March 2015

*This report is a work product, and the findings presented herein are not to be construed as an official Department of Justice Canada position, unless they are designated as such by other authorized documents and the report is posted on the official Department of Justice Canada Web site.*



Information contained in this publication or product may be reproduced, in part or in whole, and by any means, for personal or public non-commercial purposes, without charge or further permission, unless otherwise specified.

You are asked to:

- exercise due diligence in ensuring the accuracy of the materials reproduced;
- indicate both the complete title of the materials reproduced, as well as the author organization; and
- indicate that the reproduction is a copy of an official work that is published by the Government of Canada and that the reproduction has not been produced in affiliation with, or with the endorsement of the Government of Canada.

Commercial reproduction and distribution is prohibited except with written permission from the Department of Justice Canada. For more information, please contact the Department of Justice Canada at: [www.justice.gc.ca](http://www.justice.gc.ca).

©Her Majesty the Queen in Right of Canada, represented by the Minister of Justice and Attorney General of Canada, 2015

## Contents

|   |           |
|---|-----------|
| <b>1. Background .....</b>  | <b>3</b>  |
| <b>2. The Manufacturing of a Forensic Patient .....</b>   | <b>3</b>  |
| <b>3. A bit of history.....</b>   | <b>4</b>  |
| <b>4. Adding to the Picture .....</b>   | <b>7</b>  |
| <b>5. The Numbers are Growing .....</b>   | <b>8</b>  |
| <b>6. <i>Criminal Code</i> is the <i>Mental Health Act</i> of Last Resort .....</b>                 | <b>10</b> |
| <b>7. What to do? .....</b>   | <b>11</b> |
| 7.1 INVEST IN PROVINCIAL AND TERRITORIAL MENTAL HEALTH CARE .....                                   | 11        |
| 7.2 EXPAND DIVERSION PROGRAMS: MOVE THE NEW FORENSIC PATIENT BACK TO THE CIVIL SYSTEM QUICKLY ..... | 12        |
| 7.3 A FEDERAL MENTAL HEALTH ACT .....   | 14        |
| 7.4 PART XX.1 OF THE <i>CRIMINAL CODE</i> .....   | 15        |
| 7.5 ENABLE THE CHANGE WITH EFFECTIVE FEDERAL LEGISLATION.....                                       | 16        |

## 1. Background

That individuals with mental illness are over-represented in the criminal justice system is a reality beyond debate. The percentage of individuals in federal correctional institutes with self-reported mental health issues has more than doubled between 1997 and 2008. At the time of admission 65% of federal inmates were flagged for mental health follow-up. A recent one day “snapshot” indicated that 63% of female federal inmates are prescribed psychotropic medication. From across the border, at present there are five times as many mentally ill individuals in American jails and prisons as there are in American hospitals. And, while comparable statistics are not readily available for Canada there is no reason to expect that we are doing much better.

How did we end up in this state of transinstitutionalization<sup>ii</sup>? Certainly, not by design.

## 2. The Manufacturing of a Forensic Patient

**[Definition: An individual with mental illness charged with, or convicted of, a criminal offence. And, in particular, those who have obtained verdicts of “unfit to stand trial” (Unfit) or “not criminally responsible” (NCR) on account of mental disorder.]**

Here is a fictitious but very realistic example of how the mentally ill can become enmeshed in the criminal justice system – how they become “forensic patients”:

You and your family have been extremely frustrated because you can’t get your 18 year-old son any help. He hasn’t been taking his medications again. He continues to refuse medication because its poison. He has been holed-up in his room, making weird noises. He has become nocturnal. He has stopped bathing. He hears voices from the Martians. While he looks menacing, he has not actually been violent or overtly threatened violence. Your family physician is noticeably nervous when you ask that he be involuntarily hospitalized under the provincial *Mental Health Act*. You suspect that your physician is worried about his liability. You have tried to convince a Justice of the Peace that your son satisfies the criteria of the *Mental Health Act* but have been turned away because there is no clear evidence that he is dangerous to himself or others. You are exasperated with the civil mental health system. All you want is some help for your son. You say that the *Mental Health Act* has no teeth and that there are so few resources that even if he is admitted he will be discharged as soon as he can barely satisfy the *Mental Health Act* criteria. When he *is* admitted to hospital your son is discharged before he is stable. His condition deteriorates rapidly upon discharge.

But, recently the news has improved. He has been charged with a criminal offence. Yes, he punched a police officer who came to the house at your request. He has been charged with assaulting the police officer. The really good news is that he was so disorganized at the time he appeared in the bail court that the Crown Attorney had serious doubts about his fitness to stand trial. You took perverse delight in the fact that he had been charged with a criminal offence because now, in the criminal justice system, he can get a comprehensive psychiatric assessment. The court did indeed order an assessment to determine his fitness. The assessment indicated that your son was, as you knew, schizophrenic, and unfit to stand trial. You were ecstatic. Ecstatic, because the court, with his new status of unfit to stand trial, was able to order that he receive involuntary treatment in a hospital for a period of 60 days. None of this had ever been accomplished with the civil mental health system. From your perspective things just kept getting better. He was eventually found fit to stand trial. But the court ordered that he be kept in a hospital until his trial had concluded so that he wouldn't stop taking his medication and become unfit again. This was the longest time he had ever spent in a hospital and you were thrilled. Eventually, he had his trial and he was found to have been "not criminally responsible" on account of mental disorder. As a result, he is now being supervised by the Ontario Review Board. After spending a little bit of time in the hospital the Review Board sent him back home to live with you but his case is still reviewed by the Review Board at least once a year. You feel much more comfortable because the Review Board is watching over him.

The Provincial and Territorial Review Boards, operating pursuant to the provisions of the *Criminal Code*, look after all accused like your son who have been found by the criminal justice system to be either unfit to stand trial or not criminally responsible on account of mental disorder.

Unfortunately, however, the greater percentage of individuals suffering from a mental disorder who, as a result, come into conflict with the law end up in jails or correctional settings. With this their prognoses worsen, their probability of re-offending increases, and, as discussed later, at a greater cost. All of the above might have been captured with much less expensive intervention at first instance engaging civil mental health care.

### 3. A bit of history

In the 1950s and 60s, detention in a mental hospital (civil) in Ontario was predicated on the presence of a psychiatric disorder which required observation, care, and treatment. The 1967 Ontario *Mental Health Act* provided for the involuntary admission of a person to a psychiatric

facility if she was suffering from a mental disorder in the nature or degree so as to require hospitalization in the interests of his/her own safety or the safety of others and was not suitable for admission as an informal patient. A one month period of detention was authorized<sup>iii</sup>.

In 1978, the Ontario *Mental Health Act* was amended and criteria for involuntary hospitalization altered. The person must have threatened or have attempted to cause bodily harm to himself, behaved violently towards another, or caused another to fear bodily harm from him, or shown the lack of competence to care for himself and to be suffering from a mental disorder of a nature of quality that will likely result in serious bodily harm for the person and other persons, or imminent serious physical impairment of the person. The period of involuntary detention is 14 days.

In the 1950s, involuntary hospitalization assumed treatment was the *quid pro quo* for state intervention. Post 1978, as the courts defined the need for an informed consent before treatment, the union of involuntary hospitalization and treatment was broken.

There are two fundamentally different ways in which civil mental health legislation has responded to the treatment and hospitalization of the mentally ill. The 1967 Ontario *Mental Health Act* predicates hospitalization upon a “need to treat”. With this model mentally disordered individuals are hospitalized if there appears to be a need to treat them and they are not availing themselves of the necessary treatment voluntarily. This approach is a child of the state’s *parens patriae* role as guardians of the infirm. As this approach fell out of favour in the late sixties and seventies it was replaced in 1978 by the second model championed by the civil libertarians based upon dangerousness. Under the second model, we may only interfere with an individual’s freedom if he is perceived to be a danger to himself or others. If an individual is not seen as dangerous to himself or others he is free to roam the streets ‘madder than a hatter’. This latter model is the most common in North America.

What is the problem with the second model? Well, if a seriously mentally disordered person were to enter the room and he was talking to Martians and making weird noises, most of us would probably agree that there was a need to treat. Applying that test, if the individual was not prepared to come into the hospital on his own we would have him admitted on an involuntary basis. If we were to employ the second model, how many of us could feel confident concluding that he does or does not represent a danger to himself or others? The problem with this dangerousness-based legislation, some say, is that we are not able to determine with any degree of accuracy who should be detained and who should not. We make all sorts of mistakes; false positives and false negatives. That is, we make errors asserting that some individuals are

dangerous when, in fact, they are not; and, we make errors asserting that some individuals are not dangerous when, in fact, they are. As a result, the civil mental health system, quite apart from resource issues, is, with the rights-based model simply unable to reliably capture many mentally disordered individuals who are at risk for criminal activity. As long as this persists, the argument goes, you will inevitably and unavoidably have mentally disordered individuals leaking through the “civil net” and slipping downstream to be caught-up in the “forensic net”. As many have observed, forensic patients are, for the most part, patients, as any others, of the civil mental health care who received inadequate supports and treatment.

I respectfully submit that, while there are complexities, this is where the bulk of the problem lies. Aggravating all of the above, is that as governments have been cash strapped and have cut back spending on health care and social programs the mentally disordered are more likely to end-up in the forensic system. As there are fewer and fewer psychiatric hospital beds *per capita* the greater the likelihood that individuals for whom there is no room in the civil system will end-up in the forensic system. If, for example, a hospital has fifteen vacant beds and ten prospective new customers at the door there is a good chance that they will all be admitted if they satisfy the *Mental Health Act* criteria or are presenting themselves as voluntary patients. They will all be looked after. If, on the other hand, there are only five vacant beds and the same 10 prospective customers are at the door some hard choices will have to be made. Five will be admitted and five will not. Five will, as a result, be left at risk for attracting the attention of the police and the criminal justice system if their odd behaviour results in the commission of a criminal offence<sup>iv</sup>. Unfortunately, it often does. As a result of resource shortages, these customers who should have been accommodated by an adequately resourced civil mental health system have now become “forensic patients”.

With downsizing and/or restructuring of the civil mental health care systems across Canada there was inevitably the promise that by reinvesting the money saved with the bed closures into less expensive out-patient community treatment the mental health care system would actually be better off. While superficially attractive, I don't know of any compelling support for this proposition. Some say that the ineffective shift to out-patient, community-based treatment may have something to do with the increases we are observing. Others say that, in any event, those saved dollars are never reinvested in alternative community-based care as advertised. I think that it is safe to say that many mentally ill individuals can be adequately supported through community treatment but that, at the same time, there are many who cannot be supported through community mental health care. Certainly, at the time of the transitioning it was an unproven alternative.

There is probably no single explanation for the fantastic growth of the forensic population. It is undoubtedly a product of a multiplicity of factors which includes the ones cited above.

#### 4. Adding to the Picture

Further to all of the above, in the wake of a landmark decision from the Supreme Court of Canada in 1991, *Bill C-30* was proclaimed on February 5, 1992. *Bill C-30* (An Act to Amend the Criminal Code (Mental Disorder)) forms for the most part what we now know as Part XX.1 of the *Criminal Code of Canada* and provides a relatively complete procedural code for dealing with the mentally disordered accused. A new jurisdictional threshold was established based upon “significant threat to the safety of the public” rather than upon “substantial recovery”. All accused must be reviewed upon the verdict and thereafter within at least every twelve months. The *Bill C-30* amendments also modernized some of the language which had been used in the *Criminal Code* for over 100 years. “Not guilty by reason of insanity” was changed to “not criminally responsible”. The terms “natural imbecility” and “disease of the mind” were removed (NB: nevertheless, “mental disorder” is defined in s. 2 of the *Code* as “disease of the mind”).

Automatic “strict custody” was eliminated. Instead, the court is now able to hold a disposition hearing immediately following the verdict and may make its own disposition for the accused. Court-made dispositions are all reviewed by the Review Board.

It is fair to say that since the proclamation of Bill C-30, travelling down the path of “not criminally responsible” has become a more attractive option for defence counsel and their clients. Certainly, when I first started practice as a criminal lawyer raising an insanity defence for anything but the most serious of offences was viewed as tantamount to negligence. You feared that your client would be tossed into a dungeon perhaps never to see the light of day again. He could spend decades locked in a hospital for the most minor of offences. This perception was based upon more fiction than fact. In reality the disposition options under the old legislation were virtually identical to the present scheme. The significant changes came with the mandatory creation of the Review Boards, the changed jurisdictional threshold [substantial recovery / significant threat], and the time limit within which an accused must be reviewed “post-verdict”. Nevertheless, the perception is that the “new system” is less harsh - more “defence friendly”. Therefore, this explanation has it that the new legislation is itself attracting more customers<sup>v</sup>.

Perhaps the most significant change in the *Criminal Code* so far as the bar is concerned relates to the jurisdictional threshold. While under the previous scheme (pre-1978) jurisdiction was

“recovery-based”, now it is maintained only so long as the accused remains a significant threat to the safety of the public. Understandably, if “recovery” was what was required to escape the clutches of the state one could expect that the stay at “Her Majesty’s Pleasure” could be lengthy, particularly given that there are no cures for mental illness, only treatments that work to varying degrees in attenuating the most dramatic symptomatology. Recoveries would be few and far between.

Maintenance of jurisdiction over an accused in the new scheme<sup>vi</sup> requires a positive finding that the individual is a significant threat to the safety of the public. This bears no necessary relationship to “recovery”. It is well known now that the mentally disordered are no more dangerous as a population than the general population. “Significant threat” is obviously a more elevated concern than “threat simpliciter”. Some say therefore, that one’s prospects for release are very much better under the new legislative scheme. There is a real probability that you may be released in a much shorter period of time than if you had been convicted and sentenced.

## 5. The Numbers are Growing

While the impact of the various contributors is not precisely known, we do know that the numbers of mentally ill individuals in the criminal justice system is on the rise. Since the early 1990's this population has been growing at the alarming rate of up to 10% or more *per year*<sup>vii</sup>. This is juxtaposed data which shows that from the early 1990's the actual number of arrests has steadily **decreased**.

An early explanation has it that the humourless political climate with its zero tolerance, tough-on-crime - no matter how trivial attitude, is resulting in arrests for situations that might have been handled with police discretion in the past. Related to this is the explanation that the police with their heightened fear of liability and sense of accountability are more inclined to “go by the book”. It is safer to lay a minor charge and have the mentally disordered individual processed like any other criminal than to stick your neck out and do something creative like take the individual to a psychiatric emergency and forego the laying of a charge. As a result, now with the more attractive provisions contained in the *Code*, many more accused who have committed “not so serious” nuisance offences are entering the criminal justice system being found unfit and raising the defence of not criminally responsible on account of mental disorder<sup>viii</sup>. There is less concern regarding disproportionate consequences.

A significant problem results when you have a collision course of decreasing resources and increasing numbers of mentally disordered accused with verdicts of NCR or unfit to accommodate. Here, we have also been caught by judicial decisions which exacerbate the problem. It is the obligation of the Review Board to, for each accused, “... **taking into consideration the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is the least onerous and least restrictive to the accused**”<sup>ix</sup>. That is the Review Board’s statutory mandate. The person in charge of the hospital where the accused is detained or is to attend is a party to our proceedings as is the Attorney General and, of course, the accused. Appeals have been successfully made by the hospitals against Review Board Dispositions based upon the contention that, for example, there is no room at the hospital to which we ordered the accused to attend. We have been told by the Courts that we must not make Dispositions unless we know that the disposition can be effected. What the Review Board is then left with is our statutory mandate to impose the “least onerous and least restrictive disposition” compromised or limited by the resources with which the province has chosen to equip itself. Accordingly, if the Review Board is of the view that the least onerous and least restrictive disposition is that an accused be discharged conditionally to live in a place in the community approved by the administrator but the administrator says there is no such place, the disposition should not be made. The provincial governments are apparently free to defeat the statutory scheme set-out in the *Criminal Code* when they decide that money will not be spent on adequate resources for the mentally disordered accused. Hospital Administrators are able to defeat the scheme by indicating that the resources that are available are not appropriate. As a result, individuals who were first of all not served well by the civil system are now, as forensic patients, not doing any better.

This predicament causes some to wonder whether we are not creating a situation where we have parties to our proceedings of differing status; those who must comply with our orders - the mentally disordered accused; and, those who don’t need to comply with our orders - the hospitals or provincial ministries of health.

We are also receiving word from the Courts that if the least onerous and least restrictive disposition is X, we must order X, and not order Y. This would appear to be at odds with the proscription against making dispositions unless we know that they can be effected. And finally, while we understand the problems associated with making definite assertions with respect to dangerousness, we must not maintain jurisdiction over an accused unless we can state positively

that they are a significant threat to the safety of the public. Some say that we are unable to make such an assertion except in the most extreme cases.

## **6. *Criminal Code* is the *Mental Health Act* of Last Resort**

The *Criminal Code of Canada* has emerged as the *Mental Health Act* of last resort. The provisions of the *Criminal Code* appear to be robust enough to provide a comprehensive system of care and supervision for the mentally disordered individuals who are entering the system at a disproportionate rate. The most pressing problem is that unless the forensic psychiatric system is adequately resourced our legislative mandate cannot be implemented.

How to return the mentally disordered accused to the status of “patient”? Arguably, if the system had worked optimally for him at first instance, he would never have lost patient status.

In North America, American Express markets its credit card with a concept called “Front of the Line”. Consumers wanting to either get the service quickly, or the best spot, at a theatre or similar such entertainment event, can use their American Express card to get to the “front of the line”. That is, in fact, what the forensic system does. It moves people to the front of the line, to ensure that they are being monitored and supervised by some form of case manager or case management team. Entry into the community from the forensic system occurs only after the patient, who in the *Criminal Code* system we refer to as “the accused”, has managed previous passes and liberties successfully. The scheme ultimately provides careful and gradual transition into the community with minimal risk to all. But it should be understood that although the forensic system ensures services, it is not cost effective. I do not know the figures, but one learned colleague suggested that up to 20 civil patients would have been accommodated and treated in the bed space time allocated to a single forensic patient.

The development and expansion of the forensic system, while meeting a legitimate need, is a tribute to the saying “necessity is the mother of invention”. The disempowerment of the civil mental health care system necessarily led to the forensic system’s growth. There developed an inverse relationship; as the Civil System became progressively de-energized, sacrificing in particular, the custodial and social components of mental health care, the forensic system increased in strength and volume. The formula can be expressed this way. The mentally disordered offender, formerly known as a patient, forfeited his liberty in exchange for the certainty of better mental health care, and the public’s greater assuredness that its safety interests would be met. The civil system under the MHA had been originally constructed as a safety net for patients and the public, but the net needed repair and rather than fixing it, a second net – the forensic system – was put in place - it is therefore the net under the

net, or, the net further downstream.

## 7. What to do?

The over-representation of individuals with mental illness in the criminal justice system is a situation that has arisen due to a complexity of factors. The solution, to my mind, must also be multi-faceted in order to be successful. It is recognized that health care is constitutionally a provincial/territorial domain but solutions, given that the problem of the over-representation of mentally ill individuals in the criminal justice system is largely one of “transinstitutionalization”, must involve main stream civil mental health care.

### 7.1 Invest in Provincial and Territorial Mental Health Care

We know that the percentage of our population who suffer from mental illness will remain static over time and across cultures/jurisdictions. What accounts for differences, where they occur, is thought to be due to recognition or reporting of the disorders rather than actual incidence. Similarly, the percentage of that population who will present as a management problem for society will remain constant over time. What will change as a function of politics or unintended evolution is how we, as a society, choose to respond to the problem. Will the problem be addressed through new efforts in health care or will we allow the problem to continue to leak through that system and into the criminal justice system? It *will* be one or the other. I am of the view that we should not continue to expand the role of the courts and the criminal justice system as principal dispensers of mental health care.

It is much less expensive, more humane, and more appropriate that this population be looked after properly at first instance by the civil mental health care system. The best prophylactic in avoiding the growth of mentally disordered accused in the Criminal Courts is an improved civil mental health care system across the provinces and territories. Therefore, the number one remedy to the problem is reinvestment in civil mental health care. It is the failures of this system that we are seeing in the criminal justice system. If one examines the cases of extreme violence – the “headline cases” - perpetrated by individuals with untreated mental disorders<sup>x</sup> it is a virtual certainty that the individual had had contact with the civil mental health system but that she was either discharged or evaded containment and or treatment. It is alarming to note, in many cases, contact with civil mental health care was within days of the very serious offending.

Included in the concept of “civil mental health care” is the necessity of housing with appropriate levels of support. Homelessness amongst this population is an enormous problem. Aid to provincial and municipal governments to provide this support will inevitably prove to have a good return on the investment in the form of fewer individuals suffering from mental illness

entering the criminal justice system. This is not only a health concern it also engages ministries responsible for public safety, law enforcement, and criminal justice.

There is a strong business case for the federal government's investing in provincial/territorial civil mental health care. It is, as mentioned above, really all about what mechanisms should most appropriately be engaged to look after this population. To the extent that the provinces/territories are able to manage mental illness before it blooms into something that engages the criminal justice system, money has been saved, prognoses improved, and the potential for re-offending reduced. Hence, consistent with the Federal Government's published objectives, the streets and communities will be safer as a result *and*, the enhanced safety will come at a lower cost.

## 7.2 Expand Diversion Programs: Move the New Forensic Patient back to the Civil System Quickly

Various jurisdictions in Canada<sup>xi</sup> have created "diversion programs" in an effort to facilitate the diversion or transfer of mentally disordered offenders from the criminal justice system to civil mental health services. Diversion from the criminal justice system into the mental health care system can be accomplished where the offense is within the minor to mid-range and is the direct result of a mental disorder. Certain further criteria must be met, including that the safety of the public must not be compromised, the mental disorder must be amenable to treatment, and the proposed mental health care facility or practitioner must agree to accept the accused.

Diversion can occur at a number of junctures in the proceedings, including prior to the accused's initial court appearance, after the first appearance, after a bail hearing, or after a fitness evaluation and hearing.

As well, the police have always had "pre-arrest diversion" available to them. Considerable discretion rests with any police officer who observes an apparently mentally ill individual act in a disorderly or inappropriate manner, to take that individual to a psychiatric facility for evaluation pursuant to the *Mental Health Act*, rather than laying charges. There has certainly not been universal reliance on this option. The efforts of well-meaning police officers have often been frustrated by the necessity of having to wait, potentially for hours, until the individual is assessed, as they are obligated to do until actual custody can be relinquished to the psychiatric facility. Some officers have been further demoralized by knowing that the patient that they brought to hospital was released only a short while later, to repeat the behaviour, presumably because the hospital was not able to satisfy itself as to the level of the patient's dangerousness so as to detain him involuntarily.

Diversion programs are clearly aimed in the right direction, but would be fruitless endeavours in the

absence of funds and services to support them. Conventional supervision and services are often insufficient but those can often be energized with the support of the teams involved with diversion programs and mental health courts. Clinicians and mental health workers could easily collaborate and create a prescription for intensive community services for the chronically mentally ill, predominantly the schizophrenics, that would meet their medical, mental health and psychosocial needs. Programs like this include in their repertoire of interventions, medical and therapeutic services, assistance with money management and dealing with social services, housing and related support services, and close case management that may involve daily reporting and monitoring. The incentive for the client may first of all be the avoidance of penal consequences and greater constraints on their liberty, but more importantly, the patient/end-user is offered an opportunity to become reconnected to a caring environment, and in particular, to individuals who are able to deal with the numerous vexing concerns that the chronically psychotic mind experiences as an irritating distraction, if not a threat.

Mental Health Courts and Diversion programs are not part of the ‘system’ in all parts of Canada. They should be. “Graduates” from diversion programs reoffend less often and re-offend less violently. A recent Canadian meta-analysis demonstrated that Mental Health Courts have a 17% reduction in recidivism as compared with traditional courts. Graduates maintain housing, employment, and health care more consistently. They have fewer contacts with the police<sup>xiii</sup>. The Federal Government should become formally involved in promoting these programs as, mentioned above, there is a strong business case for doing so. Perhaps Grants to initiate mental health courts and/or diversion programs could be considered by the Federal Government. Prosecutions obviated result in fewer individuals with mental illness entering correctional systems.

Meanwhile, the provisions pertaining to “Alternative Measures” contained in the *Criminal Code*<sup>xiii</sup> should be amended to specifically advert to individuals who suffer from mental illness as was done in ss. 718.2(e) which deals with “aboriginal offenders”<sup>xiv</sup> (e.g. “.....with particular attention to the circumstances of offenders **suffering from mental illness.**”). Similar amendments should be made to ss.718.2. Inclusion of these amendments (both with respect to sentencing principles and alternative measures) will serve to sensitize the bench and bar as to the importance of considering alternatives for individuals suffering from mental illness even where “diversion” is not a formal program in that particular jurisdiction.

Where convicted of an offence the courts must be mindful of the relative ineffectiveness of “specific” and “general deterrence” and the appropriate case law dealing with sentencing mentally ill offenders<sup>xv</sup>. It must be recognized that the criminal justice system, with its traditional approach, as a response to behaviour driven by mental illness that is problematic for society, typically aggravates

the situation and worsens prognoses. The principles of therapeutic jurisprudence should be formally adopted by the Federal Government and injected into s.718 of the *Code* so that meaningful dispositions are obtained elsewhere than in the specialty courts. The so-called “statutory minimums” which stipulate mandatory minimum penalties should be, for the most part, discretionary where the accused suffers from a mental disorder.

### 7.3 A Federal Mental Health Act

Because the civil mental health acts for each province and territory are different there are, effectively, different criminal justice responses in every province and territory as a result of how they interact with the criminal justice system. There are some glaring differences. For example, in Ontario it is possible to hospitalize (lock up in a hospital) an individual who suffers from a mental illness yet not treat that individual if they are “capable” of consenting to treatment. In British Columbia, all individuals subject to the jurisdiction of the provincial Review Board are deemed to consent to treatment. The provincial/territorial civil mental health legislation unavoidably intersects with the *Criminal Code* either implicitly or, as with the legislation in Ontario, explicitly, as it provides jurisdiction for the ordering of psychiatric assessments in the criminal courts<sup>xvi</sup>. As a result, Ontario is the only jurisdiction where the criminal trial court can order an assessment to assist with sentencing or judicial interim release. The *Mental Health Act* acts as a supplement to s.672.11 of the *Code*.

It would be better to have, at least where civil mental health legislation and the *Code* do intersect, uniformity across Canada. This could be accomplished with a Federal *Mental Health Act* which intrudes into (from a division of powers perspective) the provincial health care domain only to the extent that is necessary to make the criminal law uniform across Canada. There are examples of intrusions of this sort by the criminal justice system; for example, the ability of the criminal courts to order unfit accused to undergo involuntary treatment.

While it may not be accomplished easily, it would be of benefit, for the reasons discussed above, if hospitalization was based upon illness and lack of insight (as well as, or perhaps instead of dangerousness). Most would agree that a system of intervention based upon dangerousness is theoretically very attractive. Why interfere with an individual’s freedom unless they are “dangerous”? However, the theory makes the assumption that determining who is and who is not dangerous is within the range of abilities possessed by mental health professionals. The determination of dangerousness is something that cannot be done accurately. Some would say that despite an industry devoted to this enterprise, predictions with respect to individuals rather than groups is no better than chance. Of course, when someone who is actually *not* dangerous is detained upon the mistaken assessment that they *are* in fact dangerous the error is very difficult to detect. The converse is all too

apparent.

There are 3 main reasons why civil mental health systems fail to adequately address a patient's needs:

- 1) Dangerousness based entry threshold,
- 2) Inability to involuntarily treat those who are hospitalized but who are 'capable'.  
(These two events should be merged.)
- 3) Discharge from hospital is pre-mature. Patients are discharged as soon as statutory criteria are barely met but before the patient has sufficient stability/insight required to maintain treatment and stability.

It is widely recognized that these deficiencies create a rather "leaky" civil net that is bound to send many mentally ill individuals into the criminal justice system.

A corrective attempt with respect to the jurisdictional threshold for state intervention is a move that would be politically charged and legally difficult. On the other hand, if we want to see the numbers of mentally ill people in the criminal justice system decrease we must have a system that will adequately deal with the issue within the provincial/territorial health care systems. As mentioned above, the population must be looked after by one system or the other. The provinces and territories may require funds in order to improve their mental health care systems. Improvements need to be made both with respect to resources and legislation. It is unclear the extent to which shifts in legislation can be connected to funding.

#### **7.4 Part XX.1 of the *Criminal Code***

Where an individual commits a crime as a result of an untreated mental illness it is generally better to have that person self-identify and seek out, where appropriate, a rehabilitative response by way of an NCR verdict. The outcomes for individuals travelling down this path are, from a public safety perspective, much better than for those who remain in the regular prosecutorial stream. Their reintegration into the community is gradual, monitored, supported, and moves only as it is safe to do so. Where the same individual comes to 'warrant expiry' after completing a sentence in the regular prosecutorial stream there is none of that and the probability of reoffending is considerably greater.

Whether or not to avail oneself of an NCR verdict is decidedly tactical and driven in part as a result of the likely outcome. That is, as between the Review Board system and the regular prosecutorial system (along with jails, corrections, parole, etc.) which route will be optimal? We know that counsel

will steer their clients away from NCR verdicts where the consequences are potentially harsh. To the extent that this happens our streets and communities become less safe. With the proclamation of Bill C-14 (*The Not Criminally Responsible Act* that came into force in July, 2014) the potential for harsh consequences has been injected into the *Criminal Code* thereby increasing the probability that mentally ill offenders will avoid those erstwhile rehabilitative provisions and end up in the jails and correctional facilities rather than in hospital<sup>xvii</sup>. We know very well from the likes of the Ashley Smith inquest, and as mentioned several times above, mentally ill individuals do particularly poorly in jails. Their conditions worsen and their prospects for rehabilitation deteriorate while the probability for future difficulties increases. The irony is that with Bill C-14 the “over-representation of individuals with mental illness in the criminal justice system” is likely to get worse.

### 7.5 Enable the Change with Effective Federal Legislation

While the Mental Health Commission of Canada has done some wonderful work, it has been, to date, “aspirational” in nature. It has funded some very worthwhile research and has prepared strategy papers. The current commission is a funded project which lapses in 2017. Presently, its future is uncertain with respect to 1) its future existence, 2) its mandate, and 3) its funding. As a result, the commission is not easily able to engage in any meaningful long term commitments. A fixed-term project is by definition hobbled during its final days.

It is recommended, as set out in *Bill S-208* (Second Session, Forty-First Parliament, 62 Elizabeth II, 2013), that a commission (“Canadian Commission on Mental Health and Justice”) be established with a mandate to not only fund research and generate strategies but to actually become involved in effecting change on the ground. The next generation of efforts in this area needs to move strategy to implementation. This could include advisory roles, links to other government agencies, and the development of evidence-based action plans that could be overseen by or partnered with the Commission. All in an effort to create systems that reduce the probability of mentally ill individuals becoming enmeshed in the criminal justice system.

---

<sup>i</sup> Prepared at the request of the Government of Canada, Department of Justice.

<sup>ii</sup> Transinstitutionalization is the migration of a particular population from one system to another. The mentally ill may be moved out of the health care system with the closure of hospitals but they only reappear in another setting which is all too often the correctional system.

<sup>iii</sup> Part of the inconsistency across Canada with respect to the plight of the mentally ill in the Criminal Justice system is that each Province and Territory has its own mental health legislation. This can create some big differences.

<sup>iv</sup> It is a poorly kept secret that, given the choice, the cooperative prospective patient will be taken over the unruly, unkempt, uncooperative prospective patient.

<sup>v</sup> Across Canada the number of mentally disordered individuals entering the criminal justice system has been steadily increasing over the past two decades. At present, there appears to be a “flattening” of the growth curve but it is too early to know whether this is a trend or a “blip”.

<sup>vi</sup> It’s not really that ‘new’ at this point but is the ‘newest’ substantial change.

<sup>vii</sup> And still, even though the number of individuals subject to the review board system has grown dramatically, the bulk of those suffering from a mental disorder charged with a criminal offence end up in the jails and penitentiaries. See Note iv, above.

<sup>viii</sup> This, while the arrest rates for other criminal activity appear to be on the decline.

<sup>ix</sup> With the proclamation of Bill C-14 on July 11<sup>th</sup>, 2014, the phrase “least onerous and least restrictive” was replaced by the phrase “necessary and appropriate” however, the Minister of Justice in testimony before the Senate has indicated that the phrases mean the same thing and that the new wording was only introduced to “add clarity”. As a result, the Review Boards have been treating the phrases as synonymous.

<sup>x</sup> It must, at the same time, be recognized that statistically speaking individuals suffering from mental disorder are no more violent than others. Their potential escalates when untreated and when substance abuse is in the mix.

<sup>xi</sup> The first Diversion Program in Canada was started in Ontario in 1994.

<sup>xii</sup> As to the efficacy of these programs: see also, for example Special Issue: Mental Health Courts and Diversion Programs, *International Journal of Law and Psychiatry*, Vol.33 (4), 2010.

<sup>xiii</sup> The provisions pertaining to Alternative Measures are set out below.

**716.** In this Part,

“accused” includes a defendant;

“alternative measures” means measures other than judicial proceedings under this Act used to deal with a person who is eighteen years of age or over and alleged to have committed an offence;

“court” means

- (a) a superior court of criminal jurisdiction,
- (b) a court of criminal jurisdiction,
- (c) a justice or provincial court judge acting as a summary conviction court under Part XXVII, or
- (d) a court that hears an appeal;

“fine” includes a pecuniary penalty or other sum of money, but does not include restitution.

R.S., 1985, c. C-46, s. 716; R.S., 1985, c. 27 (1st Supp.), s. 154; 1995, c. 22, s. 6; 1999, c. 5, s. 29(E).

#### *Alternative Measures*

**717. (1)** Alternative measures may be used to deal with a person alleged to have committed an offence only if it is not inconsistent with the protection of society and the following conditions are met:

- (a) the measures are part of a program of alternative measures authorized by the Attorney General or the Attorney General’s delegate or authorized by a person, or a person within a class of persons, designated by the lieutenant governor in council of a province;

A-67

(b) the person who is considering whether to use the measures is satisfied that they would be appropriate, having regard to the needs of the person alleged to have committed the offence and the interests of society and of the victim;

(c) the person, having been informed of the alternative measures, fully and freely consents to participate therein;

(d) the person has, before consenting to participate in the alternative measures, been advised of the right to be represented by counsel;

(e) the person accepts responsibility for the act or omission that forms the basis of the offence that the person is alleged to have committed;

(f) there is, in the opinion of the Attorney General or the Attorney General's agent, sufficient evidence to proceed with the prosecution of the offence; and

(g) the prosecution of the offence is not in any way barred at law.

(2) Alternative measures shall not be used to deal with a person alleged to have committed an offence if the person

(a) denies participation or involvement in the commission of the offence; or

(b) expresses the wish to have any charge against the person dealt with by the court.

(3) No admission, confession or statement accepting responsibility for a given act or omission made by a person alleged to have committed an offence as a condition of the person being dealt with by alternative measures is admissible in evidence against that person in any civil or criminal proceedings.

(4) The use of alternative measures in respect of a person alleged to have committed an offence is not a bar to proceedings against the person under this Act, but, if a charge is laid against that person in respect of that offence,

(a) where the court is satisfied on a balance of probabilities that the person has totally complied with the terms and conditions of the alternative measures, the court shall dismiss the charge; and

(b) where the court is satisfied on a balance of probabilities that the person has partially complied with the terms and conditions of the alternative measures, the court may dismiss the charge if, in the opinion of the court, the prosecution of the charge would be unfair, having regard to the circumstances and that person's performance

with respect to the alternative measures.

A-68

(5) Subject to subsection (4), nothing in this section shall be construed as preventing any person from laying an information, obtaining the issue or confirmation of any process, or proceeding with the prosecution of any offence, in accordance with law.

R.S., 1985, c. C-46, s. 717; 1995, c. 22, s. 6.

**717.1** Sections 717.2 to 717.4 apply only in respect of persons who have been dealt with by alternative measures, regardless of the degree of their compliance with the terms and conditions of the alternative measures.

<sup>xiv</sup> s.718 pertaining to Sentencing Principles should be similarly amended so as to encourage more thoughtful responses to people who offend while suffering from a mental disorder who might not have been found NCR.

<sup>xv</sup> See for example: Bloom, H. and Schneider, R. *Mental Disorder and the Law: A primer for Legal and Mental Health Professionals*, Irwin Law, Toronto, 2006, Chapter 9.

<sup>xvi</sup> *Mental Health Act*, R.S.O. 1990, as amended, ss.21,22.

<sup>xvii</sup> There has been much debate around the proclamation of this very controversial Bill which needn't be repeated here. Suffice it to say, the Bill was criticized widely and vociferously by medical and mental health professionals. There was apparently no empirical support for the changes made and the experts who weighed-in warned that the Bill would have precisely the opposite effect (ie. make the streets and communities *less* safe).