Centre for Addiction and Mental Health

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Submission of

Centre for Addiction and Mental Health

to

The Standing Committee on Justice and Human Rights

on

Mental Disorder Provisions of the Criminal Code

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A PAHO/WHO Collaborating Centre

Un Centre collaborateur OPS/OMS

Affiliated with the University of Toronto

Affilié à l'Université de Toronto

1. INTRODUCTION

The Centre for Addiction and Mental Health (CAMH) was created in 1998 through the successful merger of the Addiction Research Foundation, the Clarke Institute of Psychiatry, the Donwood Institute and the Queen Street Mental Health Centre. The Centre is a teaching hospital fully affiliated with the University of Toronto and is a World Health Organization Centre of Excellence. It is the largest mental health and addictions facility in Canada.

Building on the legacies of four outstanding organizations, the Centre offers a unique model for understanding and helping people with addiction and mental illness, for preventing substance abuse and for promoting mental health. It operates central clinical and research facilities in Toronto, Ontario, as well as 12 community offices across the province. While the Centre's work focuses on the needs of Ontario communities, our impact extends across the country and internationally.

Realizing the diverse needs of all of its clients, the Centre is committed to providing comprehensive and well-coordinated care for all people with mental illness and substance use problems. In addition, the Centre is focused on treating special populations, and has set up specialized programs for women, youth, couples and families, older adults, African Canadian and Caribbean youth, lesbians, bisexuals and gay men.

The Centre brings together internationally recognized biological, clinical and social research with pre-eminent treatment facilities, a range of professional training and a province-wide network of community program staff. As a result, we have a unique capacity to focus our research agenda on the most pressing needs and to translate new knowledge into action.

With clinical expertise in both addictions and mental health, the Centre is in a unique position to demonstrate a collaborative, interdisciplinary approach to prevention, care, education and research.

The Centre advocates for services that are accessible, effective and adequately funded for all people needing help. It is also working towards the elimination of the stigma that is faced by those with mental illness or substance use problems.

As a teaching hospital, the Centre provides innovative interdisciplinary education for students and health professionals from across Canada.

The Centre is dedicated to better understanding, prevention and care.

CAMH Law and Mental Health Program

The Centre for Addiction and Mental Health (CAMH) is one of nine hospitals in the Province of Ontario designated by the Minister of Health for the custody, treatment or assessment of mentally disordered accused persons. CAMH is the largest of these, and is situated in the most densely populated and most diverse racial, linguistic, and ethnic area in the province.

All work with mentally disordered accused by CAMH is mandated either by court orders or

Review Board dispositions pursuant to Part XX.1 of the *Criminal Code*.

CAMH conducts court-ordered assessments in two different settings. Psychiatrists are dispatched to the courts in Toronto to conduct mental health assessments of accused persons, primarily of their fitness to stand trial. Psychiatrists perform assessments at the Court House and immediately thereafter give *vive voce* evidence at hearings. Thirty in-court assessments are conducted each week in the City of Toronto. When required, the mentally disordered accused is sent in custody to a CAMH inpatient facility under a court order for assessment or treatment. Inpatient assessments address fitness to stand trial, criminal responsibility, and dangerousness. The 28-bed Assessment and Triage Unit performs approximately 280 such court-ordered assessments or treatment per year.

CAMH provides treatment and rehabilitation services in various inpatient and outpatient settings. CAMH inpatient settings offer two levels of security: medium and minimum.

At the medium secure level, CAMH has a total of 48 beds in three hospital wards. Eight of these beds are for the custody and control of difficult to manage inpatients (i.e., not court-ordered). At the minimum secure level, there are a total of 61 beds in two wards. These wards are devoted to the preparation of forensic patients for re-integration into the community, and to provide crisis care for forensic outpatients.

CAMH provides specialized services to women mentally disordered accused. A section of one of the minimum secure wards is devoted to women, and this section can be locked separately at night. In addition, CAMH in the process of establishing a six bed women's unit at the medium secure level.

CAMH supervises outpatients who are subject to custodial dispositions with discretion granted to permit the patient to live in the community pursuant to section 672.54 of the Code. Additionally, persons who have been conditionally discharged pursuant to section 672.54(b) of the Code are required to report to CAMH as their designated facility. These two groups comprise approximately 90 persons out of a total of 180 outpatients treated by CAMH. CAMH provides outpatient care to mentally disordered accused in its own outpatient service, but additionally collaborates with community-based outpatient services, including Assertive Community Treatment (ACT) teams, to provide forensic outpatient care.

All of the patients at CAMH who are under the jurisdiction of the Ontario Review Board have been found to represent a significant threat to the safety of the public. Having said this, our patients are quite heterogeneous both with respect to the degree of violent offences with which they have been charged, and the risk they pose to the community. On the one hand, 14% of these patients have been charged with murder and half have been charged with criminal offences at least as serious as assault causing bodily harm. Ten percent of our clientele are sex offenders. On the other hand, 50% of our patients have committed criminal offences that led to no physical injury to the victim, and more than 50% represent no particular difficulty in management in a hospital or outpatient setting.

The great majority of our patients suffer from serious mental disorder. Seventy percent have been diagnosed with some form of schizophrenia and almost 10% from bipolar affective

disorder. Approximately 60% of our mentally disordered accused have a concurrent substance abuse disorder.

We serve a surprisingly diverse population in terms of race, ethnicity and language. Only about half of our clientele were born on this continent, and the number of countries of origin for our patients is large.

Mental Disorder Provisions of the *Criminal Code* Process

CAMH has sought to inform its internal stakeholders about the review of the mental disorder provisions of the *Criminal Code* and to gather their input on the issues. We have tried especially hard to incorporate the perspectives of clients through the assistance of our Empowerment Council, which has also appeared before this Committee. CAMH is concerned with supporting the rights of its clients, and with reducing the stigma that attaches to people with serious mental disorders or addictions, which is further compounded by involvement with the criminal justice system. At the same time, this submission also reflects CAMH's need to manage its resources wisely to serve those most in need and to protect public safety.

Time has been too short to conduct our usual comprehensive consultation and policy review process. We have not been able to consult with our significant partners in this field (e.g., court support programs operated by community agencies; the judiciary, especially those at the special 102 Mental Health Court in Toronto; Crown prosecutors; review board members and counsel; corrections officials; and community agencies that provide the services for forensic patients who have been discharged or who are living in the community at the discretion of the person in charge of the hospital.) We believe that such a process would lead to the best-informed reaction and the best suggestions for improvement to the legislation. Our Board of Trustees has been informed about our appearance before the Committee and our proposed recommendations, but it has not been able to review and approve a full policy response. If there are further opportunities to make input into the Committee's deliberations, or if the Department of Justice is planning to develop amendments to the legislation, we would appreciate being informed at the earliest possible time, so that we may be as helpful as possible to the Committee and the government as they work to improve the system.

If you have any questions with respect to this submission, or if you require further information about our response, please contact Gail Czukar, CAMH General Counsel at (416) 535-8501 ext. 6923 or gail_czukar@camh.net, or Dr. Howard Barbaree, Clinical Director, Law and Mental Health Program, at (416) 535-8501, ext. 2919 or howard_barbaree@camh.net.

2. SUGGESTED AMENDMENTS TO THE *CRIMINAL CODE* TO MORE EFFECTIVELY UTILIZE HOSPITAL RESOURCES

One of the greatest pressures faced by CAMH is the lack of availability of inpatient beds to which a person can be admitted when ordered for assessment or for custodial detention. Quite frequently, unfit accused and NCR accused are detained in jail settings after an Assessment Order or Disposition has been rendered, simply because there is no place to house the individual safely in the hospital.

Similarly, NCR and unfit accused who are ordered to be transferred to CAMH from other forensic facilities often have waiting periods, as do clients of our services who are awaiting transfer to other facilities. CAMH has a duty to accept all such persons on lawful orders and Review Board dispositions properly made. The competing realities, however, include the duty at common law to maintain a safe environment for all clients and staff, and the inherent problems of constantly being ordered to take more individuals than can be appropriately and/or safely accommodated.

CAMH supports the provincial policy in Ontario that the forensic mental health system should remain integrated with the general mental health system. This is the best approach for ensuring that people receive the treatment, services and support that they need in relation to their mental disorder and/or addiction.

The more control that CAMH has over the admissions, triage, and assessment of our patients, the more effectively can we allocate and use our resources for those who will benefit most. Resources should be allocated primarily to higher risk and higher need patients. However, the effect of many court and Review Board orders is that we cannot allocate our resources in this fashion. The suggestions in these Submissions have been crafted with the dual purpose of expediting admissions to inpatient beds and services, and to facilitate discharge from those beds as soon as legally and clinically appropriate.

A) Assessment Orders Pursuant to Section 672.11 of the *Criminal Code*

Assessments may be ordered under section 672.11 for a variety of purposes. However, our comments will focus mainly on fitness assessments. Assessments of fitness to stand trial are contemplated to be done during a brief period at the beginning of a mentally disordered accused person's contact with the criminal justice system Section 672.14 (2) of the *Criminal Code* provides that an assessment order may not be in effect for the purpose of determining fitness for longer than five days unless the accused and the prosecutor agree to a longer period not exceeding thirty days. Section 672.14(3) provides that the thirty day period can be extended to a period no longer than sixty days where the court is satisfied that compelling circumstances exist.
There are several problems experienced by CAMH with respect to such assessments that impact on its ability to triage patients, and to effectively allocate its resources.

There is no obligation on the judge making an assessment order to ascertain whether or not there is a bed available to accommodate the accused and/or no requirement that the person in charge of CAMH must accept the individual for assessment. Some judges have also recently begun making orders that an accused person be taken "forthwith" to CAMH for the purposes of assessment, even after ascertaining there are no beds available for the accused person. The accused person subject to the "forthwith order" is pushed to the front of the queue, replacing those accused persons who are already waiting in jail for their assessment.

Judges commonly order fitness assessments for thirty or sixty days, rather than five days, for the true purpose of allowing an accused person to accept treatment in the hospital. In the result, thirty percent of the forensic beds at CAMH are occupied by accused persons for up to sixty days pursuant to assessment orders for the purpose of determining their fitness to stand trial. These beds could be used to accommodate 6 to 12 times as many accused persons if 5-

day assessments were ordered instead of the 30-60-day assessments. This would mean that accused persons would spend less time waiting in jail for assessments.

Although persons in charge of hospitals must consent to Review Board dispositions ordering treatment (paragraph 672.62 (1)(a)), there is no such consent requirement for assessment orders. Therefore Part XX.1 already comprehends the concept of consent on behalf of the facility for admission of accused persons. Requiring the consent of the person in charge will assist the hospital in allocating resources to those persons most in need of in-hospital assessments, which would be a genuine triage concept.

Another problem is the clinical reality is that many assessments do not require anywhere near the amount of time to complete as the *Criminal Code* allows and the court accordingly typically orders. It is rare that the assessment is not completed weeks before the accused's remand date as set out on the Assessment Order (Form 48) under the *Criminal Code*. Forensic beds therefore cannot be freed up for new admissions, which exacerbates the situation described above.

A further strain on forensic resources occurs where the assessment is completed well prior to the return or remand date stipulated on the Form 48, and the accused person could be returned to court on an expedited basis, but there is no practical legal mechanism for a facility to return the accused person to court.

RECOMMENDATIONS

Therefore, CAMH recommends the following:

Section 672.11 and section 672.13 of the Code should be amended to require the consent of the person in charge of the hospital where the accused is to be assessed before the Order can be lawfully made by a court.

Subsections 672.14(1) and (2) of the Code should be amended to require that no assessment will be for a period in excess of five days.

Subsection 672.15(1) should be amended to permit a court to extend the period the assessment order is to be in force *only under compelling circumstances*, such as where no assessment has been made.

Section 672.14 should be amended to require an accused person to be returned to jail or court, as soon as the fitness assessment is completed. Inpatient detention of the accused person will only be for the duration of time actually required for the completion of the assessment. Once concluded, the person in charge will return the assessed person to jail or court.

The Assessment Order, Form 48, should be amended to stipulate that once the assessment is completed, the accused must be returned to jail or court forthwith.

Recommendations iv. and v. refer to "jail *or* court" because there are jurisdictional and administrative problems with respect to transferring an accused person from hospital back to

court prior to the stipulated remand date of an order. A court may have no jurisdiction to take action with respect to an accused person who is not returned to court on the named remand date. Further, the court administration may be unable to coordinate the early appearance of the accused person with the various parties. One solution to this problem would be to transfer the accused person back to jail prior to his or her court appearance. The holding jail for the originating court currently has no jurisdiction to take custody of an accused person without an order specifying that institution as the proper remand centre. These issues must be addressed in the recommended amendments.

B) Permitting Assessments to Be Performed by Persons Other than Psychiatrists

The *Criminal Code* definition of "assessment" in section 672.1 should be amended to permit psychologists to perform assessments. Consideration should also be given to allowing other health care providers, such as social workers and advanced practice nurses who receive appropriate training, to perform these assessments, especially for fitness to stand trial. This is consistent with more effective utilization of resources within CAMH (and, we believe, by the forensic system generally) and with the need for more rapid assessments. It would also have a beneficial impact on costs to the health care system in general.

C) Sentencing and Judicial Interim Release

Section 672.11 of the Code sets out the exhaustive list of issues upon which a judge may order an assessment, and does not include sentencing. In Ontario, judges ordering assessments of individuals with respect to sentencing matters routinely rely on sections 21 to 23 inclusive of Ontario's *Mental Health Act*. The legality of this recourse has been upheld by the Ontario Court of Appeal: *R. v. Lenart* (1998) 158 D.L.R. (4th) 508. Section 23 of the *Mental Health Act* requires that, before a judge orders an examination pursuant to section 21 or orders a person in custody into hospital for an inpatient admission of up to two months duration pursuant to section 22, he or she must ascertain from the senior physician of the facility that the necessary services are available. If performed in accordance with the law, CAMH is thereby able to exert some appropriate control over the number and timing of admissions coming to its forensic units under the authority of the *Mental Health Act*.

To the extent that the Code may be amended to expand the categories of matters about which Judges could make orders for assessment – such as the inclusion of a sentencing provision in section 672.11 – the problems currently faced by CAMH and set out in item "2 a" above will simply be compounded unless the issue of a facility's ability to consent to admission is adequately addressed.

D) Continued Detention in Custody of a Fit Accused Person

Section 672.29 of the *Criminal Code* provides that where an accused is detained in custody after being found fit to stand trial, a court may order the accused to be detained in a hospital until the completion of the trial, if the court has reasonable grounds to believe that the accused would become unfit to stand trial if released. (The review board has similar authority under section 672.49.) These "keep fit" orders represent a considerable demand on our beds, as well. It is possible that, particularly in the case of serious offences, the accused person might not be put on trial for many months after he or she is found fit. If the person requires custody to remain fit, the person should properly be held in custody in a correctional facility.

CAMH RECOMMENDS that sections 672.29 and 672.49 of the *Code* should be amended to require the consent of the person in charge of the hospital where the accused is to be detained before the Order can be lawfully made by a court or review board.

E) The Return of the Fit Accused to Court

Should a Review Board find an accused person who is subject to a custodial disposition to be fit to stand trial after a hearing conducted pursuant to section 672.47 or subsection 672.81(1), the fit individual tends to remain in custody in hospital for a long period of time before being returned to court for the court's reconsideration of the fitness issue. Again, there is no mechanism by which the detaining facility can expedite the accused's return to court, thereby freeing the bed for the next necessary assessment or custodial disposition.

A new section of the *Criminal Code* should be drafted to require that (a) the Review Board forthwith after making a finding of fitness concerning such an accused person notify the court of its decision, and (b) that the court take custody of and hold a fitness hearing concerning such an accused person as soon as is practicable after receiving such notice, and in no event no later than thirty days after the Review Board has made its finding.

3. CAPPING AND DANGEROUS MENTALLY DISORDERED ACCUSED PROVISIONS

A) Proclamation of the Capping Provisions

CAMH program management opposes the proclamation of the capping provisions, not only because of public safety concerns, but also because of the diversion of resources from highest risk and highest need accused persons that would accrue from such an action.

The Supreme Court of Canada in *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625 imposed a high standard upon the court or Review Board to justify continued detention of the accused. Specifically, the court ruled that the correct interpretation of section 672.54 requires the determination of threshold issues. At every disposition hearing, the reviewing body must address the issue of whether or not the accused person continues to pose a significant threat to the safety of the public. The accused person has no onus to disprove his or her dangerousness. Where the court or Review Board is not satisfied that an accused meets that threshold, the person must be absolutely discharged pursuant to section 672.54(a) of the Code. The evidence to be examined includes but is not limited to the circumstances of the original offence, the past and expected course of the accused person's treatment, if any, the present state of the accused person's medical condition, the accused person's own plans for the future, the support services existing for the accused person in the community and the recommendations provided by examining experts.

If Part XX.1 as explained in *Winko* is followed by courts and the Review Board, the approach strikes a fair balance between the liberty interest of the accused and the societal interest in public safety, such that there is no need to proclaim the capping sections. The Review Board can release an accused person once he or she is no longer a significant threat to the safety of the public, even if the index offence is serious and a short time has passed since the accused person was charged.

CAMH clients/survivors would also emphasize the *Winko* requirement that the Review Board make dispositions that are the least onerous and least restrictive to the accused, and that address with greater vigour the personal needs of the accused person. Dispositions should not include standardized conditions which may have no evidentiary connection with the situation of the particular accused person.

B) Proclamation of the Dangerous Mentally Disordered Accused Provisions

If the capping provisions are to be proclaimed, it is the position of the treatment personnel and program management of CAMH that it would be necessary to simultaneously proclaim the Dangerous Mentally Disordered Accused (DMDA) provisions contained in section 672.65. Further, some provision would need to be made for facilities to be able to assess all detained accused who might become subject to a cap for certification under the *Mental Health Act* before the proclamation of section 672.64. Alternatively, section 672.65 could be amended before proclamation so that a facility could ascertain who among the current detained accused population should be designated as dangerous mentally disordered accused regardless of the current language set out in section 672.65(2) that appears to require this designation to be sought prior to the first disposition post-verdict.

CAMH patient and survivor groups would not support the proclamation of the DMDA provisions, because they appear to restrict the *Winko* interpretation of Part XX.1.

4. THE REVIEW BOARD ABSOLUTELY DISCHARGING AN UNFIT ACCUSED

The Review Board now has the power to order an absolute discharge of an NCR accused, but not a person who has been found unfit to stand trial. This raises the possibility that some accused persons might never be released from the jurisdiction of the Review Board, even though they have been found not to be a significant threat to the public. This category of accused persons could include those who are intellectually impaired, and who are likely never to be found fit to stand trial.

The program management and treatment personnel as well as clients and survivors at CAMH support the extension of the power to award absolute discharges to Review Boards. Such an amendment recognizes that low risk and low need patients should be removed from the Part XX.1 system, freeing up resources which are more properly used for higher need and higher risk patients. The Review Board should be able to utilize its expertise in determining whether or not unfit accused persons are a danger risk or require detention. Additionally, low risk and high need patients, such as some individuals with developmental disabilities, or dually diagnosed (with both a mental disorder and a developmental disability), are often more appropriately served by community and social service agencies than a forensic mental health facility.

5. THE REVIEW BOARD ORDERING PRE-DISPOSITION ASSESSMENTS

CAMH is of the view that the Review Board should have adequate evidence before it on which to base a disposition. CAMH is also of the view that it is best practice for the hospital to provide

the Review Board with an assessment prior to a disposition review. However, the power to order an assessment prior to disposition should not be granted to the Review Board. Indeed, subsection 4(b) of the *Inquiries Act* already gives the Review Board the power to summon witnesses and require them to "produce such documents and things as the commissioners deem requisite to the full investigation of the matters into which they are appointed to examine." Increasing the power of the Review Board or a court to order CAMH to perform a function increases the burden on CAMH's resources.

Where the accused person is detained at CAMH, an assessment is inherent in any clinical review and recommendations we make for a hearing. However, where the accused person is not detained in the hospital, assessments produced by CAMH would require a new investment of resources. Without knowing the nature and extent of evidence (such as therapeutic, community, family, and vocational involvement) that the Review Board may consider satisfactory for the purposes of the assessment, it is difficult to predict the full extent of the impact this new power would have on CAMH's resources, but there is no doubt that it would be a new burden.

6. ANSWERS TO QUESTIONS POSED IN THE ISSUES PAPER

1. Are you satisfied with the courts' application of the mental disorder defence set out in section 16 of the Criminal Code, or should it be narrowed or expanded through amendments?

CAMH takes no position with respect to this question.

2. Is there a need to clarify or expand the definition and/or criteria for determining fitness to stand trial? If yes, do you have specific recommendations?

CAMH takes no position with respect to this question.

3. Although the Minister of Justice circulated draft amendments in 1993 that would have codified automatism, the defence continues to be governed by the common law. Should automatism be defined in the Criminal Code? At present, a finding of non-insane automatism requires a complete acquittal, even on the most serious of charges. Is this appropriate or should courts have the power to impose supervisory orders in some cases of non-insane automatism?

CAMH takes no position with respect to this question.

4. The Criminal Code gives Review Boards the authority to determine an accused person's fitness to stand trial. A Review Board can also order a mentally disordered accused held in custody, or it can release him or her subject to conditions. Should Review Boards also have the power to order an assessment prior to reviewing an offender's disposition? Should Review Boards have the power to discharge absolutely an unfit accused?

These issues have been addressed, above.

5. Should the capping provisions be proclaimed in force? If yes, is there a need to amend

existing mental health legislation in your jurisdiction before doing so? If the capping provisions were proclaimed in force, would it be necessary or useful to bring the Dangerous Mentally Disordered Accused provisions into force at the same time?

These issues have been addressed, above.

6. Do you know how many mentally disordered accused are currently subject to supervision orders in your jurisdiction?

This question is better answered by the Review Board.

7. Should the “hospital orders” provisions be proclaimed in force? Can you provide the Committee with information respecting the availability or adequacy of treatment for mentally disordered offenders sentenced to federal and/or provincial institutions in your jurisdiction?

From a program management perspective, CAMH takes no position with respect to hospital orders. Patients and survivors groups would support the proclamation of hospital orders.

As to the availability or adequacy of treatment for mentally disordered offenders, CAMH is aware that correctional facilities frequently are not able to adequately treat mentally disordered offenders within their facility.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.