The Effects of Inadequate Mental Health Resources on the Operation of the Mental Disorder Provisions

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THE EFFECTS OF INADEQUATE MENTAL HEALTH RESOURCES ON THE OPERATION OF THE MENTAL DISORDER PROVISIONS

by

Giuseppa Bentivegna

Submitted in partial fulfillment of the requirement for the degree of Master of Laws

at

Dalhousie University
Halifax, Nova Scotia
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ABSTRACT

In this thesis, I focus on whether adequate mental health resources exist and are available to a category of persons in the forensic mental health system – those found not criminally responsible on account of mental disorder of an offence under the mental disorder provisions, Part XX.1, of the Criminal Code. I argue that adequate mental health services which address the needs of accused persons are necessary for the proper functioning of the mental disorder provisions of the Code. I argue that these provisions were designed to foster the release and re-integration into society of persons within this system as quickly as possible. My contention is that, without access to adequate mental health resources, accused persons are being arbitrarily detained longer than they would otherwise be and that this lengthier detention is contrary to section 7 of the Canadian Charter of Rights and Freedoms. Furthermore, I argue that the equality rights of accused persons are affected because a lack of adequate mental health resources results in adverse effects discrimination. Even though Part XX.1 of the Code requires a Review Board to grant the least restrictive and least onerous disposition, this does not happen because of lack of resources within the mental health system. As a result, I question the validity of the mental disorder provisions, Part XX.1, of the Criminal Code.

To explore these issues I have divided the thesis into three chapters. In chapter 1, I trace the origins and development of the mental disorder provisions of the Criminal Code and the mental health system, and discuss the factors which have fueled the reform of the mental health system and mental disorder provisions. In chapter 2, I review the mental disorder provisions and analyze the case law to isolate the principles that have shaped the courts' view of the mental disorder system. I question whether the mental disorder provisions work in reality as they were intended by Parliament. I examine the link between treatment and release of accused persons. I discuss the impact of mental health resources on the legislative scheme of the mental disorder provisions by focusing on the mental health systems in Ontario and British Columbia. I conclude that some accused persons in Ontario and British Columbia do not have access to the mental health resources required to ensure that they receive the least onerous and least restrictive disposition or, to ensure that if such a disposition is made, it is implemented. In chapter 3, I analyze the constitutional issues raised by the effect of inadequate mental health resources on accused persons. I argue that the liberty rights of accused persons are infringed in contravention of section 7 of the Charter, as well as their equality rights under subsection 15(1), when their detention is lengthened as a result of decisions of health officials regarding the allocation of mental health resources. I also argue that these infringements of the Charter rights of accused persons cannot be justified under section 1 of the Charter. I contend that accused persons should seek a remedy under subsection 24(1) of the Charter. I suggest that the appropriate Charter remedy is a declaration that the failure to fund adequate mental health services is unconstitutional and a direction to governments to administer the mental health system, including forensic services, in a manner that is consistent with the Charter.
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INTRODUCTION

Decades of closing psychiatric beds, budget cutting and a failure to establish community supports for the mentally ill have taken their toll on society's most vulnerable. ...

'The last time the [psychiatric] hospitals were downsized was just disastrous. It created social and justice problems, but most importantly, it created a tragedy in human terms.'

In the last year in Ontario and British Columbia, media reports of the mental health system's failure have emphasized the lack of psychiatric beds and the inadequacy of community mental health resources. At the same time, governments in Ontario and British Columbia are proposing in their latest mental health reform initiatives to continue...


with the closure of psychiatric beds and with the delivery of mental health services in the community. In Ontario, the Health Services Restructuring Commission was established in 1996 and given the mandate to “make decisions about hospital restructuring, and to recommend changes to other aspects of the health care system.” As a result, the Commission has proposed the closure of five psychiatric hospitals, cutbacks in


4 This description is found in Health Services Restructuring Commission, Discussion Paper, Rebuilding Ontario’s Health System: Interim Planning Guidelines and Implementation Strategies, ibid at 5. The Health Services Restructuring Commission was established as a non-profit corporation under the Savings and Restructuring Act, 1996, S.O. 1996, c. 1. As was pointed out by G. Sharpe and D. Weissstub, in “Bill 26: Towards the Restructuring of Ontario’s Health Care System” (1996) 2 Health Law in Canada 31 at 32 that “the Commission is unique in that it has Ministerial powers under the Public Hospitals Act to change the hospital system.”

5 See supra note 3, for Lakehead Psychiatric Hospital, Health Services Restructuring Commission, Thunder Bay Health Services Restructuring Report at 9; for
psychiatric beds by the year 2003 and recommended other changes respecting mental health services, which changes are discussed in chapter 2. In British Columbia, *Revitalizing and Rebalancing British Columbia's Mental Health System: The 1998 Mental Health Plan* proposed to continue the downsizing of Riverview Hospital, the main psychiatric hospital in the province, and to focus on community mental health services, also reviewed in chapter 2.

In this thesis, I focus the discussion on whether adequate mental health resources, including forensic mental health resources, exist and are available to a category of persons in the forensic mental health system – those found not criminally responsible on account of mental disorder (NCRMD) of an offence under the mental disorder provisions, Part XX.1, of the *Criminal Code* (the *Code*). These persons require mental health resources due to their mental illness. However, the unavailability and inadequacy of mental health resources may also impinge on their liberty because of the finding of NCRMD under section 672.34 of the *Code*. An accused person is subject to a

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Brockville Psychiatric Hospital see Health Services Restructuring Commission, *Brockville Health Services Restructuring Report* at 9; for St. Thomas Psychiatric Hospital see Health Services Restructuring Commission, *Kent County Health Services Restructuring Report* at 9; for London Psychiatric Hospital Health Services Restructuring Commission, *Kent County Health Services Restructuring Report* at 9; and for Hamilton Psychiatric Hospital Health Services Restructuring Commission, *Hamilton-Wentworth Health Services Restructuring Report* at 44.

*Supra* note 3.

Part XX.1 was added to the *Criminal Code* by S.C. 1991, c.43 and proclaimed in force on February 4, 1992, except for sections 672.64, 672.65 and 672.66.

The term “accused” is defined in section 672.1 of the *Code* as including “a defendant in summary conviction proceedings and an accused in respect of whom a
disposition hearing, under section 672.45 of the Code by the court that rendered the
verdict of NCRMD or where the court does not make a disposition, under section 672.47
by a Review Board.⁹ Even where a court, following a disposition hearing, has made a
disposition regarding an accused person, a Review Board must, within 90 days of the
disposition of the court, hold a hearing and make a new disposition. The only exception
is where the court grants an absolute discharge under section 672.54 of the Code. Where
the court or a Review Board does not grant an absolute discharge, the accused person is
either detained in a hospital¹⁰ or given a conditional discharge. The conditions generally
place that person under the supervision of a hospital. Very few accused persons who are
found NCRMD receive an absolute discharge on an initial disposition.¹¹ Section 672.81
of the Code requires a Review Board to conduct an annual review for each accused

verdict of not criminally responsible is rendered.” I prefer the term “accused person”
which recognizes the person as a whole rather than just their legal status.

⁹Defined in section 672.1 and established under section 672.38 of the Code.

¹⁰Definition of “hospital” in 672.1 of the Code refers to a place in a province
designated by the Minister of Health of that province for the custody, treatment or
assessment of an accused person.

¹¹A definite number is difficult to ascertain because no statistics are available
regarding number of absolute discharges granted by the court or a Review Board on an
initial hearing. I base my statement on the study done by I. Grant who found that
“absolute discharges are rare in the context of initial dispositions. Of the 112 cases, only
one person was granted an absolute discharge” in I. Grant, “Canada’s New Mental
well, seeing the growth in the number of accused persons under the jurisdiction of the
Ontario Review Board from 426 to 754 and British Columbia Review Board from 125 to
306 from 1992 to 1997, one can postulate that one of the reasons for the growth is that
not many absolute discharges are being granted by these Boards on initial dispositions.
person which results in a new disposition. An accused person remains under the jurisdiction of a Review Board and her or his liberty is restricted to varying degrees until the Review Board grants an absolute discharge. Therefore, the mental health system and criminal law are inextricably intertwined in situations where the mental disorder provisions of the Code are invoked.

I argue that adequate mental health services which address the needs of accused persons are necessary for the functioning of the mental disorder provisions of the Code. Therefore, if the mental health system does not fund the services required by accused persons, the mental disorder provisions cannot function as intended. I argue that these provisions were designed to foster the release and re-integration into society of persons within this system as quickly as possible. My contention is that, without access to adequate mental health resources, accused persons are being arbitrarily detained longer

12These issues cannot be discussed in theory alone; concrete examples on which to base my arguments were necessary. Therefore, I chose to focus on the mental health system in British Columbia and in Ontario and its impact on accused persons for the following reasons. These provinces are currently actively pursuing mental health reform which has brought issues of the adequacy of mental health resources to the fore. In my view, the problems arising from the de-institutionalization of persons with mental disabilities chronicled in the various mental health reform initiatives in these provinces are representative of those across the country. Psychiatric bed(s) closures have taken place in all provinces since the 1980s. However, governments have not provided adequate community mental health resources. Therefore, to varying degrees, accused persons in other provinces and territories face similar problems of availability of mental health resources to those described in Ontario and British Columbia. In addition, the accused persons in these provinces have challenged the mental disorder provisions and appealed decisions of the respective Review Boards which has resulted in a number of decisions at the Court of Appeal level. Furthermore, both the chairperson of Ontario Review Board, Mr. Justice D.H. Carruthers and the chairperson of the British Columbia Review Board, Mr. Bernd Walters and staff of these Boards and the officials within the forensic system and within the respective Ministries of Health extended their cooperation to me.
than they would otherwise be, since their detention under the mental disorder provisions is indeterminate,\textsuperscript{13} and that this lengthier detention is contrary to section 7 of the \textit{Canadian Charter of Rights and Freedoms} (the \textit{Charter}).\textsuperscript{14} Furthermore, I argue that the equality rights\textsuperscript{15} of accused persons are affected because a lack of adequate mental health resources results in adverse effects discrimination. Even though Part XX.1 of the \textit{Code} requires a Review Board to grant the least restrictive and least onerous disposition, this may not happen because of lack of resources within the mental health system.\textsuperscript{16} As a result, I question the validity of the mental disorder provisions, Part XX.1, of the \textit{Criminal Code}.

I believe that the current mental disorder provisions of the \textit{Code} are premised on the availability of mental health resources, as evidenced by the requirement that if an accused person is to be detained in custody under paragraph 672.54 (c) of the \textit{Code} it

\textsuperscript{13}Section 672.64 of the \textit{Criminal Code} which sets a maximum period of detention for accused persons based on the offence for which they were charged has not been proclaimed in force.

\textsuperscript{14}Part I of the \textit{Constitution Act, 1982}, being Schedule B of the \textit{Canada Act 1982} (U.K.), 1982, c.11. Section 7 of the \textit{Charter} states “Everyone has a right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”

\textsuperscript{15}Subsection 15(1) states: “Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.”

\textsuperscript{16}For example the Court of Appeal of Ontario in \textit{Brockville Psychiatric Hospital v. McGillis} (1996) 2 C.R. (5th) 242 (Ont.C.A.) held that if the necessary resources are not available in the community then the Review Board must detain the accused person in a hospital.
must be in a hospital. Though treatment cannot be ordered under the mental disorder provisions, at least the chances of an accused person being treated are greater if she or he is in an appropriate setting. The Court of Appeal of Ontario in R. v. Lepage reiterated the importance of treatment in determining whether that person represents a significant threat to the safety of the public. The Court stated

The significance of the accused person’s mental condition to that determination will depend on many variables, including the nature of the mental disorder, if any, from which the accused person suffers at the time of inquiry, the available treatment, the accused person’s understanding of his mental condition, and the accused person’s willingness to conform to any proposed course of treatment.

Without available treatment and other mental health resources, the mental condition of an accused person is not likely to improve, and without such improvement, a Review Board is unlikely to be convinced that the accused person poses no significant threat to

17 As will be discussed in the following chapters, the mental disorder provisions (previously referred to as the insanity provisions) were enacted so that persons suffering from mental disorders who as a result of the mental disorder committed a crime would not be punished but treated. This rationale was first espoused in the Criminal Lunatics Act, (U.K.), 1800, c. 94, and reaffirmed in R. v. Swain, [1991] 1 S.C.R. 933, and in a number of Court of Appeal cases regarding the legislative scheme of the current mental disorder provisions, such as Winko v. British Columbia (Forensic Psychiatric Institute), (1996) 112 C.C.C. (3d) 31 (British Columbia.C.A.); and R. v. Lepage (1997) 152 D.L.R. (4th) 318 (Ont.C.A).

18 See section 672.55 of the Code.

19 R. v. Lepage, supra note 17.

20 Ibid at 38.

21 A Review Board in making a disposition under section 672.54 of the Code has to consider the mental condition of an accused person, the need to protect the public from dangerous persons, the re-integration of the accused and any other need of an accused person.
the safety of the public. The Board is therefore unlikely to grant an absolute discharge. Furthermore, if there is a lack of psychiatric beds for accused persons, they are likely to be detained in jail, as has happened in Ontario. In addition, a number of accused persons have had to wait lengthy periods before mental health services or the appropriate psychiatric bed became available. This has resulted in a lengthening of their detention. Such a situation is contrary to the explicit philosophy that these persons should not be punished, but helped by society.

Concerns over lack of adequate community mental health resources and the impact of psychiatric beds closures have been expressed time and time again by mental health consumers and families, advocates, and mental health professionals, since the 1980s, when the first wave of mental health reform swept the country. They all argue that the current mental health system is “significantly underfunded” and express concerns

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22 As was the case in Ontario in the last few years as commented on by the Chairperson of the Ontario Review Board, D.H. Carruthers, in “Pinet and McGillis and the Cutsbacks: Some Views, Comments, and Opinions on How They Affect The Ontario Review Board,” April 28, 1997, (unpublished) and noted in a number of articles of T. Boyle, “More hospital beds urged for mentally ill offenders: Bid to address ‘illegal jailing of patients’” The Toronto Star, April 28, 1998 at A6; “Beds to open for jailed mental patients: Queen Street Centre to house patients jailed illegally” The Toronto Star, March 3, 1998 at B1; “Legal bid brings beds for 6 mental patients: All in jail because psychiatric hospital is full” The Toronto Star, February 26, 1998 at A24; “Jailing mentally ill accused illegal: Lawyer Accused should be in hospital, but no beds available” The Toronto Star, February 24, 1998 at A5.


24 See Health Services Restructuring Commission, Change and Transition: Planning Guidelines and Implementation Strategies for Home Care, Long term Care, Mental Health, Rehabilitation, and Sub-acute Care, supra note 3 at 51.
that the community mental health system is not equipped to handle the additional strain placed upon it if more psychiatric beds are closed. Furthermore, as will be discussed in

The following are examples of concerns expressed about the mental health system in Ontario: “Timely and effective diagnosis and treatment of schizophrenia under mental health reform is primarily an issue of resources... We have learned through bitter experience that the system often fails persons with schizophrenia... If this is true before reform, before the transfer of resources from institutions to the community, I suggest that after reform, the situation will be much worse, unless resource deployment follows need.” S. Volpatti, President, Ontario Friends of Schizophrenics, in “Mental Health and Restructuring: The Perspective of Patients” (1997) 4 Health Law in Canada 119 at 121; “Who has the authority to decide on the delicate balance between shifting resources and making more effective use of existing resources to ensure an adequacy of services and supports along each point in the service continuum? We know that either way this will require a rapid development of community services, especially if hospitals are expected to reach their bed targets in the face of decreasing budgets.” C. Roup, Director, Operational Planning, Metropolitan Toronto District Health Council in “The Perspective of a District Health Council” (1997) 4 Health Law in Canada 111 at 112; “What’s especially worrisome is the province’s Health Services Restructuring Commission has recommended closing five of Ontario’s 10 psychiatric hospitals by 2003 and almost 2,000 of the province’s remaining 5,282 mental health beds. Community services aren’t in place to pick up the slack and, at the current pace of change, they won’t be.” S. Lurie, Executive Director, Canadian Mental Health Association, Toronto Branch to T. Boyle and D. Vincent, “Madness: First of seven parts on how we’re failing the mentally ill,” supra note 2 at 7; “These people [homeless persons with mental disabilities] do not receive ‘care within the community’ whatever that phrase was intended to imply in the 1970s when it was first mooted- but have instead been dumped unceremoniously onto the streets and left to fend for themselves, wandering from program to program and temporary roof to roof, the client of many services but the ultimate responsibility of none.” Report of a Coalition of Neighborhood Groups cited in Editorial, “Have we abandoned the mentally ill?,” supra note 2; in British Columbia “...access to regional beds is extremely difficult. Reliance on ‘squeaky wheel’ access is not conducive to effective care and places all involved at risk.” L. Coles, CEO, Kitimat General Hospital, cited in Adult Mental Health Division, Ministry of Health and Ministry Responsible for Seniors, Revitalizing and Rebalancing British Columbia’s Mental Health System: The 1998 Mental Health Plan, supra note 3 at 30; “To me, all this stuff [the 1998 British Columbia Mental Health Plan] is kind of like the cheque’s in the mail’ said Ms. Duncan [director of British Columbia Schizophrenia Society], who argued that mental illness is vastly underfunded relative to disorders that are physically disabling,” in C. McInnes, Victoria correspondent “How the system failed a troubled mind: Case of a schizophrenic who killed his mother highlights cracks in mental-health care,” supra note 2; “Why not first improve the services for the mentally ill- access to housing, jobs, case managers, new medications? My fear is that
chapter 2, persons with serious mental illnesses have been underserved within the mental health system. Unless governments provide additional funding to community mental health programs and services and supports to persons with serious mental illnesses so that a continuum of services exists, the necessary mental health resources that these persons require will not be available. Mental health consumers and their families, advocates, and mental health professionals have argued that more community services need to be in place, prior to any further psychiatric bed cuts. The Health Services Restructuring Commission reiterates these concerns, which are also reflected in the 1998 British

it's easier to introduce these changes [compulsory treatment orders under Mental Health Act] than to guarantee services” B. Gutray, Executive Director, The Canadian Mental Health Association, British Columbia Division cited in M. Jimenez, “New Bill Governing Mentally Ill Stirs Fears” The Vancouver Sun, June 16, 1998 at A8.

This is exemplified in Adult Mental Health Division, Ministry of Health and Ministry Responsible for Seniors, Revitalizing and Rebalancing British Columbia’s Mental Health System: The 1998 Mental Health Plan, supra note 3 at 15 which emphasizes that the seriously mentally ill will in future receive the highest priority in the allocation of mental health funding because “people with the most disabling mental illness have not always received priority in services.” A similar statement can be found in Ontario’s Ministry of Health, Putting People First: The Reform of Mental Health in Ontario (Toronto: Queen’s Printer for Ontario, 1993) at 15. Another example is the comment of Dr. J. Hamilton, chair of the OMA Section on Psychiatry, that “the seriously mentally ill are under-served because there are insufficient incentives to encourage psychiatrists to see them.” in T. Boyle and D. Vincent, “Madness: Seven parts on how we’re failing the mentally ill,” The Toronto Star, January 12, 1998, supra note 1 at 8. A study in the early 1990's noted that “[p]eople with severe mental illnesses have traditionally been cared for in provincial psychiatric hospitals, and it is these people who have been the most disadvantaged by deinstitutionalization. They are the most disabled by of all psychiatric patients, yet they receive the least effective treatment and care.” D. Wasylenki, P. Goering, Eric MacNaughton, “Planning Mental Health Services: I. Background and Key Issues” (1992) 3 Can. J. Psychiatry 199 at 201.
Columbia Mental Health Plan. Additional concerns have been voiced by different stakeholders regarding the reform of forensic services, in particular regarding the need for increased access to both inpatient and community-based services. Forensic services target persons with mental disorders who come into conflict with the law who are governed by the mental disorder provisions, Part XX.1 of the Code; or who are in need of mental health services while serving a sentence in a correctional facility. Therefore.

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28 For a discussion of these concerns see Health Services Restructuring Commission, Change and Transition: Planning Guidelines and Implementation Strategies for Home Care, Long term Care, Mental Health, Rehabilitation, and Sub-acute Care, supra note 3 at 55; and in Adult Mental Health Division, Ministry of Health and Ministry Responsible for Seniors, Revitalizing and Rebalancing British Columbia’s Mental Health System: The 1998 Mental Health Plan, supra note 3 at 24. For additional discussion on the Ontario situation see D.H. Carruthers, “Pinet and McGillis and the Cutbacks: Some Views, Comments, and Opinions on How They Affect The Ontario Review Board,” supra note 22.

29 Some have argued that insufficient mental health resources have driven persons with mental disabilities into the criminal justice. For example see C. Milstone, The Mentally Ill and the Criminal Justice System: Innovative Community-Based Programs 1995 (Ottawa: Minister of Supply and Services Canada, 1995) at 13-16. Other examples are the following comments of: Judge L. Marshall of the Ontario Provincial Court who stated regarding the current mental health system in Ontario “We have tied the hands of families, police and the medical community, who can’t do anything until disaster strikes. Serious mental health issues are then dealt with in the criminal justice system, which wasn’t set up to deal with them.” in T. Boyle and D. Vincent, “Madness: First of seven parts on how we’re failing the mentally ill,” The Toronto Star, January 10, 1998, supra note 1 at 4; Dr. S. Malcolmson, Forensic Director, Queen Street Mental Health Centre who stated “[t]he Criminal Code has become the Mental Health Act of the 1990s.” in M.
these persons are affected both by inadequate mental health services in general and lack of forensic services in particular. As well, persons in the forensic mental health system have had problems accessing services in the mainstream mental health system.\textsuperscript{30}

In chapter 1, I examine the legal philosophy and developments that have shaped the present mental disorder provisions and argue that the mental disorder system is meant to be a more humane and compassionate system for accused persons. First, I discuss the origins of the mental health system and the first legislation respecting the detention of accused persons in the 19\textsuperscript{th} century. I analyze the factors that animated the establishment of the "lunatic asylum" and the failure of this institution. Then, I discuss the developments that led to the transition from asylum to mental hospital and, finally, I address the impact of deinstitutionalization in the 20\textsuperscript{th} century. Furthermore, I argue that changes during this century, the trends in criminal law, the civil rights movements, and the adoption of the \textit{Charter} have influenced the movement to reform the mental disorder provisions. I contend that these events created a societal climate more receptive to

\textsuperscript{30}As noted in the most recent documents on mental health reform, one goal is to integrate forensic services into mainstream mental health services so that persons with mental disorders in the forensic system may access mainstream mental health services. See Health Services Restructuring Commission, Discussion Paper, \textit{Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies}, supra note 3 at 56; and Adult Mental Health Division, Ministry of Health and Ministry Responsible for Seniors, \textit{Revitalizing and Rebalancing British Columbia's Mental Health System: The 1998 Mental Health Plan}, supra note 3 at 24.
inclusion of persons with mental disabilities in the community and to the beginnings of recognizing their rights.

In Chapter 2, I review the mental disorder provisions and analyze the case law to isolate the principles that have shaped the courts' view of the mental disorder system. This chapter questions whether the mental disorder provisions work in reality as they were envisioned by the Supreme Court in \textit{R. v. Swain} and as described by the Courts of Appeal in different provinces. I examine the link between treatment and release of accused persons. I discuss the impact of mental health resources on the legislative scheme of the mental disorder provisions. Then, I focus on the mental health systems in Ontario and British Columbia and survey previous and current strategies for mental health reform in these provinces. I utilize the reports of the Health Services Restructuring Commission in Ontario regarding mental health resources and the 1998 Mental Health Plan for British Columbia to demonstrate the need for more community mental health services that respond to the needs of accused persons. I discuss the problems encountered by accused persons and the impact on their liberty. I also look at the impact of inadequate mental health resources on the jurisdiction of the Review Boards and the ability of persons in charge of hospitals to carry out the orders of the Review Board. I assess the implications of the Court of Appeal decisions in \textit{Brockville Psychiatric Hospital v. McGillis} and \textit{R.}

\footnote{\textit{Swain}, \textit{supra} note 17.}

\footnote{See \textit{supra} note 3 for the listing of these reports.}

\footnote{\textit{Supra} note 3.}

\footnote{\textit{Supra} note 16.}
v. Pinet, involving mental health resources issues. I conclude that some accused persons in Ontario and British Columbia do not have access to the mental health resources required to ensure that they receive the least onerous and least restrictive disposition— or, to ensure that such a disposition, if made, is implemented.

In researching chapter 2, I attempted to gather data from the different stakeholders in the administration of the mental disorder provisions in Ontario and British Columbia. I prepared and sent out surveys to the Chairperson of each Review Board and the directors of mental health programs to determine the effects that the current level of mental health resources had on accused persons, on the implementation of disposition orders, and on compliance with the mental disorder provisions. Although the Chairpersons and the staff at the Ontario Review Board and British Columbia Review Board and the Clinical Director of the British Columbia Forensic Psychiatric Institute extended their full cooperation, it became evident that no statistics were available on the implementation of dispositions, or the problems arising from lack of enforcement of these orders as they relate to the availability of mental health resources. The Ministries of Health in British Columbia and Ontario do not appear to gather statistics on these issues. Therefore, I was unable to obtain the exact number of accused persons whose liberty was restricted or detention lengthened each year due to inadequate mental health resources. However, I was able to gather anecdotal evidence of Review Boards not granting the least onerous or least restrictive dispositions or dispositions not being implemented due to inadequate

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mental health resources.\textsuperscript{36}

I begin chapter 3, by analyzing the constitutional issues raised by the effect of inadequate mental health resources on accused persons. Then, I discuss the application of the Charter to decisions on allocation of mental health resources and the jurisdictional issues that an attack on allocation decisions raises.

I advance the argument that the liberty rights of accused persons are infringed in contravention of section 7 of the Charter when their detention is lengthened as a result of decisions of health officials regarding the allocation of mental health resources and the delivery of mental health services. I also argue that despite the deferential approach

\textsuperscript{36}I was able to obtain a copy of a paper prepared by the Chairperson of the Ontario Review Board, D.H. Carruthers, "Pinet and McGillis and the cutbacks: Some Views, Comments, and Opinions on How They Affect The Ontario Review Board," supra note 22, unreported decisions of the British Columbia Review Board outlining concerns regarding lack of community resources, see In the Matter of Robert Allen Mitchell, Reasons for Disposition, British Columbia Review Board, dated March 15, 1998 (unreported) and In the Matter of Anthony Florence, Reasons for Disposition, British Columbia Review Board, dated May 31, 1998 (unreported), a background document prepared by the Institutional Health and Community Services, Mental Health Programs and Services, Ministry of Health of Ontario, Backgrounder: The Provincial Forensic System, dated April 1997 (unpublished) and a briefing note prepared by the Ministry of Health and Ministry Responsible for Seniors, "Briefing Document: Reaction of the Criminal Justice System to a Delay in admissions Caused by a Backlog at the Forensic Psychiatric Institute" dated April 21, 1997 (unpublished). In addition, I had a number of discussions with the Chairpersons of the Ontario and British Columbia Review Boards regarding the issue of adequacy and availability of mental health resources for accused persons. Other information was gathered from the various reports of the Health Services Restructuring Commission, in particular, Change and Transition: Planning Guidelines and Implementation Strategies for Home Care, Long Term Care, Mental Health, rehabilitation, and Sub-acute Care, supra note 3, and Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies, supra note 3, from the mental health plan prepared by the Adult Mental Health Division, Ministry of Health and Ministry Responsible for Seniors, Revitalizing and Rebalancing British Columbia's Mental Health System: the 1998 Mental Health Plan, supra note 3 and from other articles referred to in chapter 2.
adopted by the Supreme Court of Canada towards the state on issues of social programs and allocation of resources and benefits, this infringement of liberty interests of accused persons cannot be justified under section 1 of the Charter.

Then, I argue that the equality rights of accused persons are adversely affected by the lack of adequate mental health resources. Allocation decisions regarding mental health resources result in a discriminatory effect on accused persons on the basis of their mental disability which is the reason that they are under the jurisdiction of the mental disorder provisions of the Code. Under these provisions, accused persons must rely on the mental health system to provide the necessary mental health resources to treat their mental disabilities to gain their freedom. Otherwise, they will be unable to do so. As well, I contend that these persons have difficulty accessing mental health services because they suffer greater stigma and discrimination as a group because they are persons with mental disabilities who receive forensic services. These accused persons are stereotyped as more violent and dangerous than those in the mainstream mental health system. I contend that the infringement of the equality rights of accused persons cannot be justified under section 1 of the Charter. I base my Charter arguments on the Supreme Court of Canada decisions in Eldridge and Vriend, as well as other equality cases.

Since I argue that the infringement of the Charter rights and freedoms of accused

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37 This term refers to the specialized service within the mental health system serving those persons who suffer from a mental disorder and are in the criminal justice system, including the correctional system.

persons results from the allocation decisions on mental health resources, I conclude that accused persons should seek a remedy under subsection 24(1) of the Charter. I suggest that the appropriate Charter remedy is a declaration that the failure to fund adequate mental health services is unconstitutional. Furthermore, accused persons would seek a direction to governments to administer the mental health program, including forensic services, in a manner that is consistent with the Charter. In support of my argument I cite the Eldridge case. 39

In conclusion, I suggest that the governments should provide funding to ensure accused persons access to adequate mental health services. I suggest accelerating current mental health reform initiatives in Ontario and British Columbia 40 which are aimed at increasing community mental health services. Furthermore, I discuss the principles recommended in Best Practices In Mental Health Reform 41 and in A Provincial Strategy To Coordinate Human Services and Criminal Justice Systems In Ontario 42 which suggest strategies for the provisions of community mental health services and devising a system aimed at supporting persons with mental disabilities in the community. The spirit and

39 Ibid.

40 Supra note 3.


42 Human Services and Justice Coordination Project, A Provincial Strategy To Coordinate Human Services and Criminal Justice systems in Ontario (Toronto: Queen’s Printer for Ontario, 1997).
intent of the mental disorder provisions would be respected if mental health resources were available to keep an accused person in the community or, if detention in custody was required, to integrate the accused person into the community as quickly as possible.
Chapter 1

The Factors that Shaped the Mental Disorder Provisions

In this chapter, I trace the origins and development of the mental disorder provisions of the *Criminal Code*. Through these provisions the criminal justice system and the mental health system are linked and interdependent.\(^\text{43}\) I examine historical developments in the mental health system and the factors which fueled the changes in various periods, as well as those which fostered reform of the criminal justice system, particularly in the mental disorder provisions. These trends must be discussed in light of societal changes and changing attitudes towards persons with mental disabilities, as well as the shifts in philosophy regarding the management and provision of services to persons with mental disabilities. In addition, I discuss parallel shifts in the criminal justice system. I contend that reforms both in the mental health system and to the mental disorder provisions have been animated by the desire to provide humane and compassionate treatment to persons with mental disabilities and to ensure that accused persons receive care and treatment rather than punishment.\(^\text{44}\)


\(^\text{44}\)See *R. v. Hadfield* (1800) 27 St.Tr. 1281 at 1354 & 1355; A. Scull, *Museums of Madness* (New York: St. Martin’s Press, 1979) at 55-124, in which the author describes lunacy reform and moral treatment which in my view grew out of concern for the plight of insane persons. Though he criticizes the motives of the reformers and posits that economic factors fueled this reform, as pointed out by V. Skultans in *English Madness*: 
Part 1: The Nineteenth Century

During this period, English society was moving from an agrarian society to an urban-industrial one and "the advent of a mature market economy" resulted in changes in the economic and social order. The hierarchically organized rural society was replaced with an urban "one based on class." As explained by Scull

The market when given its head destroyed the traditional links between rich and poor which had characterized the old order. The 'great transformation' wrought by the advent of a thoroughly market-oriented society sharply reduced the capacity of the lower orders to cope with economic reverses.

In addition, the population increased rapidly during this period. These profound changes led to new problems of "poverty and dependence in an urban environment" which was reflected in the increase in the numbers of persons that were receiving poor relief. Some authors have suggested that there was an increasing public awareness of the plight of persons with mental disabilities (referred to as lunatics or the mad or the

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45 A. Scull, Museums of Madness, supra note 44 at 30.

46 Ibid at 32.

47 Ibid at 33.

48 Ibid at 34.

49 Ibid at 27 and 35-36.
insane) and their plight, stemming from the belief that the reigning monarch, George III was insane. As argued by various authors, at this time there was a shift in the concept of madness and how persons with mental disabilities should be managed. Previously madness was attributed to demonological possession and non-human animalistic qualities were attributed to the mad. In the nineteenth century, madness was seen as a human defect which could be remedied. It was against this societal backdrop that the asylum system and the Criminal Lunatics Act, 1800 and other legislation pertaining to accused persons developed.

A. 1800-1850: Beginnings of a mental health system and the origins of the mental disorder provisions (formerly known as the insanity provisions) in England and Upper Canada

a) The rise of the lunatic asylum

In the first half of the nineteenth century, in England, persons with mental disabilities were generally detained in so-called madhouses. These were private, profit-

50 The public concern over the mental condition of George III arose out of two parliamentary inquiries into his condition in 1788 and 1790. See V. Skultans in English Madness: Ideas on Insanity, 1580-1890, supra note 44 at 10; and D. Robinson, Wild Beasts & Idle Humours: The Insanity Defense From Antiquity to the Present, supra note 44 at 140.

51 See V. Skultans in English Madness: Ideas on Insanity, 1580-1890, supra note 44 at 11; D. Robinson, Wild Beasts & Idle Humours: The Insanity Defense From Antiquity to the Present, supra note 44 at 147-182; and A. Scull, Museums of Madness, supra note 44 at 43 & 76-119.

52 There are differing views regarding whether this period ushered in the era of institutionalization of persons with mental disabilities in hospitals or lunatic asylums and on the reasons for this. See A. Scull, Museums of Madness, supra note 44 and V. Skultans, English Madness: Ideas on Insanity, 1580-1890, supra note 44. According to Scull, prior to the nineteenth century, persons with mental disabilities were "assimilated into the much larger, more amorphous class of morally disreputable, the poor, and the
making establishments. The upkeep of persons with mental disabilities who were paupers was paid by the parish. To turn a profit, the owners of these madhouses would

impotent, a group which included vagrants, minor criminals, and the physically handicapped.” Persons with mental disorder were not segregated from the rest of society and were for the most part residing in the community, at 13-14. However, according to Skultans, “institutional care for the insane was provided on a wide scale throughout the eighteenth century. There were many private hospitals for both private and pauper lunatics. General hospitals too contained wings for the insane...” at 10. These authors differ as well on the reasons which underlie the expansion of the “mad houses and asylums”. According to Scull, the economic and social structure of English society in the nineteenth century was responsible for the advent of these asylums. He argued that “[t]he changing structure of the English economy from the late eighteenth century onwards undermined and destroyed the old order.” at 31 & 32. A shift from an agrarian economy to a market based one and a rapid growth in population, led to an institutional system because “[a]mong the lower classes in this period, family members unable to contribute effectively towards their own maintenance must have constituted a serious drain on family resources... ‘The aged and children became a greater burden’, as of course did the insane. Consequently, while the family-based system of caring for the insane and other types of deviants may have never worked especially well, one suspects that by the turn of the century it was likely to have been functioning particularly badly.” at 34.

Skultans relates the rise of the public asylum to the call for uniformity in institutional care which stemmed from the growing public concern with “the plight of the insane” resulting from parliamentary inquiries into the mental condition of King George III and parliamentary reports on the conditions of the private mad houses and pauper lunatic asylums. She emphasizes the importance of the theory of moral management of persons with mental disorders and the optimism about insanity and its cure fueled lunacy reform.

As noted by R. Smandych & S. Verdun Jones, The Emergence of the Asylum in 19th Century Ontario, in N. Boyd, ed. The Social Dimensions of Law (Scarborough, Ontario. Prentice-Hall Canada Inc., 1986) at 167-168, the last few decades have produced a number of histories on the development in the nineteenth century of the asylum, “however, academics have yet to produce a coherent body of knowledge to which interested academics might refer in their search for an informative understanding of the process of institutional reform.” The more conventional, liberal perspective on the emergence of the asylum was that it resulted from the “humanitarian reform efforts of early psychiatrists and lay-reformers, whose primary concern was with ‘uplifting the mass of suffering humanity.” This perspective emphasizes that the asylum was first and foremost a place of medical care and treatment and had nothing to do with the development of penitentiaries and workhouses. This perspective was criticized by Scull.
take in as many clients as possible since there was little legal control over the admission to or the conduct of madhouses. The conditions in the early nineteenth century madhouses for criminal and pauper lunatics were marked by barbarity and neglect. These conditions were exposed in the Report of the Select Committee on Madhouses, 1815. The argument made by Scull that the emergence of the moral outrage over these inhuman conditions related to the transformation of the concept of madness is persuasive. He states:

In seventeenth -and-eighteenth century practice, the madman in confinement was treated no better than a beast; for that was precisely what, according to the paradigm of insanity, he was. In becoming crazy, the lunatic had lost the essence of his humanity, his reason.

... It was this world view which the nineteenth-century reformers, and indeed, society as a whole, were in the process of abandoning. ... For them, the lunatic was no longer an animal, stripped of all remnants of humanity. On the contrary, he remained in essence a man; a man lacking in self-restraint and order, but a man for all that. Moreover, the qualities he lacked might and must be restored to him, so that he could once more function as a sober, rational citizen.

The public outcry over the conditions in madhouses fueled the lunacy reform movement. These reformers were upper class gentlemen interested in social reform of all

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53 A. Scull, Museums of Madeness, supra note 44 at 51.

54 See M. Kingma, Mental Health Law: A Critique of the 'Dangerousness' Criterion For Civil Commitment and some Recommendations For Change, LL M Thesis (Faculty of Law, Dalhousie University, 1995) [unpublished] at 124 and A. Scull, Museums of Madness, supra note 44 at 79-82. As a result of the Report, the English Parliament adopted An Act for the better Care and Maintenance of Lunatics, being Paupers or Criminals (1808) 48 Geo III c. 96 to govern the maintenance and administration of lunatic asylums though this statute did not make it mandatory for a county to erect an asylum.

55 A. Scull, Museums of Madness, supra note 44 at 64 & 65.
types, as well as local magistrates, and belonged to either the Evangelical or Bentham schools of social reform. As argued by Scull, the "final shape of lunacy legislation in England clearly owes much to the Evangelicals' humanitarianism and paternalism, and to the Benthamite emphasis on expertise and efficiency." The lunacy reformers advocated an institutional approach to restore sanity and the use of "moral treatment".

The moral approach to treatment of mental disability emphasized the minimization of external, physical coercion or restraint on persons with mental disabilities. It focused instead on placing the insane in comfortable surroundings in pastoral settings and on re-educating them regarding self-discipline through kindness and consideration. The proponents of this approach argued that the moral treatment had to be delivered in an asylum. However, the reformers' views were not widespread in the early half of the nineteenth century. It took another report in 1827 detailing the appalling and inhuman conditions in which the paupers who allegedly had a mental disability were

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56 The Evangelical lunacy reformers proselytized about the advantages of discipline and regularity over disorder and vice. They believed that they had a religious mission to rescue the lower classes from sin and social degradation which threatened them. They deplored the treatment of the insane as well as the immorality of the slave trade and cruelty to children and animals. The Benthamite lunacy reformers espoused the need for a 'science of government'—a centralized professional administration. They adopted a type of cost-benefit analysis, the principle of utility, by which to make rational decisions between alternative courses of action that would bring the greatest happiness to the largest number of people. Then the administrators would implement these decisions in an efficient and uniform manner. For a detailed explanation of these movements as they relate to lunacy reform see A. Scull, Museums of Madness, supra note 44 at 56-59.

57 A. Scull, Museums of Madness, supra note 44 at 56.

58 For a more detailed discussion of the moral treatment see A. Scull, Museums of Madness, supra note 44 at 67-70.
kept before a system of publicly funded asylums was made compulsory in 1845 by the 
*Lunatics Act* and a permanent national Lunacy Commission was established to inspect 
all types of asylums under another *Lunatics Act*. 

The asylums which were established under this legislation reflected a more 
medicalized view of madness than that advanced by the proponents of the moral 
treatment approach. Treatises on the medical nature of insanity had begun to 
emphasize that it was not curable without the aid of medicine; this “convinced almost all 
of the educated classes that insanity was indeed a disease and its treatment ought to be 
entrusted to doctors.” As a result of this effort by the ‘mad-doctors’, the 
administration of the asylums was eventually placed in the hands of doctors. The 
*Madhouses Act* of 1828 introduced the first legal requirement that each asylum have a 
doctor visit the patients at least once a week and sign a register, and that an asylum which

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59 The Report of the Select Committee on Pauper Lunatics in Middlesex as cited in 

60 (U.K.), 1845, c. 100.

61 (U.K.), 1845, c. 126.


63 A. Scull, *Museums of Madness*, supra note 44 at 158. However, Scull argued 
that the claims advanced by the “mad-doctors” about insanity as a disease and the 
expertise of these doctors in treating insane persons were false. He criticized the view 
that the link between medicine and insanity was the outcome of the advance of science 
and human understanding.

64 This term is used by A. Scull, *Museums of Madness*, supra note 44 to describe 
the doctors that worked in the asylums.

65 (U.K.), 1828, c. 34.
housed more than 100 patients had to employ a medical superintendent. The *Lunatics* Act of 1845 required that asylums keep a record of medical visitations and the medical treatment of each patient.

**b) Rise of the lunatic asylum in Upper Canada**

A similar history of the rise of the asylum in nineteenth century Upper Canada is chronicled by Smandych and Verdun-Jones.66

As is the case of the development of the public asylum in England described by Scull, there also occurred a dramatic shift in the social response to insanity in the nineteenth century. ... Scull points to another development which seems to have occurred in both England and Upper Canada, - namely the redefinition of madness as a 'uniquely and essentially medical problem,' and the consequent handing over of the insane to the emerging profession of psychiatry.67

Up to the 1830s the “dangerous” insane persons were confined in district jails along with criminals and debtors. In this decade, the sheriffs in charge of district jails began to complain in reports to the provincial government about the jailing of insane persons in ill-equipped jails and to lobby for the creation of a lunatic asylum.68 Since this lobby was supported by politicians and magistrates, the government appointed in 1831 a select committee to inquire into the best method of establishing a lunatic asylum in the province. In its report, this committee argued that the provision of a special institution


67 *Ibid* at 178.

for insane persons would have curative powers and ensuing economic benefit for the community. The report stated

A proportion amounting to ninety percent of recent cases has been cured in some insane hospitals of the United States ... but to render the treatment of insanity thus successful the patients must be entirely separated from their friends and from all objects with which they are familiar. This can only be effected by placing them in institutions for that purpose and entirely under the control of strangers.

...[H]ow gratifying is the thought that the modern practice of the treatment of the insane, renders the recent cases as easily cured, when properly treated, as the ordinary diseases of the climate, and with less expense...  

A temporary lunatic asylum was established in 1841 in Toronto for all persons with mental disabilities and in 1853 the newly constructed Toronto Asylum opened its doors.  

c) Criminal Lunatics Act, 1800

Prior to 1800, the law respecting the disposition of persons found not guilty of a crime because they were under the influence of insanity at the time the act was committed was unclear, as noted by Lord Kenyon in R. v. Hadfield. Even though the Attorney General in this case advised Lord Kenyon that “it is laid down in some of the books, that by the common-law judges of every court are competent to direct the confinement [to a

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71R. v. Hadfield, supra note 44. See as well, M. Kingma, Mental Health Law: A Critique of the ‘Dangerousness’ Criterion For Civil Commitment and some Recommendations For Change, supra note 54 at 88.
jail, hospital or asylum] of a person under such circumstances [insanity]." Lord Kenyon was not convinced that this was the state of the law:

A case is put into my hand of a person tried for felony, who, appearing to the Court to be mad and dangerous to society, was ordered to be removed to a proper place of confinement. I do not think that is the thing to be done here; I apprehend he should be at present confined, till properly disposed of."

Lord Kenyon determined that he had to remand Mr. Hadfield back to jail where he had been detained prior to the trial. He gave the following reason for the detention:

The prisoner, for his own sake and for the sake of society at large, must not be discharged; for this is a case which concerns every man of every station, from the king upon the throne to the beggar at the gate; people of both sexes and of all ages may, in an unfortunate frantic hour, fall a sacrifice to this man, who is not under the guidance of sound reason; and therefore it is absolutely necessary for the safety of society, that he should be properly disposed of..."

However, he added that "all mercy and humanity [should] be shown to this most unfortunate creature [Mr. Hadfield] ... he must somehow or other be taken care of, with all the attention and all the relief that can be afforded him." This case appeared to be the impetus for the British Parliament adopting *An Act for the Safe Custody of Insane Persons* (also referred to as the *Criminal Lunatics Act, 1800*) which was the first

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72 *R. v. Hadfield*, supra note 44 at 1355 & 1356.

73 *Ibid* at 1355.

74 *Ibid* at 1354 & 1355.

75 *Ibid* at 1355.

76 *Supra* note 17.
legislation respecting accused persons found NCRMD.\footnote{77} This Act contributed to the public perception that persons with mental disabilities and charged with crimes were dangerous and that the public needed to be protected from them. The preamble and section 1 of the \textit{Criminal Lunatics Act} of 1800 stated:

\begin{quote}
Whereas Persons charged with High Treason, Murder, or Felony, may have been or may be of unsound Mind at the Time of committing the Offence wherewith they may have been or shall be charged, and by reason of such Insanity may have been or may be found not guilty of such Offence, and it may be dangerous to permit persons so acquitted to go at large ... the Court before whom such Trial shall be had, shall order such Person to be kept in strict Custody, in such Place and in such Manner as to the Court shall deem fit, until his Majesty’s Pleasure shall be known; and it shall thereupon be lawful for his Majesty to give such Order for the safe Custody of such Person, during his Pleasure, in such Place and in such Manner as to his Majesty as to his shall deem fit ...
\end{quote}

Section 2 of the \textit{Criminal Lunatics Act} dealt with persons found insane by a jury and unable to stand trial on indictment for any offence. Section 3 authorized the apprehension and committal of persons suspected of being insane and believed to have a criminal purpose.

The \textit{Criminal Lunatics Act} of 1800 does not specify where accused persons are to be detained and, in the first five years after its enactment, thirty-seven persons were detained in jail under the authority of this Act. Some may have been detained in the few established hospitals such as Bethlem or private madhouses, as well as in workhouses

\footnote{77}{A note at the end of the report of \textit{R. v. Hadfield}, supra note 44, at 1355 states that "[t] case gave rise to the two statutes of 40 Geo. 3\textsuperscript{rd}, chapters 93 and 94, by virtue of the latter of which (for the safe custody of insane persons charged with offences) Hadfield was continued in custody."}

\footnote{78}{Section 1 of (U.K), 1800, c. 94.}
and poor houses.\textsuperscript{79} The detention of accused persons in jails led to the complaint that "to confine such persons in a common gaol [jail], is equally destructive of the recovery of the insane and of the security and comfort of the other prisoners."\textsuperscript{80} However, after the establishment of lunatic asylums for criminal and pauper lunatics, accused persons were detained in lunatic asylums.\textsuperscript{81}

\textbf{B. 1850s-1900: The failure of the lunatic asylum and the adoption of the insanity provisions in the \textit{Criminal Code} of Canada}

\textbf{a) The failure of the lunatic asylums in England and in Canada}

The system of county public lunatic asylums continued to expand as the existing asylums became overcrowded in the second half of the nineteenth century in England. Similar developments respecting lunatic asylums took place in Canada, where a network of public asylums, patterned on the English lunatic asylums, grew during this period.\textsuperscript{82} Therefore, the factors which are discussed below and which explain the failure of the English lunatic asylums are likely applicable to Canada. These factors can be summarized

\textsuperscript{79}For a detailed discussion of the places of confinement of persons with mental disabilities, the poor and the homeless in England see A. Scull, \textit{Museums of Madness. supra} note 44 at 37-43.

\textsuperscript{80}\textit{Report of the Select Committee on Criminal and Pauper Lunatics,} 1807 at 4 as cited in A. Scull, \textit{Museums of Madness. supra} note 44 at 55.

\textsuperscript{81}\textit{An Act for the better Care and Maintenance of Lunatics, being Paupers or Criminals (U.K.),} 1808, c.96.

as follows. An increase in the number of paupers with mental disabilities and the lack of expected cures of these persons led to overcrowding and the abandonment of the moral treatment. In addition, the increase in the number of paupers with mental disabilities in lunatic asylums is explained by the emphasis on the "dangerousness" posed by persons with mental disabilities and the need to protect society from these persons. As well, funding for lunatic asylums was not increased as numbers of persons with mental disabilities institutionalized grew which led to harsh living conditions and subsistence diets for these persons.

According to Scull, the numbers of pauper lunatics in lunatic asylums increased by 363.7 % between 1844 and 1890. Different reasons have been advanced to explain the increase. The workhouse authorities used the lunatic asylums to "relieve their wards of many old people who are suffering from nothing else than the natural failing of old age, as well as to rid themselves of troublesome people in general." The lunatic asylum became the dumping ground for the "awkward and inconvenient of all descriptions."

There was also a popular belief at the time that the numbers of insane persons was increasing:

The brute fact of the growing multitudes flooding into the asylums soon, however, gave pause for thought... the alarming ideas struck many

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83See, for a discussion of the overcrowding of the Provincial Hospital for the Insane in Nova Scotia, M. Kingma, Mental Health Law: A Critique Of The 'Dangerousness' Criterion For Civil Commitment and Some Recommendations For Change, supra note 54 at 161 -164.

84A. Scull, Museums of Madness, supra note 44 at 245 and 250.

85Ibid at 250.
nineteenth-century doctors and magistrates that madness was, after all, infinitely more menacing than had been imagined. ... No sooner were asylums built than they were filled to overflowing, and still the well-springs of lunacy gushed forth more maniacs, more suicidal melancholics, more senile dments in need of care and treatment.\textsuperscript{86}

However, as Scull convincingly argues, the existence and expansion of the lunatic asylums created an increased demand for their services rather than there being an increase in the number of persons with mental disabilities.\textsuperscript{87} Furthermore, once admitted to an asylum, people stayed there longer than initially expected because “experience increasingly proved that the insane, even when placed in the much fêted utopian environment of the new asylums, did not recover as speedily, as certainly, as had been predicted. In fact most were not cured at all.”\textsuperscript{88}

Another factor which is credited with fueling the growth of the asylum was the development of psychiatry and its emphasis on the “dangerousness” which persons with disabilities pose to society. Some authors have argued that

With the ascendency of psychiatry, authorities became increasingly concerned with the relationship between insanity and violent crime. They found ready explanations in the bourgeoing rhetoric of the new profession. ‘Nineteenth-century psychiatry invented an entirely fictitious entity, a crime which is insanity, a crime which is nothing but insanity, an insanity which is nothing but crime ... They justified their right to intervene, not by searching out the thousand little visible signs of madness which may accompany the most ordinary crimes, but by insisting - a preposterous stance- that there were kinds of insanity which manifested


\textsuperscript{87}A. Scull, \textit{Museums of Madness}, supra note 44 at 245.

\textsuperscript{88}Supra note 86 at 20.
themselves only in outrageous crimes, and in no other way’.\textsuperscript{89} Since psychiatry claimed a “special knowledge concerning the interchangeability of madness and violence,” and an ability to predict violence, it acquired the “exclusive jurisdiction over the prediction of dangerousness.”\textsuperscript{90} At that time psychiatrists portrayed persons with mental disabilities as a “particularly explosive brand of social dynamite, entirely devoid of reason or internal control.”\textsuperscript{91} However, this association of “dangerousness” with persons with mental disabilities was not new; the “preventive confinement of dangerous persons ... who are thought to likely cause serious injury in the future has always been practiced, to some degree, by every society in history regardless of the jurisprudential rhetoric employed.”\textsuperscript{92}

As a result of the growth of the asylum population, history repeated itself. Pauper asylums which were intended to provided more humane treatment to persons with mental disabilities soon degenerated into overcrowded places of detention with living conditions


\textsuperscript{90}Ibid at 182 at 187.

\textsuperscript{91}Ibid.

\textsuperscript{92}Ibid at 182 cites A. Dershowitz, “the Origins of Preventative Confinement in Anglo-American Law, Part I: the English Experience” (1974) 43 University of Cincinnati Law Review 1 at 57. As previously noted above, legislation in England and Canada during this period permitted the detention of the accused persons, the “criminal lunatics”, based on the assumption that they were dangerous because insane and society had to be protected from them.
that resembled those of the early nineteenth century mad-houses for paupers.93

Mammoth asylums94 were built or existing asylums expanded to accommodate the growing numbers of pauper lunatics in the 1850s and 1860s. With the increasing numbers of pauper lunatics in each asylum, all trappings of moral treatment— to provide a comfortable environment to persons with mental disabilities— disappeared.

The buildings themselves offered mute testimony to the fact that the asylum was now ‘a mere refuge or house of detention for a mass of hopeless and incurable cases’. Whereas it had been an article of faith with the reformers that ‘the main object to be borne in mind, in the construction of lunatic asylums, is to combine cheerfulness with security, and to avoid everything which might give the impression that he is in prison’, within little more than a decade there were complaints that the county asylums were ‘built externally on the model of a palace, and internally on that of a workhouse.’95

One author chronicled a similar situation in the Maritime Provinces regarding the failure of the asylums as follows:

To be effective, moral treatment required a small number of patients, all of whom were in the acute stage of their illness, and a large staff to work with them. What happened, however; was that the asylums were immediately and continuously overcrowded, especially with what were considered chronic incurable cases, and had neither the staff nor the facilities to be anything more than more than places of confinement. The heady optimism of mid-century evaporated into exasperation, and sometimes plain brutality, as asylums proved unable to fulfill their role as successful treatment centers.”96

93A. Scull, Museums of Madness, supra note 44 at 219.

94Ibid at 194-198.

95Ibid at 194 &195.

96D. Francis, “The Development of the Lunatic Asylum in the Maritime Provinces,” supra note 66 at 34.
Once the moral treatment was abandoned, the asylums went from "being an instrument of regeneration, [to become] the dustbin of the incurable." The asylums are described as places where monotony and routine reigned to such a point that, according to one critic, persons with mental disabilities came under "a sort of routine discipline which ends in their passing into a state of dementia." The inmates of the asylums were kept sedated and on a barely subsistence diet. The conditions were so poor that "many among the higher, and nearly all among the lower classes, still look upon the County Asylum as the Bluebeard's cupboard of the neighbourhood."

Funding for lunatic asylums did not keep pace with the increasing number of inmates, thus leading to overcrowding and deteriorating conditions in the latter half of the nineteenth century, as chronicled by Scull. The local officials who controlled the

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97 Supra note 86 at 20.


99 A. Scull Museums of Madness, supra note 44 at 203.

100 J. M. Granville "Lunatic Asylums" Quarterly Review, 101 at 353 cited in A. Scull Museums of Madness, supra note 44 at 195. See also D. Francis, "The Development of the Lunatic Asylum in the Maritime Provinces," supra note 66, who paints a picture of the abuse and cruelty suffered by the inmates of the Maritime asylums at 35 to 37.

101 A. Scull Museums of Madness, supra note 44 Scull 213-219. A similar situation existed in Canada where lunatic asylums were overcrowded with chronic inmates and understaffed. See K. Kendall "Mental Illness- Tales of Madness: From the Asylum to 'Oprah," supra note 82 at 135 and D. Francis, "The Development of the Lunatic Asylum in the Maritime Provinces," supra note 66 at 35 to 38.
funding of county lunatic asylums generally kept funding at a minimum and the managers of the asylums were encouraged to economize and reduce the maintenance costs of each inmate.

b) Adoption of insanity provisions in Canada

In 1859, the Legislative Council and Assembly of Canada adopted An Act respecting the confinement of Lunatics whose being at large may be dangerous to the public.\textsuperscript{102} It contained similar provisions to those in the British legislation, the Criminal Lunatics Act\textsuperscript{103} of 1800, for the detention at the pleasure of Her Majesty of persons found not guilty by reason of insanity of any offence or unfit to stand trial. Much like the British legislation of 1800, this Act did not specify the place of detention. It simply gave the Governor the power to order into safe custody accused persons "during Her Majesty's pleasure, in such place and in such manner as the governor seems [sic] fit."\textsuperscript{104} However, asylums had been established and accused persons were detained in them.\textsuperscript{105}

Following Confederation, in 1869, the federal government adopted An Act respecting procedure in Criminal Case, and other matters relating to Criminal Law (also

\textsuperscript{102}(U.K.) 1859, c. 109.

\textsuperscript{103}Supra note 17.

\textsuperscript{104}Ibid at s.2.

\textsuperscript{105}Both Lower and Upper Canada had established asylums by the 1850s. See R. C. Smintych & S.N. Veridun-Jones, "The Emergence of the Asylum in 19th Century Ontario," supra note 52 at 171-177. In addition, Nova Scotia and New Brunswick has asylums, see D. Francis, "The Development of the Lunatic Asylum in the Maritime Provinces," supra note 66 at 28.
known as *Procedure in Criminal Cases Act*\textsuperscript{106} which included provisions on the disposition of persons acquitted by reason of insanity or unfit to stand trial that were similar to the *Act respecting the confinement of Lunatics whose being at large may be dangerous to the public*.\textsuperscript{107} However, one important change made was that these persons were held at the pleasure of the Lieutenant-Governor of the province where the case had occurred.\textsuperscript{108}

In 1886, when the first revision of the Statutes of Canada took place, the 1869 *Procedure in Criminal Cases Act* was revised and entitled the *Criminal Procedure Act*.\textsuperscript{109} This Act was incorporated into *The Criminal Code, 1892*. Sections 736 to 741 of this *Code* re-enacted sections 252 to 258 of the *Criminal Procedure Act*.\textsuperscript{110}

\textbf{Part 2: Developments in the 20\textsuperscript{th} century}

In the first part of this century, the lunatic asylums were renamed mental hospitals and attempts were made to establish in these hospitals therapeutic practices similar to those in general hospitals since mental illness was viewed as a disease. However, it appears that during this period the mental hospitals were little more than places of detention for persons with mental disabilities. The numbers of persons detained in

\textsuperscript{106} Statutes of Canada, 1869, c. 29, s.99-105.
\textsuperscript{107} Consolidated Statutes of Canada, 1859, c. 109.
\textsuperscript{108} Supra note 106 at s.100.
\textsuperscript{109} R.S.C. 1886, c. 174, s.252-258.
\textsuperscript{110} Ibid.
mental hospitals continued to grow during this period.\textsuperscript{111} Conditions in mental hospitals continued to deteriorate and the use of medical treatments in asylums added to the misery of persons with mental disabilities.\textsuperscript{112}

The second half of the 20\textsuperscript{th} century saw the rise of the welfare state. A minimal social safety net was spun in Canada which encompassed an unemployment insurance scheme, old age security and disability pensions, social assistance programs and medicare. This period also saw the advent of civil rights movements and the struggle for equality rights by various oppressed and subordinated groups in our society. The right to life, liberty and security of the individual, as well as equality rights for disadvantaged groups, were entrenched in the \textit{Canadian Charter of Rights and Freedoms}.\textsuperscript{113} It is against this backdrop that the current mental health system and the mental disorder provisions developed.

\textbf{A. 1900- 1950: Mental Hospitals in Canada}

\textit{a) The emergence of the mental hospital}

The medicalization of mental illness and the hospitalization of the asylum in Canada took place around the beginning of the 20th century in Canada. These terms are used to describe the “various attempts on the part of asylum physicians to replace the


\textsuperscript{112}K. Kendall “\textit{Mental Illness- Tales of Madness: From the Asylum to ‘Oprah}” supra note 82 at 136-142.

\textsuperscript{113}Supra note 14.
prison-like organization of the mental institutions with forms and patterns of therapeutic practice prevalent in general hospitals." One step towards this goal was to rename the mental asylums as mental hospitals in the legislation governing the asylums. Another was to recognize in legislation that a disease process was being treated in mental hospitals, for example by the passage of the Mental Diseases Act in 1922 in Saskatchewan. Dickinson and Andre argue that the development of a training program for mental hospital attendants in 1930 in Saskatchewan and the opening of a psychopathic ward in a general hospital were steps towards the medicalization of psychiatry.

Furthermore, in the 1930s and 40s, psychiatrists began to search for a physical cause for different types of mental illness. They had already found one link between a physical illness and a mental illness. This link was that third-stage syphilis caused some type of mental illness. Somatic cures for mental illness such as psychosurgery, insulin shock therapy, metrazol shock therapy, electroconvulsive shock, and gynecological

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115 An example was Manitoba's Insane Asylum Act which was amended to refer to the asylum as a mental hospital as cited in H. D. Dickinson & G. Andre, "Community Psychiatry: The Institutional Transformation of Psychiatric Practice" supra note 111 at 300.


117 K. Kendall "Mental Illness- Tales of Madness: From the asylum to 'Oprah'" supra note 82 at 136.
surgery on women were employed in the mental hospitals. As one author noted,

[T]heoretical attempts describing the treatments’ rationale were so vague that it was often difficult to take them seriously. ... Nevertheless, each therapy was applied enthusiastically soon after discovery, and both the medical profession and the press avidly promoted the treatments.

These so-called treatments had severe and sometimes fatal effects. For example psychosurgery involved the destruction of brain tissue in the frontal lobes of the brain, to eradicate mental illness. At first, it was done by drilling holes in the head of person with mental disabilities and absolute alcohol was injected into the front lobes of the brain. Later, instruments were used rather than alcohol to destroy nerve fibers of the brain.

Another example of harmful treatments were the shock therapies used to treat schizophrenia: insulin shock therapy, metrazol shock therapy. The idea behind these therapies was to cause a person to go into convulsions and coma, to improve their behaviour. In the case of electroconvulsive shock, electrical currents travel to the brain for a few seconds and result in convulsion, loss of consciousness and memory and is used as treatment for a variety of mental illnesses. Yet another example of harmful treatment arose from the belief that women’s genital and reproductive organs were linked


119 K. Kendall “Mental Illness- Tales of Madness: From the asylum to ‘Oprah’” supra note 82 at 138.

120 Ibid at 138-139.

121 Ibid at 138.

122 Ibid.
to mental illness, therefore, surgery was used to remove these organs.\textsuperscript{123} I suggest that the harm to the person with disabilities was not considered in the quest for a supposed cure to mental illness. Furthermore, these persons were captive and these “treatments” were practised on them generally without their consent.\textsuperscript{124}


In the second half of the 20\textsuperscript{th} century, humane concerns for the plight of persons confined in mental hospitals, in conjunction with the introduction of psychotropic medication, resulted in a shift in mental health policy.\textsuperscript{125} The focus became the delivery of mental health services in the community rather than the hospital. In addition, concerns respecting the rights of persons with mental disabilities arose out of the civil rights movement. As a result of the recognition of the rights of persons with disabilities, changes were made to the criteria for civil committal and the institution of procedural safeguards surrounding civil committal. These changes highlighted the differences between civil committal and the mental disorder provisions (the insanity provisions)

\textsuperscript{123}\textit{Ibid} at 137.

\textsuperscript{124}\textit{Ibid}.

\textsuperscript{125}As detailed later in this part, other explanations, such as the growing fiscal crisis of the state and the increased costs of mental hospitals, the expansion of the psychiatric units in general hospitals and mental health clinics, the rise of the civil rights movement and the anti-psychiatry movement, have been offered in support of the shift from institutional psychiatric care to community psychiatry. I favour the humane treatment explanation. See for a brief explanation of the various explanations H. D. Dickinson, “\textit{Mental Health Policy in Canada: What’s the Problem}” in B.S. Bolaria & H. D. Dickinson, \textit{Health, Illness and Health Care in Canada}, 2\textsuperscript{nd} edition, (Toronto: Harcourt Brace Canada, 1994) 466 at 468-471.
which authorized arbitrary, automatic, indeterminate detention without any procedural safeguards such as independent review nor any criteria for release.

a) Deinstitutionalization of persons with mental disabilities

In the 1960s in Canada, the focus of the delivery of mental health services shifted from provincial psychiatric hospitals to psychiatric units in general hospitals and to the community. This led to a dramatic decrease in psychiatric beds, a reduction in the number of provincial psychiatric hospitals, an increase in the number of psychiatric units in general hospitals, and the creation of community-based mental health services. Different explanations have been offered for the deinstitutionalization of persons with mental disabilities. The most common explanation is "the growth of medical scientific knowledge." The advent of psychotropic or mood-altering drugs in 1952 is seen by

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126 H. D. Dickinson & G. Andre, "Community Psychiatry: The Institutional Transformation of Psychiatric Practice" supra note 111 at 295. These changes in the delivery of mental health services were not unique to Canada, but were seen throughout the Western world. Similar movements occurred in U.K. and the U.S. in the mid-1950s. For a description and statistics on the depopulation of mental hospitals and on closures in those countries see A. Scull, Decarceration, 2nd edition (Cambridge, Polity Press, 1984) at 66-73.

127 D. Wasylenki, P. Goering, E. MacNaughton, "Planning Mental Health Services: I. Background and Key Issues" supra note 26. They note that from 1960 to 1976 the number of psychiatric beds in provincial psychiatric hospitals declined from 47,635 to 15,011 in Canada and in psychiatric units in general hospitals increased from 844 to 5,836.

128 H. D. Dickinson & G. Andre, "Community Psychiatry: The Institutional Transformation of Psychiatric Practice" supra note 111 at 296. Table I provided figures showing the decrease in number of psychiatric hospitals and increase in the number of psychiatric units in general hospitals.

129 Ibid at 297.
some authors as the main advance in the treatment of mental disorder which resulted in the obsolescence of the psychiatric hospital. These drugs produced "symptom-free" behaviour and manageable patients," allowing persons with mental disabilities to be treated in the community. The focus on mental disability as an illness led to the perception that persons with mental disabilities should be treated, like other persons who suffer from an illness, in the community. This was seen as more humane and more in step with the rights of persons with mental disabilities. Psychiatric hospitals came to be seen as prisons—"antitherapeutic institutions having a detrimental impact on their inmate populations."

Another explanation of the demise of the psychiatric hospital is advanced by

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130 Ibid at 300 and K. Kendall "Mental Illness- Tales of Madness: From the Asylum to 'Oprah'" supra note 82 at 143.

131K. Kendall "Mental Illness- Tales of Madness: From the asylum to 'Oprah'" supra note 82 at 143. She stated that in North America and Europe psychotropic drugs were widely prescribed and their use superseded all other forms of treatment for mental illness.

132H. D. Dickinson, "Mental Health Policy in Canada: What's the Problem" supra note 1125 at 468 and see also Canada, Overview of Mental Health Legislation in Canada, 1994 (Ottawa: Minister of Supply and Services Canada, 1994) at 5.

133 See for example G. Robertson, Mental Disability Law in Canada, 2nd ed. (Toronto: Carswell, 1994) at 368 and 369—"who states that "a continued shift in emphasis away from institutional care in favour of community care and a desire to afford involuntary patients greater legal protection," was largely responsible for the reform in mental health legislation.

134A. Scull, Decarceration, supra note 126 at 77 and Canada, Overview of Mental Health Legislation in Canada, 1994, supra note 132 at 5.
He acknowledges that the conventional explanation holds some truth but argues that the ‘decarceration’ of persons with mental disabilities was mainly due to the growing fiscal crisis of the state. Mental hospitals, prisons and reformatories were closed to save costs. Scull adds that the necessary pre-condition to deinstitutionalization was the existence of welfare programs including the “existence of welfare payments, guaranteeing at least a minimal maintenance to the poor living outside institutions.”

Although critics of this argument have noted that empirical studies show no decrease in total state expenditures on mental health services, they acknowledge some merit to this argument. In my opinion, Scull’s explanation certainly resonates in the Canada of the 1990s where health care cuts continue to be made in the name of budget constraints and

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135 A. Scull, Decarceration, supra note 126.

136 Ibid at 89. Scull concluded “[a]t best, therefore, one is left with the conclusion that the introduction of psychotropic drugs may have facilitated the policy of early discharge by reducing the incidence of florid symptoms among at least some of the disturbed, thus easing the problem of managing them in the community; and perhaps also by persuading doctors with an exaggerated idea of the drugs’ efficacy of the feasibility of such a policy. But that their arrival can be help[sic] primarily responsible for the change is clearly highly implausible.” Further at 170-171, he cited a study of Peter Sedgwick on the timing of the run-down of institutional populations in Western Europe which demonstrated “marked variations from one society to another in both the timing and the extent of the decline in mental hospital populations.”

137 Ibid at 1. Scull coined this term to mean the “state-sponsored policy of closing down asylums, prisons and reformatories.”

138 Ibid at 139-141.

139 Ibid at 172.

fiscal crisis.

Yet another explanation for the rise of community psychiatry is advanced by Dickinson and Andre. They argue that community psychiatry resulted from a simultaneous expansion of both the "medically dominated, general hospital-based, private-sector psychiatric services system and a mental clinic-based, public-sector psychiatric services system increasingly dominated by non-medically trained professionals such as psychologists and social workers." \(^{141}\) They argue that a struggle was waged between competing professionals "for control over the diagnosis and treatment of mental disabilities" seeing that mental disability may be both "biological and socio/psychological in origin." \(^{142}\) They conclude that there was a trend towards de-medicalization of psychiatry which would continue because it was cost-effective-- an argument similar to that of Scull for the closure of state mental hospitals. \(^{143}\)

In my view, another event which had an impact on deinstitutionalization in Canada was the exclusion of psychiatric services provided in mental hospitals from cost-sharing agreements under the *Hospital Insurance and Diagnostic Services Act* of 1957. \(^{144}\) In 1968, under the national medicare program, which combined the hospital and medical insurance programs, cost-sharing covered medically required services provided by medical practitioners. This included the services of psychiatrists in general hospitals.

\(^{141}\) *Ibid* at 295-296.

\(^{142}\) *Ibid* at 296.

\(^{143}\) *Ibid* at 305.

\(^{144}\) S. C. 1957, c. 28.
outpatient settings in private offices. However, the federal government did not share in the costs of provincial psychiatric hospitals or independent mental health clinics. In 1977, the Federal-Provincial Fiscal Arrangements Act\(^\text{145}\) blurred the distinctions in cost-sharing because it provided block funding for health and post-secondary education to the provinces.

Between 1957 and 1977 the number of psychiatric units in general hospitals increased from 23 to 169.\(^\text{146}\) However, the new general hospital psychiatric units "did not provide care for patients suffering from severe, major mental disorders. Rather these units treated patients who were less seriously ill and who had not previously received inpatient psychiatric care."\(^\text{147}\) The general hospital psychiatric unit provided short-term care to a larger number of easier-to-manage patients while the provincial psychiatric hospitals provided long-term care to more difficult-to-manage patients.\(^\text{148}\) In Saskatchewan, for example, the growth of psychiatric services provided by physicians on a fee for service basis increased from about 20 services for 1000 of population covered in 1963 to 226 in 1985.\(^\text{149}\)

\(^{145}\)S.C. 1976-77, c. 10.

\(^{146}\)H. D. Dickinson & G. Andre, "Community Psychiatry: The Institutional Transformation of Psychiatric Practice" supra note 111, Table 1 at 296.

\(^{147}\)D. Wasylenki, P. Goering, and É. MacNaughton, in "Planning Mental Health Services: I. Background and Key Issues, supra note 26 at 199 & 200.

\(^{148}\)Ibid at 200.

\(^{149}\)H. D. Dickinson & G. Andre, "Community Psychiatry: The Institutional Transformation of Psychiatric Practice" supra note 111, figure 1 at 303.
Other factors which had an impact on deinstitutionalization were the rise of the civil rights movement North America and ensuing political activism of persons with disabilities. As noted by Bickenbach,

"It has been argued, and seems reasonable that in North America political activism for people with disabilities became a viable and attractive option as a direct result of the civil rights movement in the United States. Political unrest, fueled by optimism from successes in combating racial discrimination, coupled with the dynamics of political protest and persuasion, created a vehicle for the expression of discontent among people with disabilities and their advocates."\(^{150}\)

Activists claimed that disability "is a socially constructed form of oppression."\(^{151}\)

According to Bickenbach, this flowed from the social-scientific accounts of disability and "[t]he next theoretical step was to represent people with disabilities as a minority group, a marginalized population experiencing systemic discrimination."\(^{152}\) Persons with disabilities struggled for empowerment and inclusion in society with the support of advocates. The importance of the dignity and worth of persons with disabilities was highlighted.

In mental health, this politicization is reflected in the events of the 1960s and 1970s. First, the anti-psychiatry movement\(^{153}\) took hold. This movement comprised

\(^{150}\)J. E. Bickenbach, Physical Disability and Social Policy (Toronto: University of Toronto Press, 1993) at 150.

\(^{151}\)Ibid at 152.

\(^{152}\)Ibid.

\(^{153}\)Anti-psychiatry mental health professionals argue that the "primary function of psychiatric diagnosis and treatment is the social identification, classification, and control of deviance...Szasz, for example, argues that the problems currently being diagnosed and
radical mental health professionals (such as Thomas Szasz, R. D. Laing and Thomas Scheff), patients and ex-patients. They “challenged psychiatry by publicizing psychiatric abuses, critiquing psychiatric theories and treatment, and offering alternatives.”

Second, ex-psychiatric patients’ or consumers’ rights movements emerged, seeking empowerment. They advocated for the same rights as other medical patients such as the right to informed consent to treatment and the right to refuse treatment, as well as stricter criteria for involuntary civil committal and procedural safeguards surrounding it. Furthermore, these persons argued that they could help themselves or should have the right to choose non-medical therapists to help them. A consumer advocacy ethic emerged whereby “[i]n the context of a ‘service provider-consumer’ relationship, the balance of power, at least in principle, shifts significantly toward the consumer who plays a leading role in the nature of the demand for services and how they are to be provided.”

These movements helped to sensitize Canadians to the realities of discrimination and stigma attached to mental illness and the stereotypes faced by persons with mental disabilities.

treated as medical problems by psychiatry are really best understood as psycho-social problems in living... [persons with mental disabilities] should be helped to solve their problems in living by those more suited to doing so, namely psychologists or other types of non-medical psychotherapists.” Another branch of this movement led by Laing argues that “madness was a proto-revolutionary act that was suppressed by the counter-revolutionary oppression of psychiatry. The role of the radical, anti-psychiatric therapist in this rebellion against conformity and oppression was to aid and abet the rebels in their emancipatory journey through madness.” H. Dickinson, “Mental Health Policy in Canada: What’s the Problem?” supra note 125 at 469-470.

154 Supra note 82 at 144.

155 H. Dickinson, “Mental Health Policy in Canada: What’s the Problem?” supra note 125 at 471.
An umbrella advocacy organization, the Coalition of Provincial Organizations of the Handicapped, was organized to coordinate consumer activist groups throughout the country and was instrumental in advocating for the recognition of equality rights for persons with disabilities in section 15 of the *Canadian Charter of Rights and Freedoms*.\textsuperscript{156} Discrimination against persons with disabilities\textsuperscript{157} was exposed as a social construct and as a systemic problem. In my view, this sensitization contributed to a shift in public opinion regarding the institutionalization of persons with mental disabilities. Institutionalization came to be seen as synonymous with civil committal in the context of persons with mental illness and disempowerment. These persons were deprived of their liberty and isolated from the community based on their illness. As involuntary patients in psychiatric units of general hospitals or psychiatric hospitals, they may have been deprived of the right to consent to treatment or to refuse treatment, as well as the choice of their care givers. The psychiatric abuses in institutions showed the particularly vulnerable position of these persons.

Another development which had a bearing on securing rights for persons with mental disabilities is the adherence by Canada to the United Nations’ *Declaration of the Rights of Disabled Persons*.\textsuperscript{158} The Declaration guaranteed rights to persons with disabilities.

\textsuperscript{156} *Supra* note 150 at 150-151.

\textsuperscript{157} For a detailed discussion of the social construction of handicapping and its ramifications see *supra* note 150.

disabilities including, those with mental disabilities, "the inherent right to respect for their human dignity; ... the same civil and political rights as other human beings." The emphasis was on the integration of the person with disabilities into society.

Furthermore, in the 1980s, human rights codes extended protection to persons with mental disabilities. As noted by Lepofsky, "a number of legislatures first banned discrimination based only on physical disability, leaving it legal to discriminate because of mental disability."

b) Changes in mental health legislation

Since the 1970s, numerous changes in mental health legislation have been made. Since involuntary hospitalization deprives a person who has not committed an offence of her or his liberty, it represents the most intrusive step that the state can take against a person. Therefore, procedural safeguards and precise, unambiguous legislative criteria as to the conditions and types of behaviours that justify committal were required. A number of jurisdictions responded by adopting stricter civil committal criteria based on dangerousness and procedural safeguards were inserted in mental health legislation.


160 Ibid at 331-332.

161 In the 19th and early 20th century, statutory civil committal criteria referred to the committal of persons who were "insane and dangerous to be at large." In the 1940's, the scope of civil committal was "significantly expanded by the introduction of the 'welfare test'." Basically under this criteria, a person could be involuntarily hospitalized and treated if it promoted that person's best interests and welfare. In the 1970's, Canadian mental health legislation adopted the concept of "dangerousness". This test is criticized because the "difficulties in predicting dangerousness are notorious, and there is a wealth
such as rights to periodic reviews by independent Review Boards and briefer time periods for observation and detention.

The advent of the *Canadian Charter of Rights and Freedoms*\(^{162}\) added impetus to the reform of mental health legislation\(^{163}\) and the enactment of the current mental disorder provisions. A few persons with mental disabilities have been successful in Charter challenges to mental health legislation. In *Lussa v. Health Science Centre*\(^{164}\) the validity of civil committal was challenged under the sections 7 and 9 of the *Charter*. At that time, Manitoba’s mental health legislation did not contain a dangerousness criterion and did not provide for periodic reviews by a Review Board. The court did not strike down the legislation but ordered the release of the plaintiff because it found that “involuntary confinement without proof of dangerousness, and with no meaningful opportunity to

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of literature casting serious doubt on the validity and reliability of psychiatric prediction of dangerousness.” Robertson *supra* note 133 notes that very few provinces use dangerousness as the sole criterion for civil committal and the meaning of dangerousness varies widely across Canada. Some jurisdictions incorporated dangerousness by referring to safety. The legislation in Nova Scotia is an example, see *Hospitals Act*, R.S.N.S. 1989, c.208, ss. 36(2). Robertson is of the opinion that this appears to be little more than a reformulation of the “welfare test”. Others, such as Ontario, N.W.T., Manitoba and the Yukon, adopt quite a restrictive criteria. The legislation in these provinces and territories refers to a person suffering from mental disorder of a nature or quality that likely will result in serious bodily harm to the person, another person or imminent and serious physical impairment of the person. Robertson, *supra* note 133, expresses the view that the courts have interpreted this criteria broadly. For a fuller discussion of civil committal criteria, see Robertson. *supra* note 133, at 367-437.

\(^{162}\) *Supra* note 14.

\(^{163}\) *Supra* note 133 at 426 and *supra* note 159 at 264-265.

question it, infringed ss. 7 and 9 of the Charter.\textsuperscript{165} The finding that involuntary committal requires proof of dangerousness as a pre-condition was in keeping with \textit{O'Connor v. Donaldson}\textsuperscript{166} where the United States Supreme Court declared that

\begin{quote}
A finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement.... [mental illness is] no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can safely live in freedom.\textsuperscript{167}
\end{quote}

A few years later, in \textit{Thwaites v. Health Sciences Centre Psychiatric Facility},\textsuperscript{168} the Manitoba Court of Appeal struck down the civil committal criteria. It held that these provisions infringed section 9 of the Charter, the right not to be arbitrarily detained. However, in a number of other cases, challenges to civil committal system in mental health legislation invoking section 7 or 9 of the Charter were unsuccessful.\textsuperscript{169} \textit{Re Jenkins}\textsuperscript{170} dealt with the constitutional validity of the P.E.I. Mental Health Act which did not contain dangerousness as a pre-condition to civil committal. However, the court

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  \item \textsuperscript{165} \textit{Supra} note 133 at 427.
  \item \textsuperscript{166} 422 U.S. 563 (1975).
  \item \textsuperscript{167} \textit{Ibid} at 575.
  \item \textsuperscript{168} [1988] 3 W.W.R. 217 (Man. C.A.).
  \item \textsuperscript{169} \textit{Re Jenkins} (1986) Nfld. & P.E.I.R. 62 (P.E.I.S.C.), \textit{Azhar v. Anderson} 33 A.C.W.S. (2d) 521, Ont. Dist. Ct., Locke D.C.J., Toronto No.609/85, 28\textsuperscript{th} June 1985 (unreported), and \textit{McCorkell v. Riverview Hospital} [1993] 8 W.W.R. 169. For a discussion and a critique of these cases and others for the lack of attention to the substantive aspects, in particular of the committal criteria, and the lack of examination of the legislative scheme of mental health legislation has a whole for compliance with the Charter, see \textit{supra} note 133 at 429-434.
  \item \textsuperscript{170} \textit{Ibid}.
\end{itemize}
found that a patient’s confinement was not arbitrary, capricious or without cause, nor was it contrary to the principles of fundamental justice because of the availability of review of the committal. Therefore, it ruled that the Mental Health Act did not violate sections 7 and 9 of the Charter. The issue of dangerousness as a criterion for civil committal is not discussed. In McCorkell v. Riverview Hospital, the court ruled that the absence of dangerousness as a criterion for committal was not an infringement of the Charter. Based on Lussa, Thwaites and O'Connor, I suggest that Re Jenkins and McCorkell were erroneous because they did not find that a dangerousness criterion should be required for civil committal.

C. Developments Regarding the Mental Disorder Provisions

a) Criminal Code provisions

For over a century, the insanity provisions of the Criminal Code regarding the manner and place of detention remained substantially unchanged, except for provisions which allowed but did not mandate the establishment of an advisory Review Board for each province or territory in 1968. The purpose of the Board was to advise the Lieutenant-Governor on the case of each person detained at the pleasure of the Lieutenant-Governor and to make recommendations about the disposition of the person.

\[171\text{Supra note 169.}

\[172\text{Lussa, supra note 164, Thwaites, supra note 168 and O'Connor, supra note 166.}

being reviewed.\textsuperscript{174} If a Review Board was established, it had to consist of at least two psychiatrists and at least one lawyer and had to conduct a review of each case every six months and report to the Lieutenant-Governor. In 1974, this provision was amended to require the designation of a chairman and to change the frequency of the review of each case to every 12 months after the initial six month review.\textsuperscript{175} In the case of a person found not guilty on account of insanity, the Board had to give an opinion as to "whether that person has recovered and, if so, whether in its opinion it is in the interest of the public and of that person for the Lieutenant-Governor to order that he be discharged absolutely or subject to such conditions as the Lieutenant-Governor may prescribe."\textsuperscript{176}

In summary, prior to the adoption of the current mental disorder provisions of the \textit{Criminal Code}, an accused person found not guilty on account of insanity was ordered into strict custody in the place and in the manner ordered by the court until the pleasure of the Lieutenant-Governor was known. The Lieutenant-Governor had the power to order the detention in custody of the accused person. Where the Lieutenant-Governor was of the opinion that it was in the best interest of the accused person and not contrary to the interest of the public, the Lieutenant-Governor could discharge from custody the accused person, either absolutely or conditionally. These provisions were silent on the place and manner of detention. The Lieutenant-Governor did not have to accept the recommendations of the Review Board, if one was established, and did not have to give

\textsuperscript{174} S.C. 1968-69, c. 38, s.48.

\textsuperscript{175} S.C. 1974-75-76, c.93, s.71.

\textsuperscript{176} R.S.C. 1970, c. C-34, para. 547(3)(d).
reasons for accepting or refusing the recommendations.

However, accused persons brought a constitutional challenge against the insanity provisions,\(^{177}\) one under the *Canadian Bill of Rights* and the other under subsection 15(1) of the *Charter*. In both cases, as discussed later, the challenge was not successful because the Courts of Appeal determined that the legislative intent of the insanity provisions was to protect the public from dangerous persons and to foster the treatment of the accused person. Weatherston J. A. for the Ontario Court of Appeal in *R. v. Saxell* stated

Society has a legitimate social interest in persons who have committed some serious social harm, but who have been found not to be criminally responsible on account of mental disorder; it is justified in subjecting those persons to further diagnosis and assessment, in exercising appropriate control over them, if necessary, and in providing them with suitable medical treatment. There is an underlying assumption that they have, in fact committed some act which would have been a criminal act had they not been insane when the act was committed. It may well be that in individual cases that underlying assumption is not valid, but that does not mean that the legislative scheme, in itself, offends the right of equality before the law or authorizes or effects arbitrary detention or imprisonment.\(^{178}\)

In addition, a few accused persons attempted to obtain procedural safeguards by means of judicial review of the decisions of the advisory boards given the absence of any safeguards in insanity provisions.\(^{179}\) Very limited safeguards were obtained as discussed

\(^{177}\)See *R. v. Saxell* (1980) 59 C.C.C. (2d) 176 (Ont. C.A.) and *Re Rebic and the Queen* (1986) 28 C.C.C. (3d) 154 (B.C. C.A.) which are discussed in next section.

\(^{178}\)Ibid at 187.

in the next section.

b) The case law pertaining to insanity provisions prior to 1991

Prior to R. v. Swain, no constitutional challenges of the insanity provisions were heard by the Supreme Court of Canada. However, a few constitutional challenges to the insanity provisions were decided at the appeal level. One was R. v. Saxell. The appellant argued that the disposition section of the insanity provisions contravened paragraphs 1(b) (equality before the law), 1(a) (due process), 2(a) (protection against arbitrary detention and imprisonment), and 2(b) (cruel and unusual punishment) of the Canadian Bill of Rights. In this case, the Ontario Court of Appeal held that the insanity provisions did not offend the Canadian Bill of Rights for several reasons. The Ontario Court of Appeal determined that the equality rights of an accused person were not infringed because Parliament could legislate to affect one class of persons differently if it did so for a valid federal objective. It reasoned that Parliament had a valid objective in adopting sections 542, 545 and 547 because

[T]hese provisions of the Code are not designed to punish the accused; they are for the protection of the public and the treatment of the accused. Manifestly, the public is best protected by the cure of the accused. Indeed the original statute from which ss. 542, 545 were derived recited that ‘it may be dangerous to permit persons so acquitted to go at large...’: the Criminal Lunatics Act, 1800 (U.K.) C.94.

It emphasized that the underlying assumption of the insanity provisions was that accused

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180 Swain, supra note 17. This case will be discussed later in this chapter.

181 R. v. Saxell, supra note 177.

182 Ibid at 186.
persons remain a danger to the public, but even if this assumption was not true for some accused persons, the legislative scheme remains valid, the detention was not arbitrary and it was not cruel and unusual punishment. It added that there was no evidence before the Court that accused persons continue to be detained after they no longer pose a danger to society. The Court held that the lack of a hearing before an accused person is detained in custody did not violate the guarantee of due process of law.

This case demonstrates that the *Canadian Bill of Rights* provided no protection to accused persons since Parliament could discriminate between classes of persons as long as it was for a valid federal objective. The Court accepted with equanimity that the detention in strict custody without a hearing to determine whether an accused person was a threat to the safety of the public was not arbitrary. The Court did not even refer to the lack of criteria for detention. However, the requirement in the insanity provisions that an accused person be automatically detained in strict custody without a hearing into the accused person’s present mental condition and the lack of standards or criteria for detention were the grounds on which the insanity provisions were struck down a number of years later, under the *Charter* in *R. v. Swain*.183

In another pre-*Swain* case, *Re Rebic and the Queen.*,184 the appellant argued that the equality rights of accused persons under subsection 15(1) of the *Charter* were infringed by the insanity provisions because under these provisions accused persons were treated differently than other persons acquitted of an offence. The Court of Appeal of

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183 Supra note 17.

184 Re Rebic, supra note 177.
British Columbia held that the insanity provisions did not infringe the equality rights of accused persons. The discussion of subsection 15(1) was very limited in the reasons for judgment of two of the appeal judges. Their decision is based on a narrow point that the appellant did not establish that an inequality based on mental condition exists between accused persons and other acquitted persons. They determined that the insanity provisions result in a distinction between accused persons and those found guilty.

However, the reasons for judgement of Macfarlane J.A. had more of a discussion of subsection 15(1), who held that the distinction in treatment between accused persons found not guilty by reason of insanity and those found not guilty on the basis of a legal excuse such as automatism “was sufficiently unfair or unreasonable to call for analysis and justification under s. 1.”185 He determined that the infringement was justified under section 1 because the objective of the insanity provisions was “to protect society and the accused until the mental health of the latter has been restored. The objective [was] to be achieved by treatment of the patient in hospital, rather than a prison environment.”186 The objective was sufficiently important to override a constitutionally protected right. He added that the object was rational, relevant and necessary and that there was proportionality between the effects of the disposition section and the objective of the insanity provisions because

Hospitalization, and a periodic review of the patient’s condition ensures the requisite protection, treatment, and release at a proper time under appropriate conditions... Freedom is restricted only so long as the patient is

185 *Ibid* at 166.
186 *Ibid* at 171.
in need of treatment, and society and the patient need to be protected. 187

Macfarlane J. A. found that the availability of judicial review of decisions of the advisory Review Board and of habeas corpus provided safeguards for accused persons.

In this case, no argument was made regarding the arbitrariness of automatic detention in custody under section 7 of the *Charter*. However, the justification offered by Macfarlane J.A. that the effects of the insanity provisions were proportional to the object seems thin. He found that a legislative scheme that offered no hearing on whether the accused person was a danger to the public at the time of the verdict and that had as the only criterion, recovery, for release from custody offered safeguards to accused persons. Furthermore, he did not link the detention to the protection of the public but rather the need for treatment.

The safeguards provided by judicial review of decisions of Advisory Review Boards were very limited. In 1972, the Federal Court, Trial Division, held that it had the jurisdiction to grant declaratory relief to a person detained under a Lieutenant-Governor’s Warrant (LGW) who had been refused a discharge. 188 Furthermore, in 1981, the Ontario Court of Appeal ruled that the Advisory Review Board in Ontario had a judicially enforceable duty to act fairly in its decision-making, and in particular, the Chairman of the Review Board must disclose to the subject of the hearing information placed before


the Board. In 1986, in *Re Jollimore and the Queen*, the court found that while the Lieutenant-Governor is not bound by the recommendations of the Advisory Review Board, she or he is under a duty to act fairly by considering the Board's recommendations. Otherwise, the Lieutenant-Governor would be preempting the function of the Board. In 1988, the Ontario Court of Appeal held that the Lieutenant-Governor could rely on the recommendations of a Review Board only to the extent that they resulted from a fair hearing. The Lieutenant-Governor could not impose a more onerous restriction than the one proposed by the Board without a new hearing before the Lieutenant-Governor.

Moreover, only the case of *Lingley v. New Brunswick Board of Review* dealt with criteria to be used by an Advisory Review Board in determining the meaning of "recovered" in the disposition section of the insanity provisions. The Federal Court, Trial Division, stated

I am satisfied from a reading of *s.547(5)(d)* that, in addressing itself to the question of whether an accused has recovered, the Board is entitled to interpret "recovery" as full recovery and to find if an accused can no longer be said to be legally insane as defined in *s.16*, he is, nevertheless, "not recovered" in a case like this where there is strong evidence of psychopathic disorders which render the accused "dangerous" to members

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of the public were he to be released.\footnote{Ibid at 308.}

These decisions did not result in specific safeguards for accused persons. At most, the Advisory Review Boards had a duty to act fairly and the Lieutenant-Governor had to consider the recommendations. The Lieutenant-Governor did not have to provide reasons for her or his decision. There was no right of appeal. There was no rights to counsel for accused persons, no right to be present at the hearing, or to present or cross-examine witnesses. More importantly, the criterion of “recovered” for release was vague and was not clarified in the \textit{Lingely} case.\footnote{Ibid.}

c) Proposals for reform of insanity provisions and the influence of the criminal law

Over the years, a number of reports advocating the reform of the insanity provisions have been presented to the federal government. In 1969, the \textit{Report of the Canadian Committee on Corrections}\footnote{R. Ouimet, \textit{Report of the Canadian Committee on Corrections,} (Ouimet Committee) (Ottawa: Information Canada, 1969). The highlights of this report will be discussed later in this section.} was the first to extensively review the situation of persons with mental disabilities in conflict with the criminal law and highlighted the injustice resulting from the automatic and indeterminate detention authorized by the insanity provisions; and the lack of procedural safeguards for the rights of persons detained under these provisions. In addition, the Report noted the link between treatment and release under the insanity provisions advocating community treatment as opposed to detention in a psychiatric hospital. Furthermore, the Report recommended the

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establishment of review boards to conduct hearings into the detention of accused persons and that procedural safeguards be inserted. The next report which focused on the treatment of persons with mental disabilities in the criminal justice system was the "Report to Parliament on Mental Disorder in the Criminal Process"196 authored by the Law Reform Commission of Canada. The Report reiterated the need for reform of the insanity provisions to ensure that detention was not indeterminate and used only if the least restrictive alternative. It also called for procedural fairness in the review hearings and protection of the liberty of accused persons. Subsequently, in 1982, the federal Department of Justice established the Mental Disorder Project to review the insanity provisions and make recommendations for reform. The *Mental Disorder Project Criminal Law Review: Final Report*197 also emphasized the need for mandatory establishment of review boards and annual hearings including procedural safeguards and dispositions for accused persons.198 In addition, the Report noted the criticisms leveled at the indeterminate nature of the detention under the insanity provisions and recommended a limit to the detention.199

Prior to discussing the above-mentioned reports in detail, two other reports, though not directly aimed at the situation of persons with disabilities in the criminal justice system.

196 *Supra* note 44.

197 G. Sharpe, *Mental Disorder Project Criminal Law Review: Final Report* (Ottawa: Department of Justice, 1985). The highlights of this report will be discussed later in this section.

198 Ibid at 49.

199 Ibid at 41 & 42.
justice system, appear to have had an influence on the reform of the insanity provisions. One was *The Report of the Royal Commission on the Law of Insanity as a Defence in Criminal Cases*\(^{200}\) in 1956. The Report was the first to make suggestions regarding the release of persons found not guilty by reason of insanity (NGRI). Though it stated that the issue is outside its terms of reference, the Commission was of the opinion that the detention of these persons was a matter of provincial jurisdiction since persons found NGRI were not sentenced but directed to be detained “in custody pending the pleasure of the provincial government.”\(^{201}\) However, the Commission received submissions that the criminal law should provide a procedure for the release of persons found NGRI who appeared to no longer suffer from a mental disease. The Commission expressed the opinion that the trial judge should not be given the jurisdiction to hear evidence on the mental condition of the person found NGRI to determine if that person should be released or committed to hospital. The Commission stated

> [W]e do not think that trial judges should be called upon, nor do we think that by their training they are fitted, to decide how persons acquitted on account of insanity are likely to conduct themselves in the future, nor do we think a court is the proper forum in which to determine such a matter. We think it is entirely a medical problem and not a question of law or fact. It is a matter for very specialized clinical examination and opinion.\(^{202}\)

The Commission suggested that provincial authorities “consider some regular review of all cases where persons have been committed after the verdict of the jury and, if complete


\(^{201}\) *Ibid* at 42.

\(^{202}\) *Ibid*. 
recovery can be established with assurance, provision should be made for their release."

It added that the reviews should be at least once a year and be conducted by review boards and cited the example of the province of Saskatchewan which in 1946 set up a review committee.

The other report, the Report of a Committee Appointed to Inquire into the Principles and Procedures Followed in the Remission Service of the Department of Justice of Canada (the Fauteux Report) may have influenced proposals for changes to the insanity provisions. The Report noted the shift in criminal law from retributive justice to rehabilitative justice. Established to inquire into the system of parole, the Fauteux Report noted that

"It is perhaps trite, [but] nevertheless true, to say that in the modern philosophy of corrections the old cliche 'the punishment must fit the crime' has been replaced by 'the punishment must fit the offender'."

The concern was that "no useful purpose is served by the imposition of unnecessarily harsh sanctions which, in the circumstances may well embitter the convicted person and contribute adversely to the quality of his subsequent behaviour." The Report stated that the aim of punishment was to protect the public through the reform of the offender and the deterrent effect on others. Furthermore, it added that there is "no place for

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203 Ibid.


205 Ibid at 11.

206 Ibid.
punishment which is based on nothing more than retribution. It expressed the opinion that reformation of the offender "involves training, treatment and re-education." It added

Increasingly, however, society appears to recognize that if it is to be protected to the greatest possible extent, an increasing number of offenders must receive such treatment in the institution as will promote their reformation and rehabilitation. Such a process assists the offender to resume a normal, self-directed, law-abiding life in a free society.

Of note was the Committee's opinion that "[i]n a modem correctional system 'the first principle is to keep as many offenders as possible out of prison."

Based on the Fauteux Report and the Ouimet Committee Report, I contend that the shift towards rehabilitation of an offender in the community as much as possible may have influenced the view that indeterminate detention of persons under the Lieutenant-Governor's Warrant was unjust. Furthermore, the goals of rehabilitative justice, with its emphasis on social rehabilitation such as probation, suspended sentences, education and treatment, are more humane and foster the re-integration of the offender into society. These same goals, I suggest, are reflected in the mental disorder

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207 Ibid.
208 Ibid.
209 Ibid at 46.
210 Ibid.
211 Ibid.
212 Supra note 195.
213 The principles of rehabilitative justice were reiterated and adopted by the Ouimet Committee in 1969. In addition, it emphasized the importance of including the
provisions in section 672.54 of the Code, in that the court or Review Board must consider the re-integration and other needs of an accused person in making a disposition.

In 1969, the Report of the Canadian Committee on Corrections (Ouimet Committee) highlighted the problems facing persons with mental disabilities under the criminal law. The Committee remarked that

Detention under ‘Executive Pleasure’ is a most drastic legal measure. The duration of the detention is absolutely indeterminate. There is grave doubt whether, even by extraordinary legal remedy, the discretion of the lieutenant-governor can be reviewed by the courts.

offender as a member of society and designing correctional measures to achieve the social rehabilitation of the individual. See R. Ouimet, Report of the Canadian Committee on Corrections (Ouimet Committee), ibid at 11-16.


215 On the issue of fitness to stand trial, the Ouimet Committee commented that the “concept of fitness is often confused with that of ‘certification’ to a mental hospital.” It noted that the Canadian practice addressed the issue of fitness as soon as fitness was in doubt; at times, before the prosecution has been called on to test its case against the accused. It emphasized that a number of persons unfit to stand trial would not be detained in a mental hospital if a criminal charge was not pending against them, and highlighted the plight of a person who has a certain degree of mental retardation [term used in the report] and who may always be unfit to stand trial and therefore always detained. The Report stated that “it is conceivable under the law for an innocent person who does not require hospitalization to be detained for the rest of his life.” The Committee recommended changes to the Criminal Code fitness provision to allow the postponement of the issue of fitness until the Crown makes a case against the accused person. It added that fitness should be dealt with at the preliminary inquiry stage because “the ordinary course of the criminal law could require severely disturbed persons to languish in prison awaiting assizes” and this is “to us, clearly unacceptable.” It further recommended that the assignment of counsel be guaranteed by law when fitness is at issue. These recommendations are of note because of the Committee’s concerns regarding the liberty rights of accused persons with mental disabilities and they were incorporated to a large extent in the present mental disorder provisions regarding fitness to stand trial. See ibid at 226 to 229.

216 Ibid at 230.
The Committee estimated that about 1000 persons were detained but noted that statistics were not kept.

The Committee was also concerned about the conditions of detention of persons held under an order of the Lieutenant-Governor. It stated that these conditions are “in many jurisdictions, upsetting.”217 The Committee added that Observers report that the circumstances of detention, treatment and programme offered to such persons vary from province to province. While we are told that some of these conditions are remarkably good in particular provinces, the situation in others is no less than shocking and appalling in this day and age.218

The Committee called for minimum standards respecting the conditions of detention of these persons to be established, but did not provide any details regarding such standards. The Committee recommended an amendment to the Criminal Code to allow for flexibility of disposition based on the merits of each case. It argued that detention in a maximum secure setting was not warranted in all cases— in fact a discharge from custody might be more appropriate in some cases. It added that

The reinforcement of community psychiatric facilities is making it more and more possible for a greater number of individuals to be treated and cared for in the community.219

The Committee recommended the mandatory establishment of review boards rather than permissive legislation because “[w]hat is required is a guarantee that every province have

217 Ibid.

218 Ibid at 230 & 231.

219 Ibid at 231.
a review mechanism." However, the Committee did not recommend that review boards become decision making bodies. Instead, it left the decision regarding the release of a person from custody to the Lieutenant-Governor of the province. The Committee noted that, not many years prior to their Report, discharge from custody of a person detained under an order of the Lieutenant-Governor was a rare occurrence, but by the time of the Report, persons were being discharged or returned for trial throughout the country. However, it found that “properly constituted review boards with appropriate safeguards into their procedural functions” were needed to provide greater checks and balances, and that automatic, yearly reviews of each person under an order of the Lieutenant-Governor were necessary because of the unique nature of the detention. The Committee suggested that the review board be multi-disciplinary in composition, to include psychiatric, legal and lay members. Of note was the suggestion that review procedures should take into account the civil rights of the detained persons, including right to counsel. These recommendations were for the most part ignored at that time.

In 1976, the Law Reform Commission of Canada in its "Report to Parliament on Mental Disorder in the Criminal Process" issued a scathing indictment of the LGW system and emphasized the need for reform. The Commission stated

Our study of the mentally ill in the criminal process revealed that many problems stem from an unjustifiable fear of mentally imbalanced delinquents and from the unjustified expectation that psychiatric and

\(^{220}\) *Ibid* at 233.

\(^{221}\) *Ibid* at 232.

\(^{222}\) *Supra* note 44.
criminal intervention can deal effectively with such individuals. These attitudes are largely responsible for the needlessly long terms of detention commonly imposed on mentally ill offenders and the lack of development and the infrequency of recourse to more efficient, less restrictive non-penal measures.\footnote{Ibid at 5 & 6.}

Furthermore, the Commission expressed the opinion that the law reflected policies based on "myth and misunderstanding as to the character and nature of the problems created by mentally ill offenders in the criminal process."\footnote{Ibid at 6.} It concluded that there was a "lack of positive correlation between mental disorder and criminality or mental disorder and violent behaviour"\footnote{Ibid.} and noted that the limitations of psychiatric assessment, treatment and prediction of dangerousness were well documented. On that basis, the Commission recommended that policies to deal with mentally disordered individuals be guided by the following principles:

The criminal process should be invoked when it is the best available alternative; ... [m]entally disordered persons are entitled to the same procedural fairness and should benefit from the same protections of personal liberty as any other person; ... [i]n those instances where some form of detention is deemed necessary, it must be subject to review and in no circumstances should it be indeterminate.\footnote{Ibid.}

In the Commission's opinion, a person found NGRI was "in fact worse off than if he had been convicted. The judge is required to order him 'held' in a place of 'safe custody'.
‘until the pleasure of the Lieutenant-Governor is known.’\(^{227}\) The Commission recommended that the verdict of NGRI be treated as a true acquittal and the person be subject to a post-acquittal hearing to determine whether the person should be civilly detained on the basis of psychiatric dangerousness. The Commission added that this recommendation “brings into practical effect what has always been the insanity defence’s theoretical intent - to treat the ‘insane’ individual as a psychiatric rather than a criminal problem.”\(^{228}\)

On the issue of indeterminancy, the Commission noted that the objective of a criminal sentence is to punish and the punishment is for a pre-determined length. However, the objective of the LGW system was treatment. The Commission added that Treatment is [viewed as] intrinsically ‘good’, [and] therefore may go on forever and in far too many cases, has. For the individual from the inside looking out, one form of detention may look very much like the other.\(^{229}\)

Because of the non-reviewability of the detention, the lack of criteria for continued detention, and the fact that decisions to terminate the warrant were made by the provincial Attorney General or Cabinet who might refuse for political reasons,\(^{230}\) the Commission recommended the abolition of the LGW system. The recommendations of the Commission were not adopted.

\(^{227}\)Ibid at 22.

\(^{228}\)Ibid. This recommendation was reflected in subsection 3(6) of the Law Reform Commission of Canada, Report on Recodifying Criminal Law, v.1 (Ottawa: Law Reform Commission of Canada, 1986) at 30.

\(^{229}\)Ibid at 37.

\(^{230}\)Ibid.
Furthermore, in this report, the Law Reform Commission of Canada reiterated the aims of criminal sanctions

In our view, criminal sanctions should further underline the dignity and well-being of the individual, both offender and victim. They should be humane, proportional to the offence and treat like cases in a like manner.\(^{231}\)

Again, these aims are in keeping with a rehabilitative justice philosophy. In addition, the Commission stated that the scope of the criminal law should be limited as narrowly as possible and that only conduct that “represents a serious threat to society” be defined as criminal.\(^{232}\)

Furthermore, different reports\(^{233}\) have emphasized the importance of the liberty of the accused person, fairness in the criminal process and the principle of least restraint should underlie the criminal process, “[b]ecause the criminal law is society’s most destructive and intrusive form of intervention...[i]t is society’s last resort to be used only when milder methods have failed.”\(^{234}\) In 1982, the Government of Canada stated that the purpose of the criminal law should be achieved having regard to the *Canadian Charter of Rights and Freedoms* and “in a manner which interferes with individual rights and freedoms only to the extent necessary for the attainment of its purpose.”\(^{235}\)

\(^{231}\) *Supra* note 44 at 2.

\(^{232}\) *Ibid* at 12.


\(^{234}\) *Supra* note 44 at 2&3.

\(^{235}\) *Ibid*. 
I contend that these principles ultimately came to be reflected in the mental disorder provisions, which authorizes detention only if an accused person is a significant threat to the safety of the public. Even where detention is authorized under the provisions, a court or a Review Board must make the least onerous and least restrictive disposition. Furthermore, the mental disorder provisions contain review and hearing provisions which ensure procedural fairness to accused persons.

In 1982, the federal Department of Justice established the Mental Disorder Project to review the insanity provisions of the Criminal Code and recommend changes. In September of 1985, this Project issued a final report with recommendations. This Report stated that it was guided by the philosophy set out in The Criminal Law in Canadian Society, a federal report issued by the federal government governing the review of the criminal law. In particular, it cited the principle of using the least restrictive and least intrusive form of intervention required in the circumstances and stated that procedural safeguards were needed to ensure the protection of individual rights against the unwarranted intrusion of the state. On the issue of disposition and continuing review of persons found NGRI, the Project recommended that the criminal law provide a wide range of dispositions. It recommended that the role of the Lieutenant-Governor be abolished and that the court making the finding of NGRI be given the discretion to

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236 Supra note 197.
237 Supra note 233.
238 Supra note 197 at 33.
239 Ibid at 33 to 41.
make the least restrictive and least intrusive disposition, taking into account the needs of the individual and the protection of society. The Project recommended the establishment of a mandatory, multi-disciplinary Review Board. It added that, if the court did not make a disposition, then the Review Board would do so. In any case, the Review Board would hold a hearing within 90 days after the court made a disposition order. The recommended criterion for discharge was that the person no longer suffer from a mental disorder "likely to result in a substantial risk to the safety of society". The Project provided a long list of procedural safeguards such as an annual right of review; a right to counsel; the right of the person being reviewed to participate in the hearing and present evidence and question witnesses; a right of appeal; and a requirement that the Review Board give written reasons. The Project highlighted the criticisms leveled at the LGW system regarding the indeterminate nature of the detention and recommended that an outer limit be placed on the detention under the criminal law, based on the offence committed. The Project also stated that punishment is not the aim of the detention of those persons found NGRI. A draft bill incorporating most of the

240 Ibid at 37 to 49.
241 Ibid at 49-52.
242 Ibid at 41.
243 Ibid at 50.
244 Ibid at 52-54.
245 Ibid at 41 & 42.
246 Ibid at 41.
recommended amendments to the Criminal Code was tabled in Parliament in June 23, 1986, for purposes of consultation, but was never introduced.\(^{247}\) However, most of the recommendations were reflected in Bill C-30, An Act to amend the Criminal Code (mental disorder) and to amend the National Defence Act and the Young Offenders Act in consequence thereof which was enacted in 1991.

d) \textit{R. v. Swain}\(^{248}\)

Despite the above-mentioned reports, statements of principles and the tabling of a draft bill in the House of Commons, substantive changes to the insanity provisions of the Code did not occur until the Supreme Court of Canada in \textit{R. v. Swain}\(^{249}\) struck down the disposition section of the insanity provisions. The Court held that section 542 (2) of the Code,\(^{250}\) which required the automatic detention of a person found not guilty by reason of insanity, violated sections 7 and 9 of the Charter\(^{251}\) and was not saved by section 1 of the Charter. Basically, the Court determined that automatic detention in custody following the verdict of unfit to stand trial or not guilty by reason of insanity was

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\(^{247}\)E.A. Tollefson & B. Starkman, \textit{Mental Disorder in Criminal Proceedings} (Scarborough: Carswell, 1993) at 4-6. One of the major reasons that the bill did not proceed was that the provinces were opposed to the changes, in particular, because of the costs resulting from the implementation of the proposed changes.

\(^{248}\)\textit{Swain}, supra note 17.

\(^{249}\)\textit{Ibid.}

\(^{250}\)R. S. C. 1970, c. C-34. At the time the decision was rendered subsection 542(2) had been changed to subsection 614(2) of the Code following the 1985 revision of federal statutes.

\(^{251}\)\textit{Supra} note 14.
arbitrary because the provision did not provide any criteria for detention. Furthermore, the lack of a hearing to determine whether an accused person was dangerous to the public at the time of the finding deprived an accused person of her or his liberty in a manner that was not in accordance with the principles of fundamental justice. The Court added that if an accused person was not dangerous to the safety of the public at the time of the verdict, she or he should not be detained in custody. The Court stated

In the case at bar, the lack of a hearing in s. 542(2) deprives the appellant of his right to liberty in a way that is not in accordance with the principles of fundamental justice, thereby infringing his rights under s.7 of the Charter. His right under section 9 of the Charter not to be detained arbitrarily is restricted because there are no criteria for the exercise of the trial judge’s power to detain.

... However, the minimal impairment component of the Oakes test requires that insanity acquittees be detained no longer than necessary to determine whether they are currently dangerous due to their insanity.252

The Supreme Court of Canada permitted a six month delay before striking down the impugned subsection 542(2) of the Code.

The Court did however uphold the jurisdiction of the federal government to enact the insanity provisions of the Criminal Code on the grounds that these provisions were a valid exercise of the criminal law power contained in subsection 91(27) of the Constitution Act, 1867 (U.K.).253 The Court held that the object of the insanity provisions

252 Swain, supra note 17 at 1014 and 1018. The Court, also, struck down the common law rule allowing the Crown to raise the issue of an accused person’s insanity when the accused person did not raise it as a defence because it violated the principles of fundamental justice guaranteed by section 7 of the Charter.

253 Constitution Act, 1867 (U.K.), 1867, c.3.
was "[t]he protection of society [which] is clearly one of the aims of the criminal law".254

It rejected the argument that the object of the provisions was treatment of the mentally ill.

The Criminal Code provisions do not speak directly of the administration of medical treatment. They simply stipulate the procedures for a criminal committal, procedures designed to protect society, not to treat the individual. Parliament has developed a scheme by which to protect society through the neutralization of potentially dangerous persons who have brought themselves within the criminal sphere by committing acts proscribed by the criminal law. ... However, the impugned provisions themselves deal primarily with the removal of these people from society and only relate to treatment in a secondary, ancillary way.255

The Court emphasized that treatment was only the means by which the object of the insanity provisions, the protection of the public, would be achieved.

e) Adoption of mental disorder provisions

In response to the Swain decision,256 the federal government introduced Bill C-30.

An Act to Amend the Criminal Code (Mental Disorder) and to Amend the National Defence Act and the Young Offenders Act in Consequence Thereof, on September 16, 1991. The explanatory notes to this Bill stated that

The object of these amendments is to modernize, clarify and streamline the law and procedure with respect to the mentally disordered accused bearing in mind the rights of the accused under the Canadian Charter of Rights and Freedoms and the need to protect society.257

254 Swain, supra note 17 at 1001.

255 Ibid at 1005.

256 Ibid.

257 Explanatory Notes to Bill C-30, An Act to Amend the Criminal Code (Mental Disorder) and to Amend the National Defence Act and the Young Offenders Act in Consequence Thereof, at 1a.
The Minister of Justice, in her introduction of this Bill, reiterated the problems with the LGW system, such as indeterminate detention, lack of compulsory reviews by decision-making, independent Review Boards, and the total discretion given to the Lieutenant-Governor regarding release of these persons. She stated that “[t]he situation in which these people find themselves is worse in a number of ways than if they had been convicted of the offence charged.” She noted that the bill contained procedural requirements to ensure a fair hearing to the accused and that

The bill creates a framework of principles which are to be applied when deciding what disposition should be made. They are the protection of the public from dangerous persons, the reintegration of the accused into society and other needs of the accused. Another guiding principle is that the disposition imposed initially and subsequently is to be the least intrusive or onerous option having regard to the other principles already noted.

A number of members of Parliament expressed concerns that, though the intent of the bill was to release as many persons as possible to community based programs and services and to make “a fair degree of treatment and facilities available”, it would not be realized if the government did not provide the necessary funding to implement the Bill. Their view was that additional provincial mental health services— in particular, community-based ones— were required. Without shelter and support services, persons with mental disabilities would continue to fall into the criminal justice system. These concerns were reiterated before the Legislative Committee of the House of Commons on

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258 House of Commons Debates (4 October 1991) at 3295.
259 House of Commons Debates (4 October 1991) at 3297.
260 House of Commons Debates (4 October 1991) at 3301 and 3330.
Justice which studied the Bill. Members of Parliament and witnesses expressed concerns regarding the closure of psychiatric beds, adequate funding of the mental health system, and the increased demand for mental health services for persons who would fall within the proposed mental disorder provisions. These concerns arose from the consequences of de-institutionalization of persons with mental disabilities and the shift from psychiatric hospitals to psychiatric units in general hospitals and to the community. The perception was that there did not exist adequate community mental health resources, as reflected in the following comments:

Unfortunately, until recently the planning of mental health services has not been a priority for most provincial governments, and resources do not meet the current needs. In general, in the post-institutionalization period, reform has been resisted, and there has been little or no evidence of real progress.”

These concerns did not however result in any substantive changes to Bill C-30 which was enacted on December 13, 1991 and brought into force on February 4, 1992.262

D. Conclusion

I contend that there was a common goal, which animated the movements for lunacy reform in the first half of the 19th century, to attempt to provide humane treatment and care to persons with mental disabilities since these persons were no longer viewed as beasts who had lost their reason but rather as persons lacking order and self restraint. The moral treatment was an attempt to restore the order which was lacking in the life of the


262 However, s. 672.64 to 672.66 of the Code have not been proclaimed to date.
person with mental disabilities and to teach self restraint to the person with mental disabilities which would lead to a cure of that person. The lunatic asylums as envisaged by the proponents of the moral treatment were large establishments in a pastoral setting with good living conditions. As discussed, others have attributed the rise of the lunatic asylum to the emergence of the capitalism and the societal need for techniques to control deviant behaviour.

With the rise of the state funded lunatic asylum and its expansion due to the increase of institutionalization of persons with mental disability, the seeds of the contemporary mental health system were sewn. In addition, the insanity provisions were first enacted in England to provide for the disposition of persons with mental disabilities who committed crimes but were found not criminally responsible by reason of mental disorder or the preventative detention of persons with mental disabilities who might commit crimes due to their mental disorder. The insanity provisions were adopted in the different provinces in Canada, as was the lunatic asylum.

However, the lunatic asylums in the latter half of the 19th century failed to provide humane treatment and care envisaged by the reformers, as shown from the accounts of overcrowding and poor living conditions in the mammoth asylums. More and more persons with mental disabilities were institutionalized. Although the asylums became medicalized in that asylums had to have a medical doctor in attendance and were regularly inspected, very little care or treatment appears to have been provided. The inmates were sedated, kept on subsistence rations and made to work due to lack of funding. In reality, these institutions were more like warehouses for persons with
disabilities.

In the first half of the 20th century, asylums were renamed mental hospitals and attempts were made to train the attendants employed in these institutions to provide care to persons with mental disabilities. In addition, in the quest to discover a physical basis for mental illness, the psychiatrists in the mental hospitals practised somatic treatments and experimented on the inmates, a far cry from humane treatment. In addition, during this period the insanity provisions of the Code remained unchanged.

The exposure of conditions in mental hospitals by the adherents of the anti-psychiatry movement and mental health consumers, in the latter half of the 20th century, led to humanitarian concerns about the treatment of persons with mental disabilities and their isolation from the rest of society. In addition, the discovery of psychotropic medication and its use to control some of the symptoms of mental illness also made it possible to provide treatment in the community. I contend that these factors for the most part prompted the shift of persons with mental disabilities from mental hospitals to the community. As discussed, others have suggested that deinstitutionalization was motivated by other factors such as Scull who argued that it resulted from cost saving measures because of the growing fiscal crisis of the state. Furthermore, I suggest that deinstitutionalization was also fueled by a shift towards a recognition of the rights and liberties of persons with disabilities. In reality, however, the outcome of deinstitutionalization may have been far different for all persons with mental disabilities than envisioned by those advocating the shift of the delivery of mental health services from psychiatric institutions to the community.
The latter half of the 20th century also saw different commissions and committees reviewing the insanity provisions and recommending extensive reforms to these provisions. The indeterminancy of the detention and its arbitrariness were highlighted in their respective recommendations. They called for the establishment of multi-disciplinary review boards to conduct annual hearings and the provision of procedural safeguards. Of utmost importance was the recognition that detention was a drastic measure and should only be invoked if it was the only alternative to ensure the protection of the public. However, the repeal of the insanity provisions and the adoption of the present mental disorder provisions of the Code were only brought about by the Swain case.263

263Swain, supra note 17.
Chapter 2

Mandate of a Review Board Established under Part XX.1 of the Criminal Code and the Impact of Mental Health Resources on the Board and Accused Persons

Part XX.1 of the Criminal Code, setting out the current mental disorder provisions, continues the distinctive dimension of the criminal justice system previously established for dealing with persons accused of a criminal offence who are believed to suffer from a mental disorder affecting a person’s fitness to stand trial or the person’s criminal responsibility. This thesis focuses on those sections that govern the disposition of an accused person once the court which has jurisdiction over the accused person renders the verdict of unfit to stand trial or not criminally responsible on account of mental disorder (NCRMD). I restrict my analysis to accused persons found NCRMD because the issues raised by my hypothesis that the availability of mental health resources has an effect on the length of detention of accused persons are more pertinent to these persons. I discuss the Courts of Appeal decisions that have interpreted the intent and

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264 These are sections 672.38 to 672.44 respecting the establishment and functioning of the Review Board and sections 672.45 to 672.56 and 672.81 to 672.85 governing disposition hearings. Furthermore, section 672.1 states that “verdict of not criminally responsible on account of mental disorder” means a verdict that the accused committed the act or made the omission that formed the basis of the offence with which the accused is charged but is not criminally responsible on account of mental disorder.”

265 The reason for restricting my analysis to persons found NCRMD is that a court or Review Board cannot grant an absolute discharge to a person who is found unfit to stand trial because that person once fit returns to court to continue with the criminal proceedings. However, if the person continues to be unfit, every two years from the verdict, the court must hold an inquiry as to whether the prosecution can adduce sufficient evidence to put that person on trial, under section 672.33. Where the court is satisfied that prosecution cannot adduce such evidence the person is acquitted of the criminal charge. Therefore, different mechanisms exist for persons found unfit to stand trial to be
wording of section 672.54 of the Code, the mandate and powers of a Review Board, and legislative scheme of the mental disorder provisions. I analyze the effect that the various Courts of Appeal have had on the functioning of the Review Boards and the making of dispositions.

Then, I discuss the impact that the availability of sufficient mental health resources has on the functioning of the mental disorder provisions. As noted in chapter 1, the mental disorder provisions are premised on the assumption that these persons are not to be punished but are to be treated. In discussing the previous provisions,267 (referred to as the insanity provisions), the Supreme Court of Canada states in R. v. Swain268

But these provisions of the Code are not designed to punish the accused; they are for the protection of the public and the treatment of the accused. Manifestly, the public is best protected by the cure of the accused....

For humanitarian reasons, Parliament has determined that these individuals will be transferred into the hands of the provincial authorities for treatment.... Rather than prescribing “treatment”, the provisions provide for an alternative to incarceration, based on a humanitarian

discharged from the jurisdiction of the Review Board. Furthermore, I am not dealing with dual status offenders who are persons subject to both a sentence of imprisonment and a custodial disposition under paragraph 672.54(c) for different offences. This is a small category of accused persons found NCRMD. The issues discussed in this thesis vary in their applicability to these persons because of their particular situation.

266To date no Supreme Court of Canada decisions have been rendered on the mental disorder provisions. However, the Court has heard the appeals in the cases of Winko and Lepage, supra note 17, on June 15 and 16, 1998 and reserved its decision.


268Swain, supra note 17.
concern for persons acquitted by reason of insanity.269

These statements are applicable to the current mental disorder provisions. As discussed in chapter 1, the underlying philosophy for the establishment of a mental disorder system with distinctive dispositional alternatives has not changed. Specifically, I focus my analysis on the impact of the Court of Appeal decisions respecting the availability of mental health resources.

A. The Composition and Jurisdiction of a Review Board

Section 672.38 of the Code states that each province shall establish or designate a Review Board consisting of at least five members to make or review dispositions of accused persons found NCRMD or unfit to stand trial. Section 672.39 of the Code specifies that a Review Board must include at least one psychiatrist and at least one other member with expertise in mental health and entitled to practice medicine or psychology. The chairperson of a Review Board must be a judge, a retired judge, or a person who qualifies to be appointed as a judge, as required by section 672.4 of the Code. A quorum of a Review Board is constituted by a chairperson, a psychiatrist and any other member, according to section 672.41 of the Code. The chairperson is given the powers of a commissioner appointed under Part I of the federal Inquiries Act.270 under 672.43 of the Code. A Review Board has been recognized in various Courts of Appeal decisions271 as

269 Ibid at 1005.


having a specialized expertise in mental health and the mental disorder provisions. In 

Davidson v. A. G. of British Columbia,\textsuperscript{272} the Court of Appeal of British Columbia described a Review Board as follows:

As its composition and powers indicate, a Board of review set up under Part XX.1 of the Code is a specialized administrative tribunal, the skills of whose members provide institutional insight into the legal and medical problems of mental health. It is given inquisitorial powers to summon witnesses and compel them to give evidence.\textsuperscript{273}

B. Dispositions and Powers of a Review Board

a) Disposition Hearing Provisions

Once a court has rendered a verdict of NCRMD or unfit to stand trial, a court may hold a disposition hearing and make a disposition\textsuperscript{274} respecting a person whom it found NCRMD, under section 672.45 of the Code.\textsuperscript{275} If the court makes a disposition, other

\textsuperscript{272}Supra note 23.

\textsuperscript{273}Ibid at 277. The task of a Board is the same when making a disposition for a person who is unfit to stand trial, other than that the Board cannot grant an absolute discharge. However, in those cases, the Board must first deal with the issue of fitness because, if the person is fit, the person is returned to court and the Board does not make a disposition.

\textsuperscript{274}Section 672.1 of the Code states that a “disposition” means an order made by a court or Review Board under section 672.54 or an order made by a court under section 672.58.”

\textsuperscript{275}Courts do not usually make dispositions because they are not generally satisfied that they “can readily do so” as dictated by subsection 672.45 (2) of the Code. In addition, section 672.47 states that a disposition made by the court is in force until the date set out in the order but no later than 90 days after which it was issued. Therefore, a Review Board must still hold a disposition hearing and render a disposition for a person found NCRMD and in respect of whom a court made a disposition, unless the court granted an absolute discharge. Furthermore, since the courts have recognized the expertise of the Review Board in making disposition, as stated in R. v. Peckham, supra note 271 at 778, they may be reluctant to exercise their jurisdiction in these cases. These
than an absolute discharge, it is in effect for a maximum period of 90 days, as specified in subsections 672.47 (3) and 672.55 (2) of the Code, and accused persons are placed under the jurisdiction of a Review Board which must hold a hearing and make a new disposition within those 90 days, under subsection 672.47 (3) of the Code. Otherwise, a Review Board must hold disposition hearings within 45 days of the verdict and make a disposition, under section 672.47 of the Code. A Review Board must review annually the disposition of each accused person, in accordance with section 672.81 of the Code, until it grants an accused person found NCRMD an absolute discharge.

A Review Board is required to give a notice of hearing to each of the parties to the hearing, in accordance with subsection 672.5 (5) of the Code. The parties are defined in section 672.1 of the Code as the accused person, the person in charge of a hospital where the accused person is detained or is to be detained under a disposition, the designated Attorney General, and any other interested person designated under subsection 672.5 (4) of the Code. At each hearing, an accused person who is the subject of the hearing or any other party has the right to be represented by legal counsel, in accordance with subsection 672.5 (7) of the Code. The Review Board must appoint counsel for an accused person who is unrepresented and unfit to stand trial and may appoint counsel where it determines that it is in the interests of justice to do so, under subsection 672.5 (8) of the Code.

Comments are based on conversations with the chairpersons of the Ontario Review Board and British Columbia Review Board who stated that courts render very few dispositions.

Subsection 672.5 (3) of the Code states that on application the court or Review Board shall designate as a party, the Attorney General of the province where the disposition is made or, in the case of a transfer from another province, the Attorney General of that province.
Each party at the hearing has the right to adduce evidence and make written or oral submissions, under subsection 672.5 (11) of the Code. The Review Board must forward to each party a copy of any written information or assessment report relevant to making a disposition under section 672.51 of the Code.

In making a disposition, a Review Board, or the court under section 672.45 of the Code, must consider the factors set out in section 672.54 of the Code which states:

672.54 Where a court or Review Board makes a disposition pursuant to subsection 672.45(2) or section 672.47, it shall, taking into consideration the need to protect the public from dangerous persons, the mental condition of the accused person, the reintegration of the accused person into society and the other needs of the accused person, make one of the following disposition that is the least onerous and least restrictive to the accused person:
(a) where the verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused person and, in the opinion of the court or Review Board, the accused person is not a significant threat to the safety of the public, by order, direct the accused person be discharged absolutely;
(b) by order, direct that the accused person be discharged subject to such conditions as the court or Review Board considers appropriate; or
(c) by order, direct that the accused person be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.

Section 672.54 of the Code is the key substantive provision respecting dispositions and the powers of a Review Board. It sets out the criteria on which a disposition must be based and the type of disposition orders that are possible under the mental disorder provisions.²⁷⁷ A Review Board, or a court, in the first instance, must determine whether dispositions made following an annual review are made pursuant to section 672.54 as a result of the reference in section 672.83 to the Review Board making a disposition it considers to be appropriate in the circumstances and of section 672.1 defining a disposition as "an order made by a court or Review Board under section 672.54 or an order made by a court under section 672.58." Section 672.58 does not apply to

²⁷⁷Dispositions made following an annual review are made pursuant to section 672.54 as a result of the reference in section 672.83 to the Review Board making a disposition it considers to be appropriate in the circumstances and of section 672.1 defining a disposition as "an order made by a court or Review Board under section 672.54 or an order made by a court under section 672.58." Section 672.58 does not apply to
an accused person poses a significant threat to the safety of the public. In making a decision, a Review Board or court must consider the opening words of section 672.54 of the Code. In fact, a Review Board is called upon to predict the dangerousness of the person under its jurisdiction based mainly on psychiatric evidence about the mental disorder, treatment, prognosis and past history. If a Review Board or court concludes that the person is not a significant threat, then it must grant an absolute discharge. Otherwise, it must consider whether a conditional discharge or a custodial disposition is warranted. However, a Review Board or court in the first instance cannot order treatment as a condition of a disposition under subsection 672.55 (1) of the Code. In short, in a disposition, a Review Board or the court must balance the protection of the public and the interests of an accused person.

Once a Review Board or court has made a decision to detain a person or release the person on conditions, it delegates the powers to carry out the disposition to the person in charge of the hospital where the person is detained or reports, in accordance with section 672.56 of the Code. The person in charge of the hospital then may delegate the day-to-day supervision and care to the treatment team within the hospital where the person is detained in custody. The person is integrated into the mental health system.

annual reviews because it deals with treatment orders to render unfit persons fit to stand trial.


279 This is generally the practice in British Columbia and Ontario as explained by the Chairpersons of the British Columbia and Ontario Review Boards.
but cannot be discharged from care without the approval of the Board. Under section 672.56 of the Code, the person in charge of a hospital is granted the power to restrict the liberties that a person may exercise; however, if the restrictions are to last for more than seven days, a person in charge of a hospital has to give notice to the Review Board which triggers a new hearing by the Review Board.

C. Case Law on Disposition and Disposition Hearings

Case law has considered a number of facets of section 672.54 of the Code including the circumstances in which an absolute discharge can be made; the “meaning of significant threat to the public”; the appropriate interpretation of the requirement that the least onerous and least restrictive disposition be made; and the nature of Review Board hearings. In this section, a number of Court of Appeal decisions which have had the most impact on clarifying the criteria for making dispositions are examined.

a) Meaning of “significant threat to safety of the public” and absolute discharges

*Orlowski v. British Columbia (Attorney-General)*\(^{281}\) which was subsequently followed by other Courts of Appeal and applied by Review Boards\(^{282}\) was one of the first cases to interpret section 672.54 of the *Code*. This case laid out the manner in which a Review Board must make its decision. The Court of Appeal of British Columbia interpreted section 672.54 in the context of the legislative scheme of Part XX.1 of the *Code*.

In my judgment the Board must, in the first instance, consider the ‘preamble’ factors, not just in deciding whether an accused person is a significant threat, but also in deciding what disposition it will make of each case.

In addition, however, the Board must also struggle with other questions, and it is not possible to say that any of the factors are free-standing and independent of each other. The legislative objective is to decide what disposition should be made that is the least onerous and the least restrictive upon considering the ‘preamble’ factors and the language of s. 672.54.\(^{283}\)

In addition, the Court stipulated the circumstances under which a Review Board

\(^{281}\) *Supra* note 278.

\(^{282}\) The Ontario Review Board and the British Columbia Review Board generally set out in their reasons whether the Board is of the opinion that an accused person is a significant threat to the safety of the public or not; or that it does not have the opinion that the accused person is not a significant threat. Generally, this opinion will be based on the nature of the “index” offence, past history- in particular of violence, insight into the mental disorder, prognosis, available treatments, whether an accused person is compliant with treatment, present mental condition, prospects of reintegration into the community and behaviour in the community. For a more detailed study see I. Grant, *“Canada’s New Mental Disorder Disposition Provisions: A Case Study of the British Columbia Criminal Code Review Board”* (1997) 20 International Journal of Law and Psychiatry 419.

\(^{283}\) *Supra* note 278 at 146.
should grant an absolute discharge. It stated

[I]n my view, the Board need not order an absolute discharge when it has doubts as to whether the accused is a significant threat or not. The Board must affirmatively have an opinion that the accused is not a significant threat before s. 672.54(a) applies. It seems to me, with respect, that if the Board is concerned that an accused with an appropriate history is not a present significant threat and will not become one if he continues with prescribed medication, but the Board also has the opinion that he may be a significant threat if he does not take his medication, then the Board cannot be said to have an opinion that the accused is not a significant threat. The word ‘threat’, in my view, has a future connotation.\textsuperscript{284}

The Court further added that a Review Board, out of fairness to the accused person, should expressly declare, in the reasons for the disposition, its conclusion as to whether the accused person is a significant threat to the safety of the public or declare that it cannot arrive at such a conclusion.\textsuperscript{285}

In a subsequent decision, \textit{D.H. v. British Columbia (A.G.)},\textsuperscript{286} the Court of Appeal of British Columbia agreed with \textit{Orlowski} that the phrase “significant threat” implies a consideration of future events, although, “the evidence must take the Board beyond mere speculation.”\textsuperscript{287} In this case, the Court found that

[T]he evidence was overwhelming that nothing more could be done to ease the appellant back into society; ... he suffered from no major illness; and, apart from the index offence [the offence that brought him under the jurisdiction of the Board], he presented no signs of serious danger to

\textsuperscript{284}\textit{Ibid.}

\textsuperscript{285}\textit{Ibid.}

\textsuperscript{286}\textit{D.H., supra note 280.}

\textsuperscript{287}Cited in \textit{Winko, supra note 17 at 11.}
others.\textsuperscript{288}

A subsequent Ontario Court of Appeal decision, \textit{R. v. Peckham}\textsuperscript{289} elaborated on the issue of the granting of an absolute discharge under section 672.54 of the \textit{Code}.

Finally, the section as worded by Parliament mandates absolute release only where the Board is of the opinion that the accused is not a significant threat to the safety of the public. It must follow that the section contemplates, in all other cases, further restraints on the liberty of an accused either by way of conditions attached to a release order or further confinement in hospital. The nature and extent of that deprivation does not depend on the continued existence of the mental disorder which led to the finding of not criminally responsible on account of mental disorder, but must be determined using the approach dictated by s.672.54.\textsuperscript{290}

The impact of these decisions on the liberty interest of an accused person is significant. As a result of these cases, unless an accused person, or any other party, can provide evidence that will convince the Review Board that the accused person is not a significant threat to the safety of the public, the accused person remains under the jurisdiction of the Review Board. Therefore, it is not just a question of showing that the accused person does not suffer active symptoms of a mental disorder. The expression, "mental condition" has been interpreted as the "overall mental state of the accused without limiting itself to a determination of whether that condition, or at least some aspect of it, continue[s] to fit within the confines of the legal concept of mental disorder."\textsuperscript{291} The current stable mental condition of an accused person is not the

\textsuperscript{288}Ibid.

\textsuperscript{289}Supra note 271.

\textsuperscript{290}Ibid at 776.

\textsuperscript{291}Ibid.
determining factor in the granting of an absolute discharge. The Review Board in making
a determination under section 672.54 of the Code is “essentially looking forward and
making an assessment of future risk.” The Orlowski decision held that past medication
compliance may be considered in assessing future behaviour. Other factors, such as
nature of the mental disorder of the accused person, the available treatment, the accused
person’s insight into her or his mental condition and the accused person’s willingness to
comply with treatment, may be considered in assessing future risk to the safety of the
public. Concrete evidence as to the functioning of the accused person in the community
and continued mental stability while in the community is required by a Review Board for
it to be satisfied that the accused person is not a significant threat to the safety of the
public. It is not sufficient for an accused person to demonstrate that she or he is
undergoing treatment which has stabilized her or his mental condition. Without the
necessary mental health resources and supports, in particular community resources, an
accused person will be unable to demonstrate that she or he can function in the
community and does not pose a significant threat to the safety of the public. One
example of such a situation is found in the McGillis case. The Ontario Review Board
was not satisfied that Mr. McGillis who had been detained in hospital for a number of

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292 Lepage, supra note 17 at para. 76.
293 Ibid at para 69.
294 Supra note 16 at 243-244
295 Supra note 16. No further appeal was taken in this case.
years could "safely reside outside the hospital" without supervision. The Board granted Mr. McGillis a discharge on condition that he reside in approved accommodation in the community. However, the evidence before the Board was that the supervised accommodation which Mr. McGillis needed was not available because of a lack of adequate community mental health resources. The Court of Appeal of Ontario quashed the disposition of the Board on the basis that the lack of such accommodation resulted in Mr. McGillis continuing to reside in hospital. The Court held that the Board should have made a custodial disposition. The Court of Appeal did not comment on the requirement that the Board must make the least restrictive disposition. Similarly, In the Matter of Robert Allen Mitchell where the British Columbia Review Board felt that Mr. Mitchell could only live safely in the community in a structured supervised accommodation, the Board continued his detention in custody because of a lack of appropriate community housing which would have been the less restrictive alternative.

Of note is a recent decision of the British Columbia Court of Appeal, Chambers v. A.G. of British Columbia and the Director of the Forensic Psychiatric Institute clarifying the meaning of "significant threat". In this case, Ms Chambers, an accused

\[296\text{Supra note 22 at 243.}\]

\[297\text{Supra note 36. Of note is the fact that neither the British Columbia Review Board nor the Ontario Review Board publish their decisions. However, access to decisions is permitted on request since the disposition hearings of the Board are open to the public and the hearings are a continuance of the criminal proceedings, according to the respective Chairpersons of the British Columbia Review Board and the Ontario Review Board.}\]

\[298\text{Supra note 280.}\]
person, appealed the British Columbia Review Board decision which had revoked her conditional discharge and ordered her to be detained in custody. While in the community, Ms Chambers had breached her conditional order by using drugs and alcohol and the Board based its decision on its concern about the effects of Ms Chambers’ use of drugs and alcohol on her mental condition. The Board was concerned that while disinhibited by alcohol, Ms Chambers, who was HIV positive and worked as a prostitute while in the community, posed a threat of passing the HIV virus. Therefore, the Board was of the opinion that Ms Chambers had to be detained in custody to mitigate the risk she posed to the community. The appellant argued that the “significant threat” in section 672.54 of the Code must refer to a threat of an act that constitutes an offence under the Criminal Code and it was not a crime to be a prostitute who was HIV positive. The Court ruled as follows:

I am persuaded that ‘significant threat’ must refer to criminal conduct or activity as the review procedure is part of the Criminal Code. In my opinion, Parliament never intended to deal with (detain) persons with physical (health) problems which are neither mental conditions nor mental disorders within these sections of the Criminal Code.299

The Court allowed the appeal and granted Ms Chambers an absolute discharge. Therefore, in determining whether an accused person poses a significant threat to the safety of the public, the Board must assess whether the person is likely to engage in criminal activity or conduct as a result of a mental disorder.

299 Ibid at paragraph 22.
b) Least onerous and least restrictive disposition

A number of cases\textsuperscript{300} including Orlowski have emphasized that section 672.54 of the Code requires that a Review Board grant an accused person the least onerous and least restrictive disposition. The Court of Appeal of British Columbia stated

The requirements of s. 672.54 direct that the Board put into perspective the mental condition, goals and needs of the mentally disordered person with the interests of the public, and where an absolute discharge is not warranted, to choose the least restrictive and least onerous conditions on the liberty of that person's liberty [sic].\textsuperscript{301}

However, in \textit{R. v. Pinet},\textsuperscript{302} the Ontario Court of Appeal gave the words "least onerous and least restrictive" in section 672.54 of the Code a unique interpretation.

McKinlay J.A. for the Court expressed the view that these words were only relevant to choosing the type of disposition and added that

"[I]t is not necessary for the Board, in imposing conditions under (b) or (c), (sic) consider whether the type of hospital or the conditions contemplated under (b) or (c) would be the least onerous and least restrictive."\textsuperscript{303}

In my opinion this interpretation is contrary to the principle espoused in \textit{R. v. Swain}\textsuperscript{304} and the other Courts of Appeal decisions cited above that the person's liberty interests should

\textsuperscript{300}See Orlowski, supra note 278 at 146. Davidson, supra note 23 at 278, Winko, supra note 17 at 52, Lepage, supra note 17 at para. 66, and Peckham, supra note 271 at 774-775.

\textsuperscript{301}Supra note 23 at 278.

\textsuperscript{302}Supra note 35. No further appeal was taken in this case.

\textsuperscript{303}Ibid at 101.

\textsuperscript{304}Swain, supra note 17.
not be unnecessarily restricted. A Review Board must consider the type of hospital or name the hospital in which an accused person should be detained under a custodial disposition. Otherwise, it would be shirking its duty in that it would not necessarily be rendering the least onerous and least restrictive disposition as emphasized in the Orlowski and the Peckham decisions. A Review Board has a duty to consider the needs of the accused person in fashioning a disposition appropriate to the accused person. For example, if a Review Board made a generic order stating that the accused person be detained in any medium security hospital, again it would not be carrying out its duties outlined in section 672.54 of the Code. My argument is further supported by R. v. Lepage305 where the Ontario Court of Appeal emphasized that detention in custody causes harm to an accused person if it is not the least restrictive and least onerous disposition.

The Court stated:

At the same time the scheme recognizes the harm done to accused (sic) who are unnecessarily detained in a psychiatric facility. The scheme limits detention to situations where it is the ‘least onerous and restrictive’ position available. Finally, the scheme permits the court or Review Board to tailor orders to the specific needs of each case and to make those orders sufficiently flexible to respond quickly where circumstances warrant a variation of a disposition.306

Furthermore, the legislative scheme clearly provides that a hospital must be named in an order for the following reasons. First, as previously stated, the definition of “party” in section 672.1 of the Code clearly contemplates the designation of a specific person in a particular hospital. Second, a hospital must be named in a disposition because

305 Lepage, supra note 17.

306 Ibid at 37.
the Review Board may only order a party to the hearing to implement the custodial order or a conditional discharge, where the accused person is placed under the supervision of a hospital. If a person in charge were not specified, the task of implementing the order would not fall on any one person. Third, section 672.56 of the Code permits a Review Board to delegate its powers to the person in charge of a hospital. It states:

672.56(1) A Review Board that makes a disposition in respect of an accused under paragraph 672.54 (b) or (c) may delegate to the person in charge of the hospital authority to direct that the restrictions on the liberty of the accused be increased or decreased within any limits and subject to any conditions set out in that disposition, and any direction so made is deemed for the purposes of this Act to be a disposition made by the Review Board.

(2) A person who increases the restrictions on the liberty of the accused significantly pursuant to authority delegated to the person by the Review Board shall
(a) make a record of the increased restrictions on the liberty of the accused; and
(b) give notice of the increase, as soon as is practicable to the accused and, if the increased restrictions remain in force for a period exceeding seven days, to the Review Board.

This section contains the supervision mechanism which ensures the protection of the public and the exercise of liberties by an accused person. Since the mental condition of an accused person may fluctuate, subsection 672.56 (1) of the Code permits the person in charge of a hospital to respond where the mental condition of an accused person deteriorates or improves by restricting liberties or increasing them within the limits specified by the Review Board.

307 A Review Board has no other means to make the disposition enforceable other than the delegation to the person in charge of a hospital under section 672.56 of the Code. The mental disorder provisions of the Code do not grant a Review Board any contempt powers or any powers to enforce their disposition orders.
Fourth, under subsection 672.56 (2) of the Code, a person in charge of the hospital who increases the restrictions on the liberty of the accused person is obligated to notify the Review Board. Since giving of the notice under subsection 672.56 (2) of the Code triggers a hearing by a Review Board under subsection 672.81(2) of the Code to determine whether the restrictions were warranted, it is important to identify the person who may impose restrictions and is obliged to give notice.

Fifth, based on the factors set out in section 672.54 of the Code and the case law,\textsuperscript{308} if the Review Board does not address the specific issue of where a person can receive appropriate mental health services or be more easily reintegrated into the community, it would not be considering the mental condition of the person and that person's other needs. When the evidence before a Review Board warrants certain conditions or the parties are requesting them, in fairness, the Review Board must address in its reasons why it grants or refuses those conditions since it must make the least restrictive and least onerous disposition.\textsuperscript{309}

In \textit{R. v. Pinet},\textsuperscript{310} McKinley J.A., writing for the court, opines that a generic order, rather than one which sets out the terms of privileges or conditions, would be more

\textsuperscript{308}Supra note 280.

\textsuperscript{309}Subsection 672.52 (3) of the Code requires that a Review Board state its reasons for making a disposition. Furthermore in \textit{Orlowski, supra} note 278 at 147, the Court of Appeal of British Columbia ruled that “fairness requires [that] the accused ... be given a specific finding [respecting whether she or he is a significant threat] with explanatory reasons.” I suggest that fairness would also require that the Board address in its reasons why it has made certain conditions or refused to do so.

\textsuperscript{310}Supra note 35.
practical. She states that "[i]ndeed, it would likely be appropriate in most situations to leave details of detention to the professional care-givers."³¹¹

It is important to keep in mind, in interpreting the various new statutory provisions, that health care professionals are the ones who have the day-to-day responsibility for the care and treatment of individuals involved, and undue interference with that responsibility may not be in the interests of society or of the accused.³¹²

This position permits a broad delegation of the powers from the Review Board to the person in charge of the hospital, allowing a person in charge of a hospital to determine such things as the level of security that the accused person needs (therefore deciding on transfers from one hospital to another), and the accused person's access to the community. Such a model would rely solely on the discretion of the person in charge of the hospital if there were no parameters set by a Review Board within which the person in charge of the hospital was to exercise his or her discretion. Though section 672.56 of the Code permits the Review Board to delegate to the person in charge of the hospital, it clearly states that the person in charge of a hospital can only increase or decrease the restrictions within the limits and subject to any conditions set out by the Review Board. In my view, this wording suggests that a Review Board should set specific conditions or grant specific privileges to protect the liberty interests of the accused person. Without such conditions or privileges, a hearing would not be triggered under section 672.56 of the Code, and a Review Board would lose its oversight on the person in charge of the hospital. Therefore, the Review Board would be unable to protect the liberty of the

³¹¹Ibid at 102.
³¹²Ibid at 99.
accused which would be contrary to the legislative scheme of the mental disorder provisions. In support of my views that a Review Board cannot delegate its powers as suggested by McKinley J., I cite the findings of the British Columbia Court of Appeal in *Forensic Psychiatric Institute (British Columbia) v. Johnson*. The Court ruled that, in the case where a Review Board grants a conditional discharge, “the Review Board is charged with the responsibility of crafting conditions which are relevant to the special and differing needs of each accused person.” On the question of delegation under section 672.56 of the *Code*, the Court stated

The discretion which may be delegated to the director under section 672.56 is an important vehicle through which the Review Board can achieve its mandated purpose... Nor must it be used as a means by which the Review Board can delegate to the director its paramount responsibility for ensuring that a proper balance is maintained between the liberty interests of an accused and the safety interests of the public.

In my opinion, the *Pinet* case and the *Johnson* case cannot be reconciled. Based on the arguments advanced above, I suggest that the *Johnson* case is more in keeping with the legislative scheme of the mental disorder provisions.

Furthermore, the type of generic order suggested in the *Pinet* case is contrary to

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313 *Johnson, supra* note 280. No further appeal of this case was taken.

314 *Ibid* at 47.

315 *Ibid*.

316 *Supra* note 35.

317 *Johnson, supra* note 280.

318 *Ibid*.

319 *Supra* note 35.
the practice of the Ontario Review Board and the British Columbia Review Board.\textsuperscript{320}

In a disposition, the Ontario Review Board sets out the privileges granted to or the conditions imposed on the accused person; and delegates to the Administrator of the specified provincial psychiatric hospital the powers to grant or restrict the privileges outlined in the disposition.\textsuperscript{321} Where a custodial order is made, the Review Board also specifies the name of the hospital and the level of security in that hospital. The Review Board may under a custodial order permit an accused person the privilege of living in the community where the person’s mental condition is stable. However, the Administrator of a hospital may order the accused person to return to live in the hospital where an accused person’s mental condition becomes unstable and the safety of the public is at risk.

Where the Review Board grants a conditional discharge and an accused person is placed

\textsuperscript{320}As explained in the introduction, I am using the Ontario Review Board and the British Columbia Review Board and the mental health system in Ontario and British Columbia as examples to support and illustrate my arguments. This practice is described in the various decisions of the Courts of Appeal, for example \textit{R. v. Lepage, supra note 17}; \textit{R. v. Peckham, supra note 271}; \textit{R. v. Jones, supra note 280}; \textit{Orlowski, supra note 278}; \textit{Davidson, supra note 23}; \textit{Peckham, supra note 271}; \textit{Johnson, supra note 280}. As well, a reading of dispositions of the Ontario Review Board and British Columbia Review Board shows that this is the practice, see for example \textit{In the Matter of the accused Frederick Melvin McGillis, Disposition, Ontario Review Board (May 11, 1998) [unreported]} or \textit{In the Matter of Robert Allen Mitchell, supra note 36}.

\textsuperscript{321}The practice of the Ontario Review Board is evident from the orders of disposition of the Board. In Ontario, the Minister of Health designated as hospitals, under section 672.1 of the \textit{Code}, the 10 provincial psychiatric hospitals which are the Brockville Psychiatric Hospital, Hamilton Psychiatric Hospital, Kingston Psychiatric Hospital, Lakehead Psychiatric Hospital, London Psychiatric Hospital, Mental Health Centre, Penetanguishene, North Bay Psychiatric Hospital, Queen Street Mental Health Centre, St. Thomas Psychiatric Hospital and Whitby Mental Health Centre, as well as, the Clarke Institute of Psychiatry, Royal Ottawa Hospital and the Thisletown Regional Centre for Children and Adolescents (Syl Apps Campus).
under the supervision of an administrator, the Administrator cannot order the person to return to hospital. Where the Ontario Review Board grants a conditional discharge, but does not order the accused person to report to an Administrator of a specified hospital and does not delegate any powers to the Administrator, the supervision of the accused person is lacking and psychiatric evidence about the person's mental condition is sparse.

In British Columbia, all dispositions delegate powers to the Director of the Forensic Psychiatric Institute. In a custodial order, an accused person is detained at the Institute while under a conditional discharge, an accused person is placed under the supervision of the Director of the Institute. The limits of the liberties accorded to the accused person or conditions are set out in the disposition order. The British Columbia Review Board does not specify the level of security within the Institute in a detention order. This raises the issue of whether the delegation in this respect is too broad, in that a higher level of security generally means more restrictions on the liberties of the accused person. I believe that such a delegation is open to challenge for the reasons set out above.

In addition, under a conditional order, the Director may order the involuntary detention at

322 However, the Administrator may, if the accused person meets the criteria for civil committal in that the person is a danger to self or others, detain the accused person under the authority of the Ontario Mental Health Act, R.S.O. 1990, c. M.7.

323 According to the chairperson of the Ontario Review Board, the attending psychiatrists who are in private practice generally refuse to provide reports on the mental condition and other needs of the accused person for the previous year because they are not paid to provide reports or to testify before the Board. In these cases, the Board has ordered the Crown to obtain the information from the attending psychiatrist.

324 This is evident from the dispositions rendered by the British Columbia Review Board. Examples are found In the Matter of Robert Allen Mitchell and In the Matter of Anthony Florence, supra note 36.
the Institute of an accused person, contrary to the practice in Ontario.

c) Nature of Review Board hearings

In Davidson v. A.G. of British Columbia\(^\text{325}\) and R. v. Peckham\(^\text{326}\), the Courts of Appeal of Ontario and British Columbia respectively expounded on the nature of Review Board hearings. The appellant argued that section 672.54 of the Code placed a burden on the Crown to prove that an accused person was a significant threat. In addition, the appellant asked the court to rule that the standard of proof should be “beyond a reasonable doubt”. The Court in each case held that a Review Board hearing was not “strictly adversarial in the same sense that a criminal or civil trial is strictly adversarial”\(^\text{327}\). The hearing was characterized as an inquiry into the criteria identified in section 672.54 of the Code, as had been ruled in Orlowski v. British Columbia (Attorney-General)\(^\text{328}\). Therefore, none of the parties bore the burden of proof. In R. v. Peckham, the Ontario Court of Appeal further held that the function of a Review Board was “analogous to a judge passing sentence”\(^\text{329}\). The Court made it clear that in these cases an accused person’s liberty interests require a “high level of procedural protection.”\(^\text{330}\)

The characterization of the disposition hearing as inquisitorial in nature and the

\(^{325}\) Supra note 23.

\(^{326}\) Supra note 271.

\(^{327}\) Ibid at 773.

\(^{328}\) Supra note 278.

\(^{329}\) Supra note 271 at 774.

\(^{330}\) Ibid at 773.
finding that no party had the burden of proof have had an important impact on the role of
a Review Board. This emphasis on the inquisitorial nature of a Review Board downplays
the reality that the Review Board must rely on the parties to bring forward the necessary
evidence for it to make a just and fit disposition and that the hearings are somewhat
adversarial depending on the position taken by each party at a hearing. However, the
courts have stated that when making a disposition, a Review Board need not rely only on
the evidence adduced by the parties at the hearing and may require the parties to bring
additional information necessary for it to make a disposition. In addition, when the
question of availability of mental health resources has arisen, the courts have noted that
the Review Board has the power to adjourn the hearing and require additional information
or to make a disposition and hold an early hearing. An example of such a case is that of
McGillis\textsuperscript{331} which will be discussed in detail in the next section.

D. Impact of Mental Health Resources On Mental Disorder Scheme

a) The link between treatment and release

Although treatment cannot be imposed in a disposition,\textsuperscript{332} the availability of
treatment and other mental health resources is crucial in the legislative scheme set out in
the mental disorder provisions of the \textit{Code}. As noted by Lamer C.J.C. in \textit{R. v. Swain}.\textsuperscript{333}

\textsuperscript{331}Supra note 16.

\textsuperscript{332}Subsection 672.55(1) of the \textit{Code} clearly states that treatment cannot be ordered
in a disposition under section 672.54 of the \textit{Code}. However, a condition regarding
treatment may be included in a disposition if the accused consents and the Review Board
is of the opinion that the condition is reasonable and necessary in the interests of the
accused person.

\textsuperscript{333}Swain, supra note 17.
As our understanding of mental illness has grown through the years, providing treatment for persons held under L.G.W. has come to be accepted, indeed expected, for both humanitarian and pragmatic reasons. However, this treatment is not prescribed by the impugned provisions; rather, it constitutes the means to achieving their end, the protection of society.\footnote{Ibid at 1005.}

In making dispositions under section 672.54 of the \textit{Code} relating to the mental condition of the accused person, a Review Board must consider the availability of treatment: whether the accused person is undergoing treatment, and if so, the likelihood that the accused person will continue in treatment. The following passage in \textit{R. v. Lepage}\footnote{Lepage, supra note 17.} illustrates this:

\begin{quote}
The mental condition of the accused is but one of four factors to be considered by the court or Review Board in determining whether it is of the opinion that the accused is not a significant threat to the safety of the public and should, therefore, be discharged absolutely. The significance of the accused person’s mental condition to that determination will depend on many variables, including the nature of the mental disorder, if any, from which the accused person suffers at the time of inquiry, the available treatment, the accused person’s understanding of his mental condition, and the accused person’s willingness to conform to any proposed course of treatment.\footnote{Ibid at para. 38.}

The link between treatment and the mental disorder provisions is further emphasized in \textit{Winko v. British Columbia (Forensic Psychiatric Institute)}.\footnote{Winko, supra note 23.} In this case, McEachem J. opined that the objective of a custodial order under section 672.54 of the \textit{Code} was to commit an accused person to hospital for treatment. He characterized

\begin{quote}

\end{quote}
paragraph 672.54 (c) of the Code as establishing a "regime for treatment and release" of an accused person found NCRMD. However, McEachern J. was not suggesting that treatment could be ordered but that the only reason to confine an accused person to hospital was to make treatment available.

b) Availability of Mental Health Resources

The above mentioned decisions highlight the importance of the availability of mental health resources such as psychiatric beds, treatment and inpatient programs for those that a Review Board determines must be detained in custody and community mental health resources to support accused persons in the community. Since health is a provincial matter, there are differences in the availability and delivery of mental health services in each province. For the purposes of this thesis, I examine the mental health system in Ontario and British Columbia to illustrate and argue that there is an insufficient supply of psychiatric beds. In addition, I use the experience of persons found NCRMD within these mental health systems to argue that the community mental health services are inadequate because accused persons are not being reintegrated into the community as intended by the mental disorder provisions.

1. Ontario

i) Overview of Mental Health Reform in Ontario

To better understand the factors that have fueled the present climate of closure of psychiatric hospitals and cutbacks in psychiatric beds and concerns respecting community mental health resources, a brief review of mental health reform in Ontario is necessary.

\(^{338}\textit{Ibid} \text{ at } 58.\)
As noted in chapter 1, in the 1960s and 1970s, the phenomenon of deinstitutionalization swept Canada with its emphasis on providing mental health services in the community. However, the necessary community mental health resources were not in place or envisioned to implement the community-based mental health philosophy. The discussion paper, *Towards a Blueprint for Change: A Mental Health Policy and Program Perspective*, emphasized that “the early period of deinstitutionalization was not accompanied by a sufficient emphasis upon the provision of alternative support services, including accommodation, with the result that many patients discharged into the community experienced difficulties.” Mental health planners had assumed that “[c]hanges in terms of the development of social services and welfare programs, universal health care and the development of psychiatric services in general hospitals” would provide services to mentally ill persons previously provided by the psychiatric hospitals. The discussion paper challenged these assumptions for the following reasons. First, the general hospital psychiatric units were usually treating “populations that were non-disruptive and who could be quickly discharged.” Second, the number of persons using

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mental health services increased because of a number of factors, including the creation of universal health care insurance which made mental health services available to persons who would not have previously used a psychiatric hospital; a downturn in the economy which resulted in additional life stresses; and changing public attitudes toward emotional problems, psychotherapy and psychoanalysis. Therefore, even though mental health resources increased overall, it was not enough to meet the demand for services and "communities became less able to support persons with mental illness in the community. As a result, the rate of re-hospitalization of persons with serious mental illness increased." Hence, the need for establishing mental health priorities in keeping with a community-based philosophy was brought to the fore and Ontario embarked on the road to mental health reform.

In 1979, the Committee on Mental Health Services in Ontario reviewed mental health services and in its report, *Agenda for Action: A Report of the Ontario Council of Health,* concluded that there was a clear lack of government policy or priority respecting mental health services in comparison to other provincial programs. It noted that many aspects of the mental health system needed attention. The Report proposed a


342 *Supra* note 340 at 27.


two-prong approach to the planning and delivery of mental health services. It suggested that the provincial government continue with "overall responsibility for ensuring adequate funding, availability and equitability of services that meet defined standards" and a decentralized system of delivery of mental health services. However, it would appear that little was done to implement a community-based mental health system since in 1983, the Ministry of Health in Ontario released a discussion paper, *Towards a Blueprint for Change: A Mental Health Policy and Program Perspective*, which again emphasized the need for community-based mental health services. It stated that

> It is important to strive toward a mental health system which emphasizes non-institutionalization, which directs energy and resources toward providing services outside the hospital so that hospitalization occurs only when dictated by treatment or behavioral needs.

> ...An essential corollary of deinstitutionalization and non-institutionalization is the provision of alternative settings for treatment and care in the least restrictive and disruptive settings which are as close to the patient’s or client’s home as practical.\(^{346}\)

This discussion paper led to the establishment of district health councils, local advisory boards, development of plans for provincial psychiatric hospitals and community mental health plans.

> By 1988 there existed over 400 community-based mental health programs.

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\(^{345}\) *Ibid* at 29.

increased funding for community mental health programs,\textsuperscript{347} and an increased awareness of local mental health planning; however the Provincial Auditors’ 1987 Report still noted the following problems with the mental health system in Ontario:

> [E]ven given (this) significant increase in funding, there is still a serious lack of adequate community services in the province ... better information (from both psychiatric hospitals and community-based programs) is needed to plan and manage mental health services.\textsuperscript{348}

The Provincial Community Mental Health Committee was established to develop “a framework for the delivery of community mental health services in Ontario.”\textsuperscript{349} This Committee concluded, has had previous reports, that mental health care should be focused in the community within an integrated mental health system and that additional funding was needed for community mental health services. It established targets:

- development of local mental health plans by 1991, and the establishment of an integrated mental health system with services focused in the community by 1995. Although some additional funding was subsequently provided for community mental health services, the mental health system was not refocused on community mental health services as

\textsuperscript{347}Between 1985 and 1987, there was a 65\% increase in funding for community mental health programs. However, community mental health spending accounted for 4.5\% of the total spending for mental health services. This meant that funding for community mental health services has declined in relation to other areas of spending including mental health spending in general. These figures and comments were stated by Provincial Community Mental Health Committee, \textit{Building Community Support For People: A Plan For Mental Health in Ontario} supra note 340 at 2, 3 and 27.


\textsuperscript{349}\textit{Supra} note 340 at 1.
recommended by the report.

In 1993, the Ministry of Health released yet another report respecting the reform of the mental health system in Ontario, the goal again being a balanced and integrated mental health system which shifted the focus from institutional care to community. Responding to the fact that consumers continued to experience difficulties in linking up with appropriate community-based services or consumer initiatives and that there continued to be a shortage of case management, crisis intervention, housing and other support services, the Report highlighted the need to adopt a definition of mental health needs to include broader determinants of health such as supportive housing, income support and employment opportunities. This report stated that "[w]ithout adequate services in their communities, people with mental health problems are too often readmitted to hospital." The report noted that spending on community mental health in 1991-92 was 10% of the total mental health spending and in 1992-93, about 80% of the mental health budget was spent on institutional services and 20% on community-based programs. It stated that by 2003, 40% of the mental health budget would be spent on institutional care and 60% on community services. To achieve this goal, it proposed to reduce the number of psychiatric beds from an average of 58 psychiatric beds for every 100,000 people to 30 psychiatric beds for every 100,000 people. By 1996-97, 70% of the mental health budget was spent on hospital based expenditures and 30% on community

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350 Supra note 26.

351 Ibid at 7.

352 Ibid at 7 and 28.
expenditures\textsuperscript{353} and there existed on average 56 beds for each 100,000 people.\textsuperscript{354}

The goal of mental health reform in the last 20 years has been to shape an integrated mental health system that provides a continuum of services and supports that assist persons with mental illness to live in the community and avoid hospitalization. This lengthy mental health reform process in Ontario has not to date yielded adequate community mental health services. Persons with severe mental illnesses have “been poorly served by past policy initiatives and, as a result, have consumed a disproportionate share of expensive inpatient and treatment services with little benefit to themselves or their families.”\textsuperscript{355} Concerns expressed by academics, health service providers, consumers and their families, and the media respecting the inadequate community mental health services demonstrate that in 1998 the goal of “comprehensive and integrated system that puts people first” is not at hand.\textsuperscript{356}

\textbf{ii) Current Mental Health System}

Concerns continue to be expressed that the mental health system is underfunded and that community mental health services are inadequate and insufficient to respond to

\textsuperscript{353}Figures provided by the Ontario Ministry of Health dated 13/08/97.

\textsuperscript{354}This average was calculated using provided in Health Services Restructuring Commission, Discussion Paper, \textit{Rebuilding Ontario’s Health System: Interim Planning Guidelines and Implementation Strategies}, supra note 3 at 54 and 55.

\textsuperscript{355}\textit{Supra} note 26 at 1.

\textsuperscript{356}\textit{Supra} note 26 at 14.
the needs of persons with serious mental illness which include accused persons.\textsuperscript{357} For instance, the report, \textit{The Mentally Ill and the Criminal Justice System: Innovative Community-Based Programs 1995}, stated that "the reality of mental health service delivery remains problematic."\textsuperscript{358} The report observed that persons with severe and chronic mental illnesses often cannot gain access to mental health resources while in the community, are unable to find adequate housing, are socially isolated, lack community acceptance and continue to be stigmatized. This report reflected the often-voiced concern that the severely mentally ill are ‘falling through the cracks’ of the mental health system and into the criminal justice system. Similarly, the study of D. Wasylenki, P. Goering, and E. MacNaughton in "Planning Mental Health Services: I. Background and Key Issues" in Ontario, concluded that by 1990, many of the community mental health programs in Ontario had drifted away from their original role, which was to care for those with severe mental illnesses."\textsuperscript{359}

Gilbert Sharpe, editor of \textit{Health Law in Canada}, stated:

\textsuperscript{357}Accused persons found NCRMD are included in the the class of persons with serious mental illness. In the Ministry of Health, \textit{Forensic Patient Database 1996 Annual Report} (Toronto: Ontario Ministry of Health, September, 1997) at 10, it states that "[t]he majority of forensic clients [who are primarily accused persons] (76%) meet the diagnostic criteria for classification as the seriously mentally ill."

\textsuperscript{358}Health Canada, \textit{The Mentally Ill and the Criminal Justice System: Innovative Community-Based Programs 1995} (Ottawa: Minister of Supply and Services Canada, 1995) at 13.

\textsuperscript{359}\textit{Supra} note 26 at 200. This is supported by the finding of a 1992 survey of community mental health services in Ontario that "most crisis, day treatment and counseling programs available in Ontario communities do not provide these services to people with severe problems" which is cited in the Ministry of Health, \textit{Putting People First: the Reform of Mental Health Services in Ontario supra} note 26 at 23.
While the deinstitutionalization has been a trend for some time, few governments have followed through on promises to provide ample funding for community services. Indeed, most efforts at integration of health services have accorded a low priority to services for the mentally ill in the community.  

A proposal of the Coalition of Ontario Psychiatrists reiterated these concerns:

Any reasonable person must today acknowledge that in the context of mental health reform, ‘community’ is a rubric for neglecting or abandoning the ill, and that it is immoral to attempt a further deinstitutionalization without first establishing a well-functioning community mental health system.  

Carol Roup, Director of Operational Planning, Metropolitan Toronto District Health Council noted that “a significant number of consumers and families are still dissatisfied.”  The concern about the lack of mental health resources is echoed again and again in the media and in a recent coroner’s recommendations.

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360 (1997) 17:4 Health Law in Canada 101. In the same issue of Health Law in Canada at 110, Dr. Paul Garfinkel, president and psychiatrist-in-chief of the Clarke Institute of Psychiatry, stated “Recently, the Ontario Health Supplement reported that about 16 per cent of people in Metro require psychiatric care and three out of four of these don’t receive any help. Any survey data of mental disorder demonstrates astounding findings: close to 20 per cent of the adult population suffer from a mental disorder within any six-month period; schizophrenia will affect over 250,000 Canadians; major depression and manic depression affect one in ten; at least 25 per cent of the medically ill have a treatable psychiatric disorder; 40 per cent of the 12,000 homeless in Ontario have an Axis I diagnosis; the Ontario child survey found almost 20 per cent in need of care and only a tiny minority receiving it.”

361 Cited in T. Boyle and D. Vincent, “Madness: First of seven parts on how we are failing the mentally ill,” supra note 1 at 5.

362 Supra note 25.

363 An editorial, “Have we abandoned the mentally ill?”, supra note 1, reiterated the concerns of community groups in Metropolitan Toronto about the lack of resources in the mental health system as follows: “Last month, the hostels warned that a growing number of mentally ill people were using their services by default ‘because there is no
Concerns about the sufficiency of psychiatric beds were heightened when the Health Services Restructuring Commission established in 1996\textsuperscript{364} issued reports recommending the closure of five provincial psychiatric hospitals: Lakehead Psychiatric Hospital\textsuperscript{365}, Brockville Psychiatric Hospital\textsuperscript{366}, St. Thomas Psychiatric Hospital\textsuperscript{367}, London Psychiatric Hospital\textsuperscript{368} and Hamilton Psychiatric Hospital.\textsuperscript{369} These hospitals are where else for them to turn.' ... 'Workers report that de-institutionalization has been carried out without developing the necessary community-based support and transition services,' the report said. 'Many homeless people, without necessary mental health supports, end up using the shelter system'."

In early January, 1998, the Toronto Star ran a seven part series on "Madness: How we are failing the mentally ill" supra note 1. It stated "[d]ecades of closing psychiatric beds, budget cutting and a failure to establish community supports for the mentally ill have taken their toll on society most vulnerable" January 10, 1998, first of seven Parts at 2.

In November, 1997 a coroner's jury in Ottawa inquiring into the death of a local television personality caused by a person suffering from paranoid schizophrenia recommended the establishment of a community mental health program and an end to the closure of psychiatric hospitals, reported on the CBC radio program, "As It Happens". on November 26, 1997.

\textsuperscript{364}Established under the \textit{Savings and Restructuring Act, 1996}, S.O. 1996, c.1. The Health Services Restructuring Commission has the mandate to restructure hospitals, including the provincially-operated psychiatric hospitals, through amalgamations, transfer of programs or closure.

\textsuperscript{365}Health Services Restructuring Commission, \textit{Thunder Bay Health Services Restructuring Report}, supra note 3 at 9.

\textsuperscript{366}Health Services Restructuring Commission, \textit{Ottawa Health Services Restructuring Report}, supra note 3 at 55.

\textsuperscript{367}Health Services Restructuring Commission, \textit{Kent County Health Services Restructuring Report}, supra note 3 at 9.

\textsuperscript{368}Health Services Restructuring Commission, \textit{London Health Services Restructuring Report}, supra note 3 at 16.

\textsuperscript{369}Health Services Restructuring Commission, \textit{Hamilton-Wentworth Health Services Restructuring Report}, supra note 3 at 44.
had forensic beds and some of this capacity was to be transferred; for example a number
of the beds in the Brockville Psychiatric Hospital were going to be transferred to the
Royal Ottawa Hospital and to the Kingston Psychiatric Hospital. In addition, by the year
2003, as a result of this restructuring, a large number of psychiatric beds, in psychiatric
and general hospitals, would be closed. Using the figures set out in various reports of the
Health Services Restructuring Commission, I have calculated that 1109 beds will be
closed\textsuperscript{370} between 1998 and 2003. These closures are in addition to the psychiatric bed
cuts that have been made from 1993 to 1996\textsuperscript{371}. The Health Services Restructuring
Commission noted the following concerns about its timetable and magnitude of bed
closures:

While there is widespread agreement of the goal to shift provision of
mental health from hospital settings to community based services, many
continue to express concerns that the planning target is too ambitious and
does not allow sufficient time and flexibility to achieve this shift without

\textsuperscript{370}If the current total beds of 4992 represent 45 beds for 100,000 of population and
the interim target by 2003 is 35 beds for 100,000, it means that the total beds in 2003 will
be 3883. However, the Health Services Restructuring Commission still maintains that the
ultimate bed target is 30 beds for 100,000 which would result in 3328 beds and a loss of
1664. The figures for the number of beds and the target figure of 30 beds/100,000 people
are set out in the Health Services Restructuring Commission, Discussion Paper.
Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation
Strategies, supra note 3 at 54; the interim target for 2003 of 35 beds for 100,000 is found
in Health Services Restructuring Commission, Change and Transition supra note 3 at 59;
and the ratio that at present there are 45 beds/100,000 people is found in Health Services
Restructuring Commission, Ottawa Health Services Restructuring Report, supra note 3 at
45 as being the Ministry of Health estimate.

\textsuperscript{371}I note from the Health Services Restructuring Commission, Discussion Paper,
Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation
Strategies, supra note 3 at 53 that in 1993 the provincial average for psychiatric beds was
58 beds/100,000 which by 1997 had been reduced to 45/100,000.
putting access and quality of care at risk.\textsuperscript{372}

These concerns arose from the fact that insufficient community mental health services exist and that beds will be closed before necessary community services are in place.\textsuperscript{373}

The Health Services Restructuring Commission has clearly indicated that it continues to support the original planning rate of 30 beds/100,000 if the appropriate shift occurs in the provision of services from institutional-based services to community-based services. However, the Commission wants to ensure that the pace of change is appropriate to ensure an orderly restructuring of mental health services and that the right level of community-based services and supports are established before beds are closed.\textsuperscript{374}

The Health Services Restructuring Commission and the District Health Councils have stressed to the Minister of Health that “[r]esources freed up from the downsizing of psychiatric inpatient services will be reallocated for the development of community mental health services...”\textsuperscript{375}

The Health Services Restructuring Commission stated that two major concerns about the funding of the mental health system were expressed by persons making submissions. One was that “the current [mental health] system is significantly

\textsuperscript{372}Ibid at 53 and 54.

\textsuperscript{373}Ibid at 54.

\textsuperscript{374}Ibid at 55.

\textsuperscript{375}This is an example of these types of recommendations. It is from Ottawa-Carleton Regional District Health Council and is set out in the Health Services Restructuring Commission, \textit{“Ottawa Health Services Restructuring Report”} (Toronto: Health Services Restructuring Commission, February 1997). However, neither the Health Services Restructuring Commission nor the district health councils can direct financial resources from hospitals to community mental health programs.
The other concern was that, after restructuring, mental health funding may be reassigned to other areas of health services. These persons suggest that the mental health funding envelope created in 1993 should continue to be protected, increased and used only to fund mental health services. The Health Services Restructuring Commission has recommended that funding for mental health "should be pooled into a funding envelope, adjusted for equity in terms of population needs, and administered by a central agency."

The Health Services Restructuring Commission in its report, *Changes and Transition*, reiterated the concerns about the lack of community mental health resources and recommended that "the Ministry of Health, working with other ministries, enhance supports for the development of community mental health services, and that this support precede downsizing of acute/long term inpatient services." The Report recognized that "access to safe and affordable housing is essential to maintaining clients in the

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378Supra note 375 at 56.


380*Ibid* at 60.
community, and recommended that government support programs be reviewed. In addition, the Report recommended the establishment of transitional agencies at the regional level to ensure the planning, coordination and funding of the mental health system and to build an integrated system of institution and community based services. It has stated that "the restructuring of mental health and addiction services is an urgent matter, requiring the oversight and management of an independent body during the transition to an integrated health system." The need for such agencies arose from the fragmented and diverse nature of mental health program delivery and lack of consistent standards for mental health programs. If the psychiatric bed target ratios endorsed by Health Services Restructuring Commission are to be met by 2003, such transitional agencies need to be established without delay. As of August, 1998, the Minister of Health in Ontario has only established a pilot mental health agency in Thunder Bay.

In Ontario, accused persons under the jurisdiction of the Ontario Review Board on the whole suffer from severe mental illnesses. The majority suffer from schizophrenia and a smaller number suffer from addictions, affective psychosis, and sexual and other non-psychotic disorders. Therefore, the concern that the mental health system in the past has not served those suffering from severe mental illnesses is very pertinent to the

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381 Ibid.

382 Health Services Restructuring Commission, Frontenac, Lennox and Addington Health Services Restructuring Report, supra note 3 at 49.

383 Supra note 357.

384 Ibid at 10.
situation of accused persons. Furthermore, the adequacy and availability of mental health resources has an impact on accused persons within the mental disorder provisions who also require mainstream mental health services.

The question of the sufficiency of the number of forensic beds\(^{385}\) came to the fore in 1996 and 1997 because an increasing number of persons detained under orders of the Ontario Review Board remained in jail, awaiting a bed in the hospital designated in the order. According to the Chairperson of the Ontario Review Board,\(^{386}\) as of March 15, 1997, 13 accused persons who were unfit to stand trial were in the Toronto Jail awaiting a transfer to the Queen Street Mental Health Centre where the Board had ordered that they be detained. One of these accused persons had been waiting since October, 1996. The Chairperson noted that, on average, it took 128 days before an accused person was transferred from the Toronto Jail to the Queen Street Mental Health Centre. He added that the medium security unit at the Queen Street Mental Health Centre had a waiting period of 18 months when it opened in May, 1996; the wait had increased to 30 months as of March, 1997. As of April, 1997, the average wait for a transfer to the medium security unit was three months at the Brockville Psychiatric Hospital, up to a year at the St. Thomas Psychiatric Hospital, and up to six months at the North Bay Psychiatric Hospital. The Chairperson stated that, in general, the wait for a transfer from a jail to a minimum

\(^{385}\)In 1997, there existed 5282 adult psychiatric beds in Ontario out of which 628 were designated as forensic beds.

\(^{386}\)The statistics are cited above are contained in D.H. Carruthers, "Pinet and McGillis and the Cutbacks: Some Views, Comments, and Opinions on How They Affect The Ontario Review Board," supra note 22 at 37 and 38.
security facility of a hospital, ranges from one to three months. The wait is considerably longer for those being transferred from one hospital to another. In addition, service providers have expressed considerable concern “about the insufficient supply of forensic beds available provincially...” The concern about the supply of forensic beds is compounded by the fact that since the coming into force of the mental disorder provisions of the Code in 1992, the number of accused persons under the jurisdiction of the Ontario Review Board increased by 10% every year and that “there is no reason to believe that this trend will not continue.” The increase in accused persons will place more stress on the ability of the mental health system to respond.

The concern that forensic beds were in short supply and that the “shortage of forensic beds, [was] resulting in long periods of incarceration for those awaiting for access to these services” were expressed to the Health Services Restructuring Commission. In response to these concerns, the Health Services Restructuring Commission clarified that “forensic beds were not included as part of the acute or longer...


388D.H. Carruthers, “Pinet and McGillis and the Cutbacks: Some Views, Comments, and Opinions on How They Affect The Ontario Review Review Board”, supra note 22 at 13. He also noted that as of March 31, 1997, 754 accused persons were under the jurisdiction of the Review Board, 88 of whom were women and in the previous twelve months, the Review Board held 920 hearings.

389Health Services Restructuring Commission, Change and Transition: Planning Guidelines and Implementation Strategies for Home Care, Long term Care, Mental Health, Rehabilitation, and Sub-acute Care, supra note 3 at 52.
term bed planning targets but are intended to be in addition to those beds."390 The Commission recommended that more research was needed on forensic mental health services and stated that the Ministry of Health was undertaking a provincial review of forensic services and setting planning targets for forensic services.391 The Commission further added that explicit direction was needed from the Ministry of Health regarding support to the forensic population and the restructuring of this system. Furthermore, the reform of forensic services should ensure that “action is taken to increase accessibility to both inpatient and community-based forensic services.”392

As part of the forensic reform initiative, which began in 1993, the Ministry of Health intended to develop a plan for forensic services that ensures that “mentally disordered offenders"393 who do not require secure or specialized care would have easy access to the services they need (access to programs that serve other people with severe mental illness).”394 In 1997, in a discussion paper, the Ministry of Health declared that it

390 Ibid at 55.

391 It appears that, in response to the recommendations of the Health Services Restructuring Commission, the Ministry of Health has prepared a draft discussion paper “The Distribution of Forensic Beds in Ontario" dated August 6, 1997 (unpublished). The paper deals only with tertiary beds capacity but states that “[t]here is also a need for forensic resources to support patients in integrated mental health settings and in the community which has not been quantified and will be addressed through follow up analysis” at 1.

392 Ibid at 55.

393 Mentally disordered offenders are accused persons and those with mental disabilities serving sentences in the correctional system.

394 Ministry of Health, Putting People First: the Reform of Mental Health Services in Ontario, supra note 26 at 26.
[h]as recently adopted strategic directions for the forensic system (*The Provincial Forensic System: Strategic Directions*). Central components of this strategy include the establishment of a provincially coordinated, dedicated forensic system (comprised of a provincial forensic hospital and regional forensic services), and a protected stream of general mental health resources to serve forensic clients in integrated mental health settings. The goals of interministerial and health forensic policy are to decriminalize people with mental illness who come into conflict with the law; to prevent where possible antisocial behaviour arising from mental illness through the provision of appropriate community supports; to treat forensic patients as close to home as possible and economically feasible; and to integrate low risk forensic patients with the general psychiatric population."

In 1997, Ontario adopted a provincial strategy as "the policy blueprint for all operational and policy initiatives for people with a mental disorder and/or developmental disability who come into conflict with the law." This strategy, developed in response to "a recognized need to better coordinate, resource, and plan services" within the forensic system, calls for a redesign of the mental health forensic system and enhancements of community supports. In Ontario, there does not seem to exist a continuum of care for persons with mental disorders that focuses on supporting these persons in the community. The result for accused persons is that

Under present circumstances the chances of any proposed disposition being capable of being implemented at the time it is being made are

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396 This statement is made in a letter of Deputy Ministers of Community and Social Services, Health, Correctional Services and Deputy Attorney General and Solicitor General enclosed in Human Services and Justice Coordination Project, *A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario* supra note 42.

virtually nil.
...

[A]ccuseds will remain in jail longer than would otherwise be the case, and therefore be denied an opportunity to be treated at their required time. It is accepted that the longer a person goes without required treatment the more difficult it becomes for that person to respond positively to that treatment when it is eventually received. In all probability this will mean that such a person will remain in hospital longer than would have been the case had treatment started earlier. 398

2. British Columbia

i) An Overview of Mental Health Reform in British Columbia

As in Ontario, British Columbia experienced “critical service shortages in mental health care” 399 arising from the deinstitutionalization of persons with mental disabilities.

As a response to these problems, in 1984, the Ministry of Health began a provincial consultation on mental health reform which culminated in the 1987 Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital. 400 In 1990, the government adopted the Report, proposing to shift mental health services away from institutional care to a decentralized, integrated mental health system. To achieve this goal, Riverview Hospital was to be replaced by regional tertiary care facilities, enhanced acute care services, and expanded community mental health services, including housing and crisis intervention. Implementation of this plan began in 1992 and $53 million was

398 Supra note 22 at 54 & 55.


injected to improve mental health services. However, $17 million of this was required to offset inflation and fund an increase in the demand for mental health services resulting from a growth in population. Only $36 million was left “to develop new services in the areas of housing, emergency response, rehabilitation, clinical services, consumer/family services, child and youth services, and alcohol and drug services for aboriginal people.”

While this funding did provide additional community mental health services, “it did not address the inadequate supply of services relative to the needs of the most disabled individuals.” Furthermore, additional pressures were placed on community mental health services due to psychiatric bed closures at Riverview Hospital. Between 1992 to 1995, 163 beds were closed at Riverview Hospital. Additional pressures resulted from “a continuing migration of people with mental illness to the Lower Mainland for services, a lack of admission and discharge planning between Riverview Hospital, acute care hospital and community services” and a lack of policy coordination between ministries. Furthermore, the Ministry of Health had not developed a long range plan for the shift in services to be implemented. By 1996, it became more obvious that adequate community mental health resources were still lacking. As a result, the reduction of

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401 Supra note 3 at ii.

402 Ibid.

403 According to the Adult Mental Health Services Division in 1992/93 Riverview hospital had 971 beds and in 1995/96 it had 808.

404 Supra note 3 at ii.

405 For a discussion on the planning requirements see Auditor General Report of British Columbia, supra note 399 at 34-41.
hospital beds at the Riverview Hospital was halted and the Provincial Mental Health Advisory Council Working Group was asked to review the community mental health system. The Working Group recommended an additional injection of $34 million into the community mental health system for emergency response services, housing, community clinical staff, rehabilitation and other programs.\footnote{Supra note 3 at 43.} Subsequently, the Ministry of Health and the Ministry Responsible for Seniors released a consultation document, \textit{Developing a New Mental Health Plan for British Columbia}.\footnote{Ibid.} In response to this document, a large number of stakeholders and some advocacy groups expressed the view that the planning ratio of 37 psychiatric beds for each 100,000 of population (15 acute beds and 22 tertiary beds) was problematic because a “fully resourced community care system is currently not in place and that [mental health] planning needs to include beds necessary for treating children, youth and elderly people with mental illness.”\footnote{Ibid at 58.} In particular, there was concern that acute hospital psychiatric beds were unavailable because inadequate community mental health resources led to an inappropriate use of many of these beds.

Another major concern expressed by stakeholders and advocacy groups related to the unavailability of safe and affordable housing for persons with mental disorders. Persons with mental disorders involved in the criminal justice system were identified as particularly difficult to house. In addition, many respondents reiterated the need for a significant change in the mode of service delivery, shifting from an office-based model to

\footnote{Supra note 3 at 43.}
\footnote{Ibid.}
\footnote{Ibid at 58.}
an outreach community based system. The Working Group also made the interesting point that a shift in attitude was needed from "a system where individuals must comply behaviorally or face discharge from a program to a 'no reject' system that flexibly responds to individual needs."\(^{409}\) The respondents made clear that adequate community mental health services and support must precede or parallel the Riverview Hospital replacement process.

ii) Current Mental Health System

In 1998, the government of British Columbia adopted *The 1998 Mental Health Plan*,\(^{410}\) reiterating the government’s commitment to community based mental health services. The Plan established that the highest priority in allocating mental health funding shall be given to persons with the highest level of functional impairment. It recognized the need to improve interministerial policy coordination to address support services to persons with mental disorders such as housing, income security, training, employment and other social supports.

Funding of *The 1998 Mental Health Plan* will be spread over a seven year period. The Plan stated that more than $34 million in additional funding will be needed to bring mental health services up to the current provincial guidelines. The listing of required new mental health services outlined in the Plan speaks volumes of the present lack of community mental health resources and of regional psychiatric beds: for example, 2,600 supported, independent living units are required; assertive or intensive case management

\(^{409}\) *Ibid* at 68.

\(^{410}\) *Ibid.*
for 8,200 persons with mental illness at a ratio of 20/1 are needed; crisis services are needed in over 30 communities; 113 additional tertiary beds are needed; and planning and facility acquisition is required for 663 community-based tertiary treatment beds in the regions. The government has proposed to allocate $125 million to increase community mental health services and the decentralization of mental health services. Funding for mental health services will be in a protected mental health funding envelope.

While in British Columbia accused persons are not being detained in jail to await hospital beds, similar issues regarding the sufficiency of community mental health resources and the supply of forensic beds have been raised. In a briefing note last year, a Ministry of Health official stated that the "community does not have sufficient resources in terms of housing, supervision and medical support to be able to cope with many discharges from the Institute," and further that most of the accused persons found NCRMD who occupy the 203 beds at the Forensic Psychiatric Institute are unable to be gradually reintegrated in the community because of lack of resources. In addition, 70% of

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411 Both the Chairperson of the British Columbia Review Board and the Clinical Director of the Forensic Psychiatric Institute declared that accused persons under the mental disorder provisions were not detained in jail to await a bed at the Forensic Psychiatric Institute. Furthermore, the bed capacity of the Institute was increased to 203 beds in 1997 because a new Institute was built.


413 This figure was provided by Dr. Derek Eaves, Clinical Director of the British Columbia Forensic Psychiatric Institute. These beds consist of 90 maximum secure beds, 70 medium secure beds and 43 minimum secure beds. The Institute has 6.5 regional forensic clinics to supervise and provide treatment and support to persons under the jurisdiction of the British Columbia Review Board.
these persons return to the Forensic Psychiatric Institute after being discharged because of insufficient community mental health resources.\footnote{See the discussion in the Adult Mental Health Division, Ministry of Health and Ministry Responsible for Seniors, \textit{Revitalizing and Rebalancing British Columbia's Mental Health System: The 1998 Mental Health Plan}, supra note 3 at 30-35 on community mental health services required to assist a person with severe mental illness to remain in the community. In addition see \textit{Best Practices}, Discussion Paper, supra note 41 at 6 and 7 regarding programs required to support the individual in the community.}

In British Columbia, the forensic mental health system is administered and coordinated by the Forensic Psychiatric Services Commission,\footnote{The Commission was established under the \textit{Forensic Psychiatry Act}, R.S.B.C. 1996, c.156.} part of whose mandate is to provide forensic psychiatric services to persons held under the mental disorder provisions of the \textit{Criminal Code}. Because the forensic mental health system has operated separately from the mainstream mental health system, a “canyon” has developed between forensic and mainstream mental health services,\footnote{This description summarizes the lack of integration between forensic mental services and mental health services. This comment is cited in The Adult Mental Health Division, Ministry of Health and Ministry Responsible for Seniors, \textit{Revitalizing and Rebalancing British Columbia's Mental Health System: The 1998 Mental Health Plan}, supra note 3 at 24.} such that persons within the forensic system have had difficulty in accessing services in the mainstream mental health system.\footnote{\textit{Ibid.}} Therefore, \textit{the 1998 Mental Health Plan}\footnote{\textit{Ibid.}} proposes to integrate forensic mental health services within the mainstream mental health system; the Forensic Psychiatric Institute will be placed under the governance of the British Columbia Mental Health System.
Health Society which operates the Riverview Hospital, and the forensic community clinics will be transferred to the health authorities.

As in Ontario, the shift from institutional care to community mental health services has resulted in an “inadequate supply of services relative to the needs of the most disabled individuals.” Lack of funding of community mental health services, as well as lack of coordination and planning between Riverview Hospital, (the main psychiatric hospital in British Columbia), acute care hospitals and community mental health services and of coordination among relevant social services ministries have contributed to the current state of the mental health system. This situation was compounded by additional pressures on the mental health system such as an increase in the number of persons requiring mental health services in emergency departments of hospitals in the Lower Mainland and of person with more acute levels of mental illnesses which necessitated longer stays in acute care hospitals.

e) The Impact of Insufficient Mental Health Resources

The lack of adequate mental health resources, coupled with the decisions in McGillis and Pinet (discussed below). result in a significant impact on an accused person and the jurisdiction of a Review Board. The legislative scheme of the mental disorder provisions outlined in sections A and B is undermined because a lack of

419 Ibid at ii.
420 These factors are identified in Adult Mental Health Division, Ministry of Health and Ministry Responsible for Seniors, Revitalizing and Rebalancing British Columbia’s Mental Health System: The 1998 Mental Health Plan, supra note 3.
421 McGillis, supra note 16 and Pinet, supra note 35.
resources results in the orders of a Review Board not being implemented. Furthermore, if a Review Board must consider the implementation of the order and the mental health system does not provide the necessary resources, the Review Board is unable to grant the least restrictive or least onerous order. Therefore, it cannot protect the liberty of the accused person.

In *Brockville Psychiatric Hospital v. McGillis*,^422^ the hospital appealed a decision of the Ontario Review Board. In April 1996, the Ontario Review Board had ordered the conditional release of Mr. McGillis, an accused person found NCRMD. The Board stipulated as one of the conditions that Mr. McGillis reside in accommodation outside the hospital approved by the Administrator of the Brockville Psychiatric Hospital. The Board had issued the same conditional order in May, 1995 following Mr. McGillis’ annual review. As well, in 1994, the Board had made a custodial order with a condition that Mr. McGillis could be permitted to reside in the community if suitable accommodation were found. The Court of Appeal of Ontario found that the evidence before the Board was that no suitable accommodation was available in May, 1995 or April 1996. As a result of this situation, the Court concluded that the Ontario Review Board should have made a custodial order rather than a conditional discharge. The Court relied on *British Columbia (Forensic Psychiatric Institute) v. Johnson*^423^ to find that the order of the Board was a “hybrid of the two separate orders contemplated by s. 672.54(b) (conditional discharge)

^422^ Supra note 16.

^423^ Johnson, supra note 280.
and s. 672.54(c) (detention order) and is not contemplated by the statutory scheme in Part XX.1 of the Criminal Code.”424 In this situation, the Court stated that the Board should have issued a custodial order and “given the hospital administrator the discretion to permit the respondent to reside outside the hospital if suitable accommodation could be found.”425 As well, the Court added that since

[T]he proceedings before the Board are not adversarial [but inquisitorial in nature]... if the Board felt that further steps should be taken to explore the availability of suitable accommodation outside the hospital, it should have directed the hospital and/or counsel for the respondent to take those further steps.426

The order of the Board was quashed and a new hearing ordered.

The Johnson case referred to above is easily distinguished from McGillis because the wording of the orders was different. In McGillis, the Ontario Review Board ordered the Administrator of the Brockville Psychiatric Hospital to carry out the conditions of the conditional discharge order, one of which was to discharge Mr. McGillis to live in the community in accommodation approved by the Administrator. In Johnson, however, the British Columbia Review Board granted a conditional discharge which contained “conditions which give the Director authority to confine her to the Forensic Psychiatric Institute.”427 The British Columbia Court of Appeal determined that such conditions

[I]n effect gives the Director the power to convert the conditional

424 Supra note 16 at 243.
425 Ibid at 243.
426 Ibid at 244.
427 Johnson supra note 280.
discharge order into a custody order under s. 672.54(c), without any attendant requirement that such a direction be reviewed by the Review Board. Such a power is inconsistent with the concept of a conditional discharge order.428

In the *McGillis* case, the Ontario Review Board ordered the release of Mr. McGillis on condition that he live in accommodation approved by the Administrator. The Administrator could not choose to designate the hospital as approved accommodation. Nothing in Mr. McGillis’ order permitted the Administrator to detain Mr. McGillis in hospital. Rather it placed the onus on the Administrator to discharge Mr McGillis from detention and assist him in finding appropriate living accommodation in the community. In effect, Mr. McGillis continued to live in hospital because the Administrator did not implement the conditional discharge order since no suitable accommodation in the community existed.

Furthermore, even if a Review Board made an order adjourning a hearing or continuing the *status quo* and directing the person in charge of a hospital or the accused person to gather additional information for an early hearing, neither the person in charge of a hospital nor the accused person would be any further ahead, if the mental health system did not provide adequate mental health resources to reintegrate the person in the community. The parties cannot create the necessary mental health resources. The *McGillis* case is the perfect illustration of this point. From 1994 to 1996, the Administrator of the Brockville Psychiatric Hospital was unable to find suitable accommodation for Mr. McGillis in the community and no amount of direction from the

428 *Ibid* at 48.
Board was able to change this. Without mental health resources, disposition orders are not implemented, as shown by the numbers of persons that were detained in jail in Ontario or not transferred expeditiously from a higher level of security to a less restrictive environment.

The British Columbia Review Board decision, *In the Matter of Robert Allen Mitchell*\(^{429}\) also demonstrates the impact of inadequate mental health resources. In this case the British Columbia Review Board noted that the Director of Adult Forensic Psychiatric Services has recommended a custodial order and conceded the possibility of a conditional discharge if a 24 hour supervised community placement were found. The Board noted that since July 2, 1996, it had expressed concerns about the lack of progress in finding a supervised and structured community placement. At a hearing in June 1997 the Board was informed that the system was not designed to deal with Mr. Mitchell. At that time the Board rendered a custodial order and set a date for a new hearing by January 1998 (which was adjourned) to permit the appropriate action to be taken to remove the bureaucratic obstacles to finding an appropriate community placement for Mr. Mitchell. When the next hearing was held in February 1998, the Board determined that

> Given the Director’s strong views as to the potential threat posed to public safety by the accused, and the absence of any current less restrictive alternative, the Review Board was constrained to continue Mr. Mitchell’s custodial disposition.\(^{430}\)

However, the Review Board ordered a new hearing by April 30, 1998 (which was

\(^{429}\) *Supra* note 36.

\(^{430}\) *Ibid* at 4.
adjourned). The next hearing was held May 20, 1998. In the Reasons for Disposition of this hearing, the Board emphasized the lack of community resources and the effect of this situation on Mr. Mitchell and the powers of the Board. It stated:

All parties agree that Mr. Mitchell does not need to reside in a hospital setting, and he could function in the community if there were available an appropriate community facility that would provide the kind of structure and supervision that he requires in order to ensure public safety. In the absence of this, the default position is a custodial disposition in a hospital: 


... Like previous panels of the Review Board, the members of this panel are very concerned that the effect of the shortage of supervised community placements in British Columbia is to prevent many mentally disordered accused, like Mr. Mitchell, from being granted the least onerous and least restrictive appropriate disposition on the basis of considerations set out in sec. 672.54.431

The Board continued the detention in custody of Mr. Mitchell and ordered another early review in this case.

In addition, the McGillis decision appears to be contrary to the position taken by the Ontario Court of Appeal in an earlier decision, R. v. Pinet432. In that case, it decided that the Board erred because it had determined that Mr. Pinet could be detained in a medium secure facility but made an order detaining him in a maximum secure facility until the Administrator made the arrangements for the transfer. The Court stated:

I am of the view that once the Board determines the appropriate type of facility in which to detain an accused person, it must make a disposition in conformity with that determination.433

431 Ibid at 8.
432 Supra note 35.
433 Ibid at 102.
Using this reasoning, the Board in the *McGillis* case determined that where a conditional discharge was warranted, it could not order him detained in hospital; however this approach was rejected by the Court.

In my opinion, the *McGillis* decision goes against the legislative scheme of the mental disorder provisions, whose objective is to reintegrate a detained person found NCRMD into the community, as quickly as the accused person's mental condition permits. I do not think the Ontario Review Board had any other choice but to make the least onerous and least restrictive disposition once it considered the factors set out in section 672.54 of the *Code*. The mental disorder provisions do not require a Review Board to enquire into the implementation of its order. The Chairperson of the Ontario Review Board supports this view that the ruling in the *McGillis* case is contrary to the legislative scheme of the mental disorder provisions. He stated that

To require that the Review Board, over and above those factors specifically outlined in the *Criminal Code*, be satisfied that its proposed disposition can be implemented at the time it is being made, strikes at the heart of the Review Board's jurisdiction.

... If the Review Board is prevented from doing what it finds 'to be the least onerous and least restrictive for the accused', then in my opinion the accused is denied the benefit of the legislated scheme.434

The Chairperson of the British Columbia Review Board has stated similar concerns. He has declared that

Having heard that the plan is in fact practically achievable, we believe that for the Board to primarily concern itself with or be constrained by matters of administration, such as the allocation of funds or resources, would be inappropriate. To do so would enlarge the Board's statutory duties under

434 *Supra* note 22 at 53 & 54.
S. 672.54 by importing the additional criterion or dimension of implementation. It would also render s.672.54 which directs the Board to make the least onerous and least restrictive disposition, an empty admonition. (emphasis in the original)\footnote{B. C. Review Board, \textit{In the Matter of George Michael Peters}, Reasons for Disposition dated March 15, 1998 (unreported) at 8. Similar comments were made in the \textit{In the Matter of Anthony Florence}, Reasons for Disposition dated February 12, 1998 (unreported) at 15 & 16.}

The Ontario Court of Appeal in \textit{R. v. Pinet}\footnote{\textit{Supra} note 35.} made comments on the question of resources which are worrisome when coupled with the decision in the \textit{McGillis} case. Counsel for the Administrator argued that in Mr. Pinet’s case insufficient evidence was adduced before the Ontario Review Board that there was a medium secure facility with space and appropriate facilities and treatment for Mr. Pinet. Therefore, the Ontario Review Board should not have ordered the transfer of Mr. Pinet to a specific hospital. Rather, it should have made a generic order for the administrator to transfer Mr. Pinet to an appropriate medium secure hospital. McKinley J.A. noted in \textit{obiter} that this raises the potential conflict that exists between the “traditional care-givers of accused persons and the persons now charged with protecting their liberty rights.”\footnote{\textit{Ibid} at 103.} However, she adopted the position of the Administrator because

\Reviewer{It would be of no assistance to anyone to have an accused person arrive at a hospital where there was no room, inadequate security, and inappropriate treatment facilities to deal with him. This is a practical type of problem which can be dealt with best by co-operation developed between hospital}
administrators and the Board.\textsuperscript{438}

In response to this \textit{obiter}, first, I would point out that if a hospital bed is unavailable because of lack of resources, co-operation between hospital administrators and a Review Board is unlikely to create a bed. In practice, in Ontario, an accused person is not transferred from one hospital to another unless a bed is available in the receiving hospital which results in lengthy waiting lists.\textsuperscript{439} Furthermore, a Review Board cannot enter into a dialogue with just one party to the proceedings. The mental disorder provisions are clear that a Review Board may only decide issues at a hearing with all the parties present. Second, a Review Board has specialized expertise which makes it knowledgeable about facilities and programs in the psychiatric hospitals in their respective province\textsuperscript{440}, and it hears evidence from the parties on these issues. Third, as previously discussed, the \textit{obiter} would place a Review Board in a quandary because "the court appears to have introduced for the first time a factor of implementation into the scheme into which the Review Board is bound to operate."\textsuperscript{441} A Review Board must consider the mental condition and other needs of an accused person, as specified in section 672.54 of the \textit{Code} and determine a fit disposition. Considerations such as family and other supports and the appropriate community for reintegration of the accused person

\textsuperscript{438}\textit{Ibid} at 103 and 104. I would note that these comments affect the independence of the Review Board.

\textsuperscript{439}\textit{Supra} note 22 at 24.

\textsuperscript{440}This expertise is recognized in \textit{Davidson supra} note 23; \textit{Peckham supra} note 271; \textit{D.H. supra} note 280 and \textit{Winko supra} note 17.

\textsuperscript{441}\textit{Supra} note 22 at 29.
enter into the decision. Therefore, if a Review Board cannot order an accused person transferred to a specific hospital, it would be remiss in its duties. Fourth, where a person found NCRMD is detained in jail prior to an initial hearing by the Review Board, a Review Board could not detain an accused person in jail even if neither a bed nor treatment was available.

E. Conclusion

In conclusion, at present, some accused persons in Ontario and British Columbia who might otherwise be able to live in the community are unable to do so because of lack of supervision, appropriate housing and other community supports, and other accused persons are detained in a more restrictive environment because of an insufficient supply of psychiatric beds. Although I cannot give a precise number of persons found NCRMD who have been directly affected by the lack of adequate resources, I suggest that

442 This is the case in Ontario. However, in British Columbia persons found NCRMD are not detained in jail while awaiting their initial Review Board hearing.

443 However, a Review Board may detain dual status offender in jails, section 672.68 of the Code. Until recently, in Ontario, the provincial corrections authorities would not deliver an accused person to the specified hospital as ordered by the Review Board unless the hospital informed the jail that a bed was available. However, in conversation with Ministry of Health officials, I was informed that a directive had been issued that persons under the jurisdiction of the Review Board had to be delivered to the psychiatric hospital named in the order of the Board within 48 hours. This followed a habeas corpus application by a number of persons detained in jails even after the Board had issued an order, see T. Boyle, "Jailing mentally ill accused illegal: Lawyer Accused should be in hospital, but no beds available" The Toronto Star Article February 24, 1998 at A5.

444 There are no statistics kept on this topic by the Ontario Review Board or the British Columbia Review Board and I could not ascertain any other source that would keep such statistics. To ascertain the numbers of persons found NCRMD affected since 1992, a review of all the disposition reasons of both Boards would have to be done from
numerous persons have not received the least onerous and least restrictive disposition as mandated by section 672.54 of the Code. Consequently, they are held under the jurisdiction of a Review Board for a longer period than if adequate mental health resources were available.

The question remains whether mental health reform will provide the necessary mental health resources to ensure that persons who do not need to be detained in a psychiatric hospital or at a certain security level are given the least restrictive alternative. Seeing the past track record of mental health reform and its pace, I am doubtful that adequate mental health resources will be available. Furthermore, more pressure will be brought to bear on the strained mental health resources if the number of persons with mental illnesses who commit minor offences and who are dealt with under the mental disorder provisions continues to increase. Accused persons whose liberties are affected by the lack of mental health resources cannot afford to wait. In the next chapter, I examine the Charter remedies available to these persons.
Chapter 3

Charter Challenge

In this chapter, I examine whether a Charter remedy is available to accused persons\(^{445}\) whose rights have been infringed. As argued in chapter 2, the lack of adequate community mental health resources in both Ontario and British Columbia, and the inadequate supply of forensic beds in Ontario, result in some accused persons being detained longer in custody than required to ensure the protection of the public. The reasons are that a Review Board may not grant the least restrictive or the least onerous disposition due to inadequate mental health resources, or, if it does, lengthy delays occur in the implementation of the dispositions or these dispositions are not implemented at all. As previously stated, the lack of data on the timeliness of implementation of disposition orders by the Ontario Review Board, the British Columbia Review Board, or provincial or federal governments makes it difficult to ascertain the number of accused persons whose detention has been lengthened because of the inaction on implementing disposition orders. However, the basis of my argument that accused persons’ rights have been infringed rests on the concerns raised by the Chairperson of the Ontario Review Board and those of the Chairperson of the British Columbia Review Board that inadequate mental health resources result in delays in the implementation of dispositions of the Review Board or act as a restraint in the Board granting the least onerous and least restrictive disposition. These are in addition to the concerns of advocates, ministry of

\(^{445}\)As previously explained, “accused persons” refers to persons who were found not criminally responsible on account of mental disorder and are under the jurisdiction of a Review Board established under the mental disorder provisions of the Code.
health officials and the Health Services Restructuring Commission regarding waiting lists and inadequate mental health resources for the seriously mentally ill, as detailed in chapter 2. In addition, accused persons in Ontario have had on occasion to resort to \textit{mandamus} or \textit{habeas corpus} applications to get a psychiatric bed.\footnote{In discussions with legal counsel to the Ontario Review Board, Mr. Richard Schneider, and legal counsel on a recent \textit{habeas corpus} application, Mr. Joseph Kenkel, in June and September, 1998, I was informed that there have only been a few \textit{mandamus} or \textit{habeas corpus} applications issued. However, following the service of a \textit{mandamus} or \textit{habeas corpus} application on the person in charge of a hospital named in the disposition and within the two-week notice period required by the rules of court, the accused person's disposition is implemented and therefore the application is not heard. The Ontario Review Board does not keep copies of these applications.} That, in itself, suggests that problems exist with the implementation of the disposition sections of the mental disorder provisions.

I argue that the problem does not lie with the mental disorder provisions themselves. Instead I contend that the infringements of the rights of accused persons— for example by the lengthening of the detention or more restrictive detention— result from the delays in implementing Board disposition orders or from disposition orders which themselves do not represent the least restrictive or least onerous disposition. I argue in turn that these situations occur because the provincial governments do not provide adequate mental health resources to accused persons.\footnote{This argument will be dealt with more fully below.} Therefore, I argue that decisions by provincial public officials regarding the allocation of mental health resources infringe the rights of accused persons guaranteed by two provisions of the \textit{Canadian Charter of Rights and Freedoms}. 

 

\footnote{446}
Rights and Freedoms: section 7 (the right to life, liberty and security of the person and not to be deprived of these rights except in accordance with the principles of fundamental justice) and subsection 15(1) (the right to equal protection and equal benefit of the law without discrimination).

Before proceeding with an analysis of section 7 and subsection 15(1) of the Charter however, there are a number of preliminary issues to be addressed. First, an understanding of the framework of the Charter is necessary to situate the arguments advanced in this chapter. Therefore, in the first part of this chapter, I set out a brief explanation of the framework of the Charter to guide the discussion. Then, I discuss the preliminary issues raised by advancing the proposed Charter challenge. I examine the possible Charter remedies available to accused persons and explore the reasons for proposing a remedy under subsection 24(1) of the Charter. The next question which needs to be addressed is how such a Charter challenge might be advanced given the cross-jurisdictional issues involved and possible overlap of jurisdiction. Both levels of government are involved: accused persons are governed by the mental disorder provisions of the Code, enacted by Parliament under subsection 91(27), the criminal power, of the Constitution Act, 1867 while the provincial government has jurisdiction over health under its jurisdiction over hospitals and asylums (subsection 92(7)), property and civil rights (subsection 92(13)), and matters of a merely local or private nature.

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448 Supra note 14.

449 Ibid.

450 Supra note 253.
(subsection 92(16)) including the allocation of mental health resources. The federal
government does not provide funding to the provinces for the implementation of the
mental disorder provisions of the Code.\textsuperscript{451}

The rest of the chapter focuses on specifics of the proposed Charter challenge. I
argue that where, because of inadequate mental health resources, an accused person does
not receive the least onerous or least restrictive disposition or the disposition is not
implemented, her or his liberty and equality rights are infringed contrary to section 7 and
subsection 15(1) of the Charter.\textsuperscript{452} and that these infringements cannot be justified under
section 1 of the Charter.

Part 1- Setting the Context

A. Charter Framework

a) Subsection 52(1)- Constitutional Supremacy and the Charter

With the enactment of the Constitution Act, 1982,\textsuperscript{453} the Canadian Constitution

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\textsuperscript{451}In a discussion in September, 1998 with an official of the Ministry of Health of Ontario, I confirmed that the federal government does not provide any specific funding for the implementation of the mental disorder provisions of the Code. The only funding a province receives with respect to health is the federal contribution to the provincial health insurance plan under the Canada Health Act, R.S.C., 1985, c. C-6. Section 3 of this Act states: "It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers." The Act requires that to qualify for a cash contribution the health insurance plan of a province has to be, amongst other things, comprehensive and accessible.

\textsuperscript{452}Supra note 14.

\textsuperscript{453}(UK) 1982, c.11
underwent a fundamental change. Subsection 52 (1) of the Constitution Act, 1982, states

The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.

The Constitution went "from a system of Parliamentary supremacy to constitutional supremacy." With the inclusion of the Charter in the Constitution, the individual and group rights set out in the Charter are given constitutional protection. The Supreme Court of Canada, in R. v. Therens, held that the constitutional character of the Charter is "a new affirmation of rights and freedoms and of judicial power and responsibility in relation to their protection." Furthermore, in the recent case of Vriend v. Alberta the Supreme Court of Canada emphasizes the interpretive role that the Charter places upon the courts. Iacobucci J. states that "[i]nevitably disputes over the meaning of the [Charter] rights and their justification would have to be settled and here

454 Ibid.
456 Supra note 14.
459 Ibid Le Dain J. at 638.
460 Supra note 38.
the role of the judiciary enters to resolve these disputes. Two early Charter cases, *Hunter v. Southam Inc.* and *R. v. Big M Drug Mart Ltd.* discuss the nature of the Charter and the approach which should be taken to its interpretation. In *Hunter*, Dickson CJC, for the Court, states that the Charter is

[A] purposive document. Its purpose is to guarantee and to protect, within the limits of reason, the enjoyment of the rights and freedoms it enshrines. It is intended to constrain governmental action inconsistent with those rights and freedoms; it is not in itself an authorization for governmental action.

With respect to the approach, the Supreme Court of Canada determines that a purposive approach must be used in interpreting the Charter. As the Court states in *R. v. Big M Drug Mart Ltd.*

The meaning of a right or freedom guaranteed by the Charter [is] to be ascertained by an analysis of the purpose of such a guarantee; it [is] to be understood, in other words, in light of the interests it [is] meant to protect.

...This analysis is to be undertaken, and purpose of the right or freedom in question to be sought, be reference to the character and the larger objects of the Charter itself... The interpretation should be ... a generous rather than a legalistic one, aimed at fulfilling the purpose of the guarantee and securing for individuals the full benefit of the Charter's protection.

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*Supra* note 463.

Therefore, the purposive approach to Charter interpretation separates the Charter argument into two stages; “the first stage being the claim of infringement and the second stage being the government’s limitation argument.”

b) Application of the Charter

Subsection 32 (1) of the Charter states

32. (1) The Charter applies
(a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and
(b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

The Supreme Court has held that subsection 32 (1) of the Charter applies to the legislative, executive and administrative branches of government and their actions. Furthermore, the Court states that the Charter applies to the common law other than between private parties because the language of subsection 52 (1) of the Constitution Act, 1982. In addition, the Supreme Court of Canada ruled that the actions of the executive even when exercising a prerogative power are subject to the Charter. In subsequent cases, the courts have determined that different forms of delegated legislation are subject to the Charter, for example municipal by-laws or rules of professional conduct of

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467P. Macklem et al. supra note 457 at 630.


469Supra note 453.

different professional bodies, as well as persons and bodies exercising decision-making authority pursuant to legislation. A number of cases have raised the issue of whether bodies that are established by legislation such as universities, hospitals, community colleges are subject to the Charter. In McKinney v. The University of Guelph the Supreme Court of Canada reiterated that the Charter applies only to government and stated that the mere fact that an institution is created by legislation or even that it carries out a public function is not sufficient to make it "government" for the purposes of section 32. La Forest J. in McKinney determined that the focus is on the control exercised by government on the institution. If the institution was substantially controlled by government then it falls into the definition of "government" under the McKinney test and the Charter applies to all its activities. However, in Eldridge v. AG of British


473[1990] 3 S.C.R. 229. See also Harrison v. University of British Columbia, [1990] 3 S.C.R. 451, Stoffman v. Vancouver General Hospital, [1990] 3 S.C.R. 483, and Douglas/Kwantlen Faculty Assn. v. Douglas College, [1990] 3 S.C.R. 570. In these cases the Court was asked to decide whether the mandatory retirement policies adopted by the various institutions were subject to Charter review. In McKinney, Harrison, and Stoffman, a majority of the Supreme Court of Canada decided that these institutions were autonomous bodies and not subject to the Charter. However, in Douglas the majority of the Court found that the community college was an emanation of government because it was a Crown agency established to implement government policy.

474In Lavigne v. Ontario Public Service Employees Union, [1991] 2 S.C.R. 211, the Supreme Court of Canada reiterated that when an institution is found to be a part of the "fabric of government", the Charter applies to all its activities, including those considered private.
Columbia, the Supreme Court of Canada determined that there may be situations where one function of an entity may be found to be a government function, although the entity, as a whole, would not be considered government under the McKinney test. then the Charter applies only to that function.

c) Specific Charter Rights and Freedoms Infringed

Section 7 and subsection 15(1) are the two most likely to be used by accused persons who wish to challenge that the disposition or the implementation of a disposition made under section 672.54 of the Code. Section 7 states

Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

The word “everyone” in section 7 refers to any person whose life, liberty or security is infringed in Canada and encompasses corporations. Section 7 contains three rights:

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475 Supra note 38.

476 Supra note 473.

477 Though there are other possible grounds of infringement of rights under section 9 (the right not to be arbitrarily detained or imprisoned), paragraph 10(c) (the right to have the validity of the detention determined by way of habeas corpus and to be release if detention not lawful), and section 12 (the right not to be subjected to cruel and unusual punishment) of the Charter, these are not germane to the proposed Charter challenge which attacks the allocation of resources as opposed to the mental disorder provisions.


479 See supra 462.
narily, the right to life, the right to liberty and the right to security of the person, to the extent that these rights cannot be infringed except in accordance with the principles of fundamental justice; "[f]or all practical purposes, then, section 7 creates a right to fundamental justice." In R. v. Swain, the Supreme Court of Canada reiterates that to invoke section 7 of the Charter, "an individual must establish an actual or potential deprivation of life, liberty or security of the person" and show that the deprivation of liberty or security is not in accordance with the principles of fundamental justice.

Subsection 15(1) of the Charter states

Every individual is equal before and under the law and has a right to the equal protection and equal benefit of the law without discrimination and, in particular without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Cory J. in Vriend v. Alberta states

The rights enshrined in s.15(1) of the Charter are fundamental to Canada. They reflect the fondest dreams, the highest hopes and finest aspirations of Canadian society... Canada by the broad scope and fundamental fairness of the provisions of s. 15(1) has taken a further step in the recognition of the fundamental importance and the innate dignity of the individual... In order


Supra note 17.

Ibid at 969.

Supra note 38.
to achieve equality the intrinsic worthiness and importance of every individual must be recognized regardless of age, sex, colour, origins or other characteristics of the person.\textsuperscript{485}

In subsection 15(1), the emphasis is on equality before and under the law and equal protection and benefit of the law without discrimination.

\textbf{d) Limits to Charter rights and freedoms}

The rights and freedoms protected by the Charter are not absolute. Section 1 of the Charter\textsuperscript{486} sets out the following limits:

The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

The reasons for stating that a limit to a Charter right or freedom must be prescribed by law\textsuperscript{487} are two-fold. First, it is to "preclude arbitrary or discriminatory action by government officials"\textsuperscript{488} which is not authorized by law. Second, individuals must "have a reasonable opportunity to know what is prohibited by law so they can act.

\begin{itemize}
\item \textsuperscript{485} *Ibid* at para. 67.
\item \textsuperscript{486} *Supra* note 14.
\item \textsuperscript{487} For a more detailed discussion of the term "limits prescribed by law" see P. W. Hogg in *Constitutional Law in Canada. supra* note 457 at 861-863. The case law has held that the term "prescribed by law" includes a statute, regulation or a rule of common law, see *R. v. Therens supra* note 414, *RWDSU v. Dolphin Delivery supra* note 468, *Irwin Toy v. Quebec* [1989] 1 S.C.R. 927, *Swain supra* note 17. However, Professor Hogg states that "directives or guidelines which, although issued by government department or agencies, fall outside the class of officially published delegated legislation, will probably not qualify" as a limit prescribed by law. Furthermore, the Supreme Court of Canada has held in *Therens supra* note 458 at 645 that a limit on a right need not be express but can result "by necessity from the terms of a statute or a regulation or from its operating requirements."
\item \textsuperscript{488} P. W. Hogg, *supra* note 457 at 862.
\end{itemize}
Therefore, unless an action of the government is authorized by law, the government cannot use section 1 to justify a Charter violation.

In a few cases, the courts deal with only the requirement that the limits be prescribed by law. However, in the majority of cases, the courts adopt a broad interpretation of a limit “prescribed by law” because of

“[A] concern that an excessive emphasis on precision in language may unduly restrict legislatures in accomplishing their objectives and a concern that a stringent application of prescribed by law will circumvent the entire balancing process contemplated by s.1.”

R. v Oakes sets out the framework for analysis for determining whether a law qualifies as a reasonable limit on a right or freedom in a free and democratic society. First, the objective of the law must be sufficiently important to justify infringing a Charter right. Second, there must be a rational connection between the law and its objective. Third, the law must minimally impair the right. Fourth, the effects of the infringement on the Charter right must not outweigh the legislative objective.

e) Remedies

Where the Charter rights and freedoms of a person or groups are infringed and the infringement cannot be justified, the court may grant a remedy under subsection 52 (1) or

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489 Ibid.

490 See P. Macklem et al., supra note 457 at 635. The authors note that the Therens case and the cases that followed it are the exceptions where the court did not proceed to the justification argument in section 1 of the Charter.

491 Ibid.

24(1), depending on the circumstances.

i) Subsection 52(1)

Under subsection 52(1) of the Constitution Act, 1982, where legislation infringes on a Charter right and is not saved by section 1, the court may make a declaration that the legislation as a whole is invalid. In addition, it may grant a temporary suspension of a declaration of invalidity to permit the government in question to fill the legislative void. In cases where only some provisions of the legislation in question or some of its applications result in a violation of the Charter, the courts may use the techniques of severance, reading down and constitutional exemptions so as to invalidate only those parts or applications and may also grant a temporary suspension of the invalidity to give the government time to act. Lamer C.J.C. notes in Rodriguez v. British Columbia (Attorney General) that

[T]his Court has recognized that an immediate declaration of invalidity is not always advisable, especially where, as here, the provision pursues an important objective but is over-inclusive: were this Court to strike down the provision effective immediately, those whom the government could protect constitutionally with a more tailored provision, and who indeed should be protected, would be left unprotected. This would clearly pose a 'potential danger to the public' as understood in Swain and Schachter.

Where the legislation is underinclusive because it provides benefits to some individuals

\footnote{493}{Supra note 453.}
\footnote{494}{P. Macklem et al., supra note 457 at 1149.}
\footnote{495}{[1993] 3 S.C.R. 519.}
\footnote{496}{Ibid at 570.}
but not to others, as in *Schachter v. Canada*\(^\text{497}\) or *Vriend*,\(^\text{498}\) the court may read in an extension of benefits.

While it is clear that courts are competent to enforce the *Charter* under subsection 52(1), the question has arisen as to whether administrative tribunals and other arbiters have a similar power. The answer to this question lies in the statutory scheme which created the administrative tribunal or empowered the decision-making body.\(^\text{499}\) The Supreme Court of Canada in *Cuddy Chicks Ltd. v. Ontario (Labour Relations Board)*,\(^\text{500}\) found that the Board had the authority to determine questions of invalidity under section 52(1) of the *Charter*, as did the arbitrator in *Douglas/Kwantlen Faculty Assn. v. Douglas College*, because the Board and the arbitrator respectively were granted the authority to determine questions of law by their enabling legislation and therefore, were required to determine if a law was constitutionally valid.\(^\text{501}\) However, the Court ruled in *Tétreault-\[1992\] 2 S.C.R. 679.*


\(^{498}\)*Supra* note 38.

\(^{499}\)As far as I could ascertain, there has not been a determination by a court of whether a Review Board established under the mental disorder provisions can be considered a court. However, the majority of the Ontario Review Board in a Pre-disposition Ruling In the *Matter of the accused*, James Peter Lappin dated October 24, 1994 (unreported), determined that it had jurisdiction to deal with the application of the *Charter* because it had the power to consider questions of law. But, the Board could not deal with a *Charter* challenge to the validity of sections 672.47 and 672.54 of the *Code* because it was limited to matters incidental to and within the ambit of disposition hearings. The minority decided that it had the jurisdiction to determine the constitutional validity of these sections. However, the Board unanimously ruled that it was not a "court of competent jurisdiction" under subsection 24(1) of the *Charter*.


\(^{501}\)*Supra* note 473.
Gadoury v. Canada (Employment and Immigration Commission)\textsuperscript{502} that the Commission did not have the authority to decide questions of invalidity because it did not have the power to interpret laws.

\textbf{ii) Subsection 24(1)}

While subsection 52(1) provides remedies where legislation, or a portion of it, is found to be invalid, subsection 24(1) of the Charter provides remedies where a Charter right or freedom is infringed by the actions of a decision-maker in applying the legislation. It is the actions taken pursuant to legislation that are unconstitutional, rather than the legislation itself.\textsuperscript{503} Subsection 24(1) of the Charter states

\begin{quote}
Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.
\end{quote}

A person whose Charter rights are infringed may seek a remedy under this section. If a remedy is being sought in the public interest, it is in the discretion of a court of first instance to determine whether the person is granted standing.\textsuperscript{504}

Section 24 does not create a particular court with jurisdiction to grant a Charter remedy; indeed the courts have interpreted the reference to “court of competent jurisdiction” to mean any court which already has jurisdiction independent of the Charter


\textsuperscript{503}See Eldridge supra note 38 at para. 20. See also P. Macklem et al. Canadian Constitutional Law, supra note 457 at 1146-1169.

to grant the remedy sought. Given that the "normal remedial armaments" of the superior courts are "virtually unlimited," in granting a remedy under subsection 24(1) superior courts are limited only by "the need for the remedy to be 'appropriate and' just; and the breadth of judicial imagination." Also, given the requirement that the jurisdiction to grant a particular remedy must exist "external to the Charter itself." lower courts would be somewhat limited as to the kinds of remedies that these courts could grant. Under subsection 24(1), a court might make a declaration of rights, issue an injunction or writ of mandamus, or award monetary damages.

B. The Appropriate Charter Remedy

Given that the Constitution Act, 1982 provides two possible remedies where a person's rights have been infringed under the Charter and the infringement cannot be justified under section 1, an accused person would have to decide whether to seek a declaration of invalidity of all or part of the mental disorder provisions of the Code. under

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505 See Singh v. Canada (Minister of Employment and Immigration), supra note 478 at 222 where Wilson J. states that "[s]ection 24(1) of the Charter provides remedial powers to a 'court of competent jurisdiction.' As I understand this phrase, it premises the existence of jurisdiction from a source external to the Charter itself." See also D. Gibson & J. Gee, "Enforcement of the Canadian Charter of Rights and Freedoms" in G.-A. Beaudoin & E. Mendes, The Canadian Charter of Rights and Freedoms, supra note 471 at 19-20 & 19-21 who points out that some authors argue that administrative tribunals are included in the expression "court of competent jurisdiction" and notes a few cases of the lower courts or Boards which adopt this view.

506 Ibid at 19-28 & 19-29.

507 Wilson J. in Singh v. Canada (Minister of Employment and Immigration), supra note 478 at 222.

subsection 52(1), or seek a remedy under subsection 24(1) of the *Charter* by challenging the action taken pursuant to the mental disorder provisions and provincial health legislation. However, in cases where the court grants a declaration of invalidity but temporarily suspends its effect, the court may grant an individual remedy under section 24(1) in conjunction with a suspended declaration of invalidity. Lamer C.J.C. in *Rodriguez v. British Columbia (Attorney General)*\(^{509}\) reiterates his reasoning in *Schachter v. Canada*\(^{510}\) on the relationship between subsections 24(1) and 52(1) remedies.

An individual remedy under s. 24(1) of the *Charter* will rarely be available in conjunction with an action under s. 52 of the *Constitution Act, 1982*.... It follows that where the declaration of invalidity is temporarily suspended, a s.24 remedy will not often be available either. To allow for s. 24 remedies during the period of suspension would be tantamount to giving the declaration of invalidity retroactive effect. [emphasis in the original]\(^{511}\)

The other option is to seek both remedies as alternatives, in that if the mental disorder provisions were found to be constitutional then a remedy could be sought under subsection 24(1).

**a) Remedy under subsection 52(1)**

An argument can be made, based on the appeal decisions in *Winko*\(^{512}\) and

\(^{509}\) *Supra* note 495.

\(^{510}\) *Supra* note 497.

\(^{511}\) *Supra* note 497 at 572. In this case, Lamer C.J.C. and Cory J. who were dissenting would have granted Ms Rodriguez a constitutional exemption with specific conditions as a personal remedy in conjunction with the suspended declaration of invalidity.

\(^{512}\) *Supra* note 17. The *Charter* challenge to section 672.54 of the *Code* was heard in conjunction with appeals on the same issues in *Bese v. Forensic Psychiatric Institute*
Lepage,513 that the disposition sections of the mental disorder provisions, specifically section 672.54 of the Code in Part XX.1 of the Code, are constitutionally valid because they do not infringe an accused person’s rights under section 7 and subsection 15(1) of the Charter.514 Winko is an appeal from a disposition of the British Columbia Review Board where the appellant argued that section 672.54 of the Code infringed his Charter rights under section 7 and subsection 15(1) and sought a declaration of invalidity of section 672.54. In Lepage,515 Mr. Lepage, an accused person detained in custody, was charged and convicted of criminal charges (four counts of threatening hospital staff).

(British Columbia) 129 W.A.C. 12 and Orlowski v. Forensic Psychiatric Institute (British Columbia) 129 W.A.C. 16. Leave to appeal to the Supreme Court of Canada was granted in all these cases on May 8, 1997. The Supreme Court of Canada heard the appeals in Winko and Lepage jointly on June 15 and 16, 1998.

513Supra note 17.

514In Winko, supra note 17, the Court of Appeal of British Columbia was asked to rule on whether section 672.54 of the Code violated sections 9 and 12 of the Charter in addition to section 7 and subsection 15(1). Under section 9, it was argued that the test of "not a significant threat to the safety of the public" in section 672.54 of the Code does not detail the type of threat or harm contemplated and is therefore arbitrary. The Court rejected this, stating that "[u]nder the impugned section, however, criteria do exist: that is, whether or not an accused is a significant threat to the safety of the public." at 37. The Court added that it was also clear from the other provisions in Part XX.1 of the Code that arbitrariness had been eliminated to a large extent by the requirement of periodic reviews by an independent Board, the provision of specific time lines for review, the requirement for a Review Board to give reasons for its disposition, and the provision of a right of appeal. In short, the mental disorder provisions provide "a good deal of flexibility and discretion capable of being exercised by the Board and Court of Appeal." at 38. The Court gave short shrift to the section 12 argument that the effect of section 672.54 of the Code subjected the appellant to cruel and unusual punishment because "[n]either the wording nor the effect of s.672.54 could possibly be characterized as outraging the standards of decency or grossly disproportionate treatment." at 38.

515Supra note 17.
Prior to his sentencing, Mr. Lepage raised the issue of the validity of Part XX.1 of the Code before the sentencing judge and sought relief under section 52 of the Constitution Act, 1982 and subsection 24(1) of the Charter.

i) Section 7 Argument

In *Winko*, the British Columbia Court of Appeal, applying the reasoning in *R. v. Heywood*, rejected the argument that the phrase “significant threat to the safety of the public” was so vague or overbroad as to infringe section 7 of the Charter. With respect to vagueness, the Court found that section 672.54 of the Code contains a sufficient framework to guide legal debate. On the issue of overbreadth, the Court determined that

The legislative object is and must be to protect the public with as little intrusion as possible into the lives and liberty of those who are so unfortunately afflicted. Section 672.54 requires the Board to choose the least onerous and restrictive disposition, and requires it to schedule periodic reviews not only once a year, but under s. 672.82, the Board may hold a hearing at the request of the accused or any other party. In my view, such a regime could not be said to be overbroad in these circumstances.

The Court added that even though the word “threat” has a future connotation, it is the “only way unpredictable behaviour can be dealt with”, but that the “potential threat must

516 *Supra* note 453.

517 *Supra* note 17.


520 *Supra* note 17 at 41.
take the Board beyond mere speculation."\textsuperscript{521} Therefore, the Court concluded that section 672.54 of the \textit{Code} does not "curtail liberty anymore than necessary in achieving the legislative objective."\textsuperscript{522}

However, the Court of Appeal was split on whether section 672.54 of the \textit{Code} infringes section 7 of the \textit{Charter} by placing a reverse onus on an accused person to establish that she or he is not a significant threat before being granted an absolute discharge. The majority of the Court reaffirmed the ruling in \textit{Davidson v. British Columbia (Attorney General)}\textsuperscript{523} that section 672.54 of the \textit{Code}, by its terms, does not impose a burden on any of the parties to a disposition hearing; rather it establishes an inquisitorial process. The majority of the Court in \textit{Winko} reasoned that an inquiry

\textsuperscript{524}

On the other hand, "one of the hallmarks of adversarial proceedings" was the concept of onus whose purpose is usually to decide, on the evidence adduced by the parties whether "a specified conduct has or has not occurred."\textsuperscript{525} However, a conclusive answer on questions as subtle as dangerousness may not be possible in some cases. A Review Board

\begin{itemize}
\item \textsuperscript{521} \textit{Ibid} at 42.
\item \textsuperscript{522} \textit{Ibid}.
\item \textsuperscript{523} \textit{Supra} note 23.
\item \textsuperscript{524} \textit{Supra} note 17 at 52 \& 53.
\item \textsuperscript{525} \textit{Ibid} at 52.
\end{itemize}
must have the opportunity for further inquiry before it can form the opinion as to whether an accused person is not a significant threat to the safety of the public. The majority of the Court was of the opinion that, if a Review Board were required when in doubt to apply an onus, this could result in an override of the "the instructions of Parliament to protect the public from dangerous persons." Furthermore, as a result of the inquiry approach, the Review Board is expected to seek out information to determine whether an accused person presents a significant threat to the safety of the public. The majority of the Court reiterated that the Review Board must make the least onerous and least restrictive disposition taking into account the factors stipulated in section 672.54 of the Code and the protections afforded by early and periodic reviews and by the appeal provision and by the remedy of judicial review. On this basis, the majority concluded that section 672.54 of the Code did not infringe section 7 of the Charter because the "provisions leading to absolute discharge strike a fair balance between the state and a person found NCRMD." (Emphasis added.) I contend that the finding of the majority of the Court in Winko, that section 672.54 of the Code does not infringe the accused person's rights under section 7 of the Charter because it does not impose a reverse onus on the accused person, is correct. Furthermore, this decision is in keeping with the earlier decision in

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526 Ibid at 55.
527 Ibid at 52.
528 Ibid.
Davidson\textsuperscript{529} and Peckham\textsuperscript{530}. Therefore, I disagree with the dissenting opinion of Williams J.A. that, in reality, for an accused person to gain an absolute discharge, she or he must acquire the necessary information to convince the Review Board that she or he is not a significant threat to the safety of the public. Williams J.A. attempted to distinguish the Winko case from Davidson v. British Columbia (Attorney General)\textsuperscript{531} by stating that the Davidson decision does not deal with the question of onus, irrespective of the standard of proof, placed on the accused person. However, as the majority of the Court states, Davidson generally deals with the issue of onus and is binding authority. In addition, Williams J.A. determines that Peckham v. Ontario (Attorney General)\textsuperscript{532} does not apply in that it does not deal directly with the issue of whether a reverse onus in section 672.54 of the Code infringes section 7 of the Charter. It is true that Peckham does not deal with a section 7 argument. However, it did rule that section 672.54 did not impose a reverse onus on an accused person and therefore the case was applicable to Winko.

In Lepage\textsuperscript{533} in the first instance it was argued that the failure of the government to

\begin{itemize}
  \item \textsuperscript{529}Supra note 23.
  \item \textsuperscript{530}Supra note 271.
  \item \textsuperscript{531}Supra note 23.
  \item \textsuperscript{532}Supra note 271.
  \item \textsuperscript{533}(1995) 40 C.R. (4th) 43 (Ont. Gen. Div.).
\end{itemize}
proclaim the capping provisions\textsuperscript{534} violated section 7 of the \textit{Charter}. The judge rejected the section 7 argument on the grounds that a failure to proclaim a legislated provision in force is not an abuse of process that a court is capable of remedying. On appeal, Mr. Lepage abandoned the section 7 argument, and so it was not dealt with by the Court of Appeal of Ontario.

\textbf{ii) Section 15 argument}

On the issue of subsection 15(1) of the \textit{Charter}, the majority of the Court of Appeal in \textit{Winko} ruled that section 672.54 is not discriminatory and does not impose an impermissible burden, disadvantage or obligation. It reasoned that the deprivation of liberty of an accused person is based on the significant dangerousness an accused person represents and not on her or his mental disorder. The Court pointed to the fact that the legislation provides that an accused person who continues to suffer from a mental disorder must be given an absolute discharge if not a significant threat to the safety of the public.\textsuperscript{535}

In my opinion, the Court of Appeal in \textit{Winko}\textsuperscript{536} appears to be correct in its finding that section 672.54 of the \textit{Code} does not infringe subsection 15(1) of the \textit{Charter}. As emphasized by the Court, the object of the mental disorder provisions is the protection of the public from dangerous persons based on the presumption that some accused persons

\begin{footnotesize}
\textsuperscript{534}Section 672.64 of the \textit{Code} sets a maximum number of years that an accused person can be detained in custody depending on the offence committed.

\textsuperscript{535}Williams J.A., in the minority judgment, does not deal with the subsection 15(1) argument because of his finding on section 7 of the \textit{Charter}.

\textsuperscript{536}\textit{Supra} note 17.
\end{footnotesize}
who come under the mental disorder provisions continue to be dangerous as a result of their mental illness, as stated by Lamer C.J.C., writing for the Court, in Swain.\textsuperscript{537}

[I]t is reasonable to assume that some insanity acquittees will continue to represent a danger to the public. While I recognize that not every individual will pose a continued threat to society, I do agree that this assumption, while certainly not irrefutable, is \textit{reasonable}....

It seems reasonable to assume that these individuals could still be legally “insane” and that this incapacity to appreciate the nature and quality of their actions or their amorality could result in future dangerous conduct. [emphasis in the original]\textsuperscript{538}

If an accused person is not a significant threat to the safety of the public, that person must be granted an absolute discharge even though the person may continue to suffer from a mental disability.\textsuperscript{539} The mental condition of an accused person is only one of the factors in determining whether the person is a significant threat. In my opinion, the purpose of the legislative scheme of the mental disorder provisions is “to humanely treat those suffering mental disorder, and to limit their liberty only to the extent necessary to ensure public safety.”\textsuperscript{540}

In \textit{Lepage} \textsuperscript{541} the majority of the Court of Appeal of Ontario used \textit{R. v. Swain}\textsuperscript{542}

\begin{footnotes}
\footnote{\textit{Supra} note 17.}
\footnote{\textit{Ibid} at 1014.}
\footnote{The question of significant threat was discussed in chapter 2.}
\footnote{\textit{Supra Winko} note 17 at 60.}
\footnote{\textit{Supra Lepage} note 17.}
\footnote{\textit{Supra Swain} note 17.}
\end{footnotes}
and *Winko v. British Columbia (Forensic Psychiatric Institute)*\(^ {543}\) to reiterate that the NCR verdict is not discriminatory in and of itself. Then, the Court considered whether the disposition hearing resulted from stereotypical assumptions about the mentally disabled or from an individualized assessment based on the merits of each case. The majority of the Court found that the disposition hearing is an inquiry into risk posed by each person found NCRMD to determine the danger, if any, an accused person poses to the community. The Court stated

The risk assessment scheme contemplated by Part XX.1 recognizes that proven past dangerousness, combined with present uncertainty as to the mental condition of the accused, warrants inquiry to determine what risk, if any the NCR accused poses to the community. At the same time, Part XX.1 demands that any restraint on the accused’s liberty pending assessment be justified under statutory criteria which require an individualized assessment of the accused and the circumstances of the offence. None of these criteria make any assumption about the dangerousness of a NCR accused at the time of the verdict. Part XX.1 also demands that the eventual disposition be the product of an inquiry which looks at the circumstances of each case and each accused individually. In doing so, it avoids the shortcomings of the previous system which was found unconstitutional in *Swain*, *supra*. In short, the inquiry requirement in Part XX.1 ‘treats individuals as individuals.’\(^ {544}\)

Furthermore, the majority of the Court of Appeal of Ontario cited the *Peckham*\(^ {545}\) decision with respect to the disposition hearing being an inquiry and not an adversarial process, and reiterated the views of the Court expressed above in the *Winko* case on the effect of this characterization of a disposition hearing. It emphasized that “the scheme

\(^{543}\) *Supra Winko* note 17.

\(^{544}\) *Supra Lepage* note 17 at para. 58.

\(^{545}\) *Supra* note 271.
limits detention to situations where it is the ‘least onerous and restrictive’ position available.”\textsuperscript{546} The Court adopted the findings in \textit{Winko v. British Columbia (Forensic Psychiatric Institute)}\textsuperscript{547} that although the mental disorder provisions are “engaged by the presence of mental disorder, which remains a relevant factor, the deprivation of liberty continues not because of mental disorder, but only because of significant dangerousness.”\textsuperscript{548} Therefore, a majority of the Court of Appeal of Ontario in \textit{Lepage} ruled that a distinction based on dangerousness did not attract Charter scrutiny under subsection 15(1) of the \textit{Charter} because it was not a distinction based on mental disability and because dangerousness cannot “be regarded as an analogous category to mental disability.”\textsuperscript{549} The equality rights of accused persons were not infringed.

Goudge J.A., in the minority in \textit{Lepage}, found that section 672.54 of the Code infringed the equality rights of accused persons but was saved under section 1 of the \textit{Charter}. He was of the view that the mental disorder provisions treat a person found NCR differently than any other person under the criminal law. Therefore, the provisions create a legislated distinction based on a personal characteristic, namely mental disorder, because “it cannot be said that the respondent’s continued subjection to the procedures of s.672 is due to his dangerousness rather than his mental disability.”\textsuperscript{550} He further found

\textsuperscript{546} \textit{Supra Lepage} note 17 at para. 66.

\textsuperscript{547} \textit{Supra Winko} note 17.

\textsuperscript{548} \textit{Ibid} at 58.

\textsuperscript{549} \textit{Ibid} at 60.

\textsuperscript{550} \textit{Supra Lepage} note 17 at para. 104.
that the legislated distinction constitutes discrimination based on the particular disadvantage suffered by persons with mental disabilities. He added that the discrimination is confirmed by the fact that section 672.54 results in a burden on accused persons because of the adoption of a negative test which “presumed possible dangerousness of those in his situation, all of whom share the characteristic of mental disability. This stereotypical outcome is at odds with the purpose of s.15 (1).”

I agree with the majority judgment in Lepage in that it characterizes the mental disorder provisions as a risk assessment scheme to determine an accused person’s dangerousness to the public. The British Columbia Appeal Court in Winko, and earlier in Davidson, made the same finding. Furthermore, the Court in Lepage unanimously agree that the mental disorder provisions are sensitive to the rights of accused persons.

However, the Court in Lepage added a warning that

There is always a concern that the actual operation of a statutory scheme does not accord with the spirit of the law it is intended to implement. In adjudicating constitutional challenges, a court must always be concerned with the reality faced by those who assert denial of their rights. Section 15(1) demands more than “paper equality”. The words of the Criminal Code would offer cold comfort to persons caught in a scheme which lacked the will, expertise or fiscal resources needed to give effect to the statutory scheme.

The Court specified that in this case, the record contained extensive evidence on the day-

551 Ibid at para. 109.
552 Supra Winko note 17.
553 Supra note 23.
554 Supra Lepage note 17 at 45.
to-day operation of Part XX.1 in Ontario and that nothing in the record suggested that accused persons are subject to *de facto* discrimination based on their mental disabilities. However, the specific issue of fiscal resources was not raised by any of the parties in the appeal. No evidence appears to have been provided regarding the adequacy or availability of mental health resources for accused persons.

Despite the approach taken in *Winko* and *Lepage*, an argument can be made that the disposition sections, in particular section 672.54 of the *Code*, are constitutionally invalid because they infringe the *Charter* rights of an accused person under section 7 and subsection 15(1) and the sections are not saved by section 1 of the *Charter* on the grounds that the actual operation of the disposition sections of the *Code* do not accord with the intent of the mental disorder provisions. If a Review Board cannot grant an accused person the least restrictive and least onerous disposition because the Board has to take into consideration the lack of resources, then the provisions are not being applied as the appellate case law, for the most part, suggests they should be and a plain reading of section 672.54 makes clear. Furthermore, lengthy delays due to inadequate mental health resources in the implementation of some dispositions results in lengthier detention for some accused persons. The lack of resources infringes on an accused person’s right to liberty under section 7 of the *Charter* because the deprivation of liberty is not in accordance with the principles of fundamental justice.\(^{555}\) An accused person could also use the reasons of the minority in *Winko* to argue that section 672.54 of the *Code* contravenes section 7 of the *Charter* on the grounds that it places a reverse onus on an

\(^{555}\)This argument is discussed more fully later in this chapter.
accused person to prove that she or he is not a significant threat to the safety of the public and that the infringement is not justified under section 1. In addition, the lack of mental health resources deprives an accused person of equal benefit of the law on the grounds of mental disability, contrary to subsection 15(1) of the Charter.556 The first part of the minority judgment in Lepage which recognizes a subsection 15(1) infringement can be used by an accused person to argue that the mental disorder provisions contravene subsection 15(1).

It could also be argued that a Review Board’s inability to direct the implementation of dispositions or to censure the non-implementation of dispositions contributes to a contravention of the spirit of the legislative scheme, and that this renders the provisions invalid.

Since section 672.54 of the Code is the provision under which dispositions are made, if it is declared invalid, the whole of the legislative scheme of the mental disorder provisions would fall. This was the case in Swain,557 where the previous mental disorder provisions were struck down, although the effect of the declaration was temporarily suspended to permit the government to act. Without a suspension of the declaration of invalidity, a legislative vacuum is created until new provisions are enacted. The Supreme Court of Canada states in Mahe v. Alberta:558

[T]he effect of a declaration of invalidity should be considered. In this

556 This argument is discussed more fully later in this chapter.

557 Supra note 17.

case, as it is impossible for the court to rewrite the impugned legislation, the result would be to create a legislative vacuum. This result would not help the position of the appellants. Indeed, the appellants might be worse off, because if the above legislation is invalidated the public authorities in Alberta would presumably be temporarily precluded from exercising their powers so as to change the existing system in order to comply with s. 23.559

I suggest that, based on R. v. Swain560 and R. v. Lepage,561 if a court did find the mental disorder provisions to violate the Charter, the court would not attempt to rewrite the provisions but would suspend the declaration of invalidity for a certain period. The result might be that public officials would wait to see the terms of the new legislation rather act to ensure that adequate funding is allocated for mental health resources. In addition, accused persons would continue to need adequate mental health resources under whatever mental disorder scheme was in place and on this score might not be any further ahead in attaining adequate mental health resources, unless the mental disorder provisions addressed the issue of the provision of mental health resources directly.

The advantage of a declaration of invalidity of the mental disorder provisions is that new provisions might contain criteria more weighted in favour of accused persons. They might provide for the provision of mental health services to accused persons or empower the Review Board with additional powers to direct the implementation of the mental disorder provisions or to sanction persons in charge of hospitals who do not implement the dispositions. In addition, new provisions might clarify the issue of onus, whether the

559 Ibid at 105.
560 Supra note 17.
561 Supra note 533.
burden of proof lies with the Crown or the accused person to demonstrate that the accused person does not present a significant threat to the safety of the public, or whether a Review Board must be of the opinion that an accused person is not a significant threat to the safety of the public before she or he can receive an absolute discharge. As well, new provisions might clarify the meaning of “significant threat” in section 672.54 and specify that implementation concerns should not impinge on the making of the least restrictive and least onerous order.

While one could make arguments that the mental disorder provisions violate the Charter, I argue that Winko and Lepage are correctly decided and that the mental disorder provisions themselves would withstand Charter scrutiny. I suggest that a stronger argument can be made that the mental disorder provisions and provincial health legislation do not result in the Charter infringements, rather the infringements arise out of the decisions regarding the allocation of mental health resources. Therefore, as discussed in the next section, subsection 24(1) is the more appropriate remedy for accused persons.

b) Subsection 24(1) remedy

An accused person seeking a remedy under subsection 24(1) of the Charter might argue that the infringement of her or his Charter right arose from actions or inaction of provincial or federal officials under the provincial health legislation and the mental disorder provisions, rather than out of the mental disorder provisions or the provincial legislation. An accused person might also argue that inadequate funding of mental health services is the reason that they are being detained longer than they would be if the mental health system was adequately funded. A declaration of rights of accused persons could be
sought to order the appropriate level of government to provide adequate mental health resources to remedy the Charter infringements.

_Mahe v. Alberta_\(^{562}\) and _Eldridge_\(^{561}\) suggest that where it is the decisions of public officials that cause the breach of the Charter right, then a remedy under section 24(1) is the appropriate remedy. The Supreme Court of Canada in _Mahe_ declares:

[I]t is not clear that the existing legislation in Alberta is a bar to the realization of the appellant’s rights. The real obstacle is the inaction of the public authorities. The government could implement a scheme within the existing legislation to ensure that these s. 23 parents and other s. 23 parents in the province receive what is due to them. The problem is that they have not done so.\(^{564}\)

The Supreme Court of Canada in _Mahe_ opts for a declaration of rights which describes the general requirements necessary to implement the rights. The Court adds that “[w]here there are alternative ways of satisfying the requirements, the public authorities may choose the means of fulfilling their duties.”\(^{565}\)

I suggest that the _Eldridge_ case\(^{566}\) also supports the argument that a Charter challenge regarding implementation of dispositions should be brought against delegated decision makers, in this case, the public officials allocating mental health resources. La Forest J. in _Eldridge_ states

\(^{562}\) _Supra_ note 558.

\(^{563}\) _Supra_ note 38.

\(^{564}\) _Supra_ note 558 at 106.

\(^{565}\) _Ibid_ at 93.

\(^{566}\) _Supra_ note 38.
First, legislation may be found to be unconstitutional on its face because it violates a *Charter* right and is not saved by s.1. In such cases, the legislation will be invalid and the court compelled to declare it of no force or effect pursuant to s.52(1) of the *Constitution Act, 1982*. Secondly, the *Charter* may be infringed, not by the legislation itself, but by the actions of a delegated decision-maker in applying it. In such cases, the legislation remains valid, but a remedy for the unconstitutional action may be sought pursuant to s.24(1) of the *Charter*.  

La Forest J then declares that the proper framework for determining whether the *Charter* infringement arises from the impugned legislation or the actions of an entity or official pursuant to the legislation is set out in *Slaight Communications Inc. v. Davidson*. Under this framework, the Court must first decide whether the impugned legislation can be interpreted in conformity with the *Charter*. La Forest J. decides in *Eldridge* that since the statutes in question “could be read to conform with s. 15(1) ... it is not the legislation that is constitutionally suspect, but rather the actions of delegated decision-makers in applying it.” This conclusion is based on the finding that the provincial health legislation in question was silent with respect to the provision of sign language interpretation but the legislation gave discretion to entities authorized under the legislation to make decisions with respect to the provision of services. Therefore, the *Charter* infringement arose from the exercise of discretion by authorized decision-makers.

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568 *Supra* note 472.

569 *Supra* note 38 at para. 24.
C. Preliminary Question of Jurisdiction

Given that the Code is federal legislation and that the mental disorder provisions are administered by the provincial ministries of health, the issue arises of whether a Charter challenge should be brought against the federal or provincial Crown where an accused person wishes to argue that a disposition order or the implementation of a disposition order infringes his or her rights under the Charter.

a) Jurisdiction of provincial government

McKinnon J. of the Supreme Court of British Columbia dealt with this issue in C.(J.) v. British Columbia (Forensic Services Commissioner).\(^{570}\) In this case, the plaintiff was detained in custody at the British Columbia Forensic Institute under a warrant of the Lieutenant-Governor issued under the insanity provisions of the Code. She sought a declaration that the defendants, the Forensic Psychiatric Service Commissioner, the Attorney General of British Columbia and the Attorney General of Canada, had breached her right under subsection 15(1) of the Charter in the distribution of services that they are mandated to provide. She argued that, in particular, the policy of the institute in refusing to permit female patients to reside in premises known as the “cottages” was discriminatory and offended subsection 15(1). Regarding the question of jurisdiction, the Attorney General for Canada argued that

\[\text{[S]he has no role to play in the treatment of the plaintiff, rather the federal role is strictly one of custody and release. She submits that the issue is not}\]

\(^{570}(1992)\ 65\ B.\ C.L.R.\ (2d)\ 386\ (B.C.S.C.\ ).\ \text{Though this case arose prior to the coming into force of the current mental disorder provisions, the issue of whether a} \text{Charter challenge should be brought against the federal or provincial government remains applicable.}\]
one about the status of J.C. [the plaintiff], rather it is all about treatment and facilities which are solely within the scope of the province: see R. v. Swain... Re Kleinys, the Constitution Act, 1982, s. 92(7), and Schneider v. British Columbia... It is contended that access to facilities that are within the scope of the province is an aspect of treatment and rehabilitation, not an aspect of custodial status. There is no federal funding of any programs except shared medical services and there is no federal administration or functional control over the institute. Finally it is contended that the manner of confinement of a person in J.C.'s position is within the sole competence of the provincial government: see R. v. Coleman.571

The provincial Attorney General did not dispute these submissions. McKinnon J. agreed with the submissions of the Attorney General of Canada and found that the federal Attorney General was not a proper party to the action. However, McKinnon J. found that the Attorney General of British Columbia and the Forensic Psychiatric Service Commissioner were proper parties to the action because the Forensic Psychiatry Act572 authorized the Forensic Psychiatric Services Commission to provide custody and treatment for persons held in custody under the insanity provisions of the Code.573

571Ibid at 390.
573Of note is that British Columbia is the only province which has a Forensic Psychiatry Act. However, in Alberta, Saskatchewan, Ontario, Quebec, New Brunswick, Nova Scotia, and Prince Edward Island, the respective legislation governing mental health refers to the admission and detention of accused persons under the jurisdiction of the mental disorder provisions of the Code. In some of these jurisdictions, the provision refers to treatment of these persons. See the Mental Health Act, R.S.A. 1980, c. M-13.1, s.3; the Mental Health Services Act, S. S., 1984-85-86, c. M-13.1, s. 23; the Mental Health Act, R.S.O. 1990, c. M.7, s. 25; the Mental Patients Protection Act, R.S.Q., c. P-41, s.33; the Mental Health Act, R.S.N.B. 1973, c. M-10 as amended by S.N.B. 1989, c. 23, s. 18; the Hospitals Act, R.S.N.S. 1989, c. 208, s. 40; and the Mental Health Act, S.P.E.I. 1994, c.39, s.19. Since none of these provisions order that services be provided to accused persons, as is the case under the Forensic Psychiatry Act, the argument regarding the provision of mental health services to accused persons might be more difficult to make. An accused person might have to delve more into the policy of the
In addition, an argument can be made that the decision on the jurisdictional issue in *C. (J.) v. British Columbia (Forensic Services Commissioner)* is well founded on the basis of *Schneider v. The Queen*, *R. v. Swain* and other cases which have held that the general jurisdiction over health matters is provincial (allowing for a limited federal jurisdiction either ancillary to the express heads of power in s.91 or the emergency power under peace, order and good government) has prevailed and is now not seriously questioned.

The Supreme Court of Canada reiterates that to determine whether health legislation falls within section 91 or 92 of the *Constitution Act, 1867* the "pith and substance" of the legislation has to be ascertained. In *Schneider*, the Court determines that the "pith and substance" of the *Heroin Treatment Act* is "the medical treatment of heroin addicts and is respective Ministries of Health on forensic services. For example in Ontario, the Ministry of health has adopted *The Provincial Forensic System: Strategic Directions* respecting the provision of services to accused persons, as stated in the *Discussion Paper: The Distribution of Forensic Beds in Ontario*, supra note 391.

574(1992) 65 B.C.L.R. (2d) 386 (B.C. S.C.). Though this case arose prior to the coming into force of the current mental disorder provisions, the issue of whether a *Charter* challenge should be brought against the federal or provincial government remains applicable.


576 *Supra* note 17.


578 *Supra* note 575 at 439.

579 *Supra* note 253.
within the general provincial competence over health matters under 92(16)." As argued in Schneider, civil committal criteria under provincial mental health legislation authorizes the detention of persons with mental disabilities, however, the mental health legislation is *intra vires* of provincial legislatures because it provides for treatment. The Court in Schneider adds that "[e]xamples of compatible federal and provincial legislation abound, in health legislation." Fawcett v. Ontario (Attorney General)\(^5\) is one example of compatible health legislation. In this case the constitutionality of the *Mental Hospitals Act*\(^5\) is in issue because a provision of the *Criminal Code* authorized a magistrate to remand an accused who the magistrate believed was mentally ill and section 38 of the *Mental Hospitals Act* also authorized a magistrate to require the Superintendent to admit an accused to a psychiatric hospital. The Supreme Court of Canada determined that the *Mental Hospitals Act* "is legislation in relation to the subject-matter described in head 7 of s. 92 of the B.N.A. Act and not in relation to criminal procedure, that the relevant provisions of the *Criminal Code* are complementary to, and not in conflict with, each other."\(^5\) R. v. Lenart\(^5\) provides another example of compatible legislation respecting health. The Court of Appeal of Ontario in Lenart is asked to determine whether sections

\(^{580}\) *Supra* note 575 at 439.

\(^{581}\) *Ibid* at 436-437. Also see R. v. Hydro-Québec *supra* note 577 at 103-104.


\(^{583}\) R.S.O. 1960, c. 238.

\(^{584}\) *Supra* note 582 at 267.

\(^{585}\)(1998) 158 D.L.R. (4\(^b\)) 508 (Ont. C.A.).
21 and 22 of the Ontario *Mental Health Act*\(^{586}\) which permit a judge to remand a person who was either in custody, or charged or convicted of an offence and who appeared to be suffering from a mental disorder to a psychiatric facility for assessment for a period not exceeding two months was *ultra vires* of the provincial legislature.\(^{587}\) Sections 720 and 721 of the *Code* also permit a judge to remand a person after a finding of guilt and order a pre-assessment report. The Court of Appeal states that sections 21 and 22 are not “prohibitive of federal matters, but are expansive insofar as they do not restrict Parliament’s authority to legislate on criminal law or procedure.”\(^{588}\) Sections 21 and 22 are in *pith and substance* provincial legislation which touch on federal matters. The Court of Appeal declares that the fact that the *Mental Health Act* and the *Criminal Code* “work together in dealing with individuals who have mental disabilities and are involved in the criminal justice system”\(^{589}\) was not in question.

In *R. v. Morgentaler*,\(^{590}\) the Supreme Court of Canada declares that

The provinces have general legislative jurisdiction over hospitals by virtue of s. 92(7) of the *Constitution Act, 1867*, and over the medical profession and the practice of medicine by virtue of s. 92(13) and (16). Section 92(16) also gives them general jurisdiction over health matters within the province...

\(^{586}\)R.S.O. 1990, c. M.7

\(^{587}\)The provisions were not being challenged as being in *pith and substance* an exercise of the criminal law power. Rather the constitutional challenge was that sections 21 and 22 were not available to a judge on sentencing.

\(^{588}\)Supra note 585 at 531.

\(^{589}\)Ibid at 530.

\(^{590}\)Supra note 577.
In addition, there is no dispute that the heads of s.92 invoked by the appellant confer on the provinces the jurisdiction over health care in the province generally, including matters of cost and efficiency, the nature of the health care delivery system, and privatization of the provision of medical services.\(^{91}\)

*R. v. Swain\(^{92}\) deals with the issue of whether the insanity provisions (as the mental disorder provisions were then referred to) of the *Code* were *ultra vires* of Parliament's criminal law power under subsection 91(27) of the Constitution Act, 1867 (U.K.).\(^{93}\) The appellant argued that the *pith and substance* of the insanity provisions is to treat and cure the mentally ill rather than punish them, and therefore, the provisions fell within the scope of provincial powers of subsections 92(7) (hospitals, asylums), 92(13) (property and civil rights) and 92(16) (matters of a merely local or private nature) of the *Constitution Act, 1867* (U.K.). In *Swain*, Lamer C.J. discusses whether "health" falls within the federal or provincial competence. He cites with approval *Schneider v. The Queen*.\(^{94}\) He notes that in *Schneider*\(^{95}\) the main object of the provincial legislation in question was treatment and the coercive aspect was incidental. On the other hand, Lamer C.J., writing for the majority of the Court in *Swain*, describes the object of the insanity provisions as follows:

It is true that the dominant characteristic of these provisions is not

\(^{91}\)Ibid at 558-559.

\(^{92}\)Supra note 17.

\(^{93}\)Supra note 253.

\(^{94}\)Supra note 575.

\(^{95}\)Ibid.
punishment; however, neither is it treatment. The 'pith and substance' of the legislative scheme dealing with individuals acquitted by reasons of insanity is the protection of society from dangerous people who have engaged in conduct proscribed by the Criminal Code through prevention of such acts in the future. While treatment may be incidentally involved in the process, it is not the dominant objective of the legislation.\footnote{Supra note 17 at 998.}

He emphasizes that the criminal law power of the federal government includes the prevention of crime. Furthermore, Lamer C.J. notes that the insanity provisions "do not speak directly of the administration of medical treatment. They simply stipulate procedures for a criminal committal, procedures designed to protect society, not to treat the individual."\footnote{Ibid at 1005.} In addition, Lamer C.J. in Swain declares that "it is not Parliament's responsibility to treat these people [accused persons]; Parliament must concern itself with the consequences for society if these individuals are released while dangerous."\footnote{Ibid at 1006-1007.}

The Supreme Court of Canada in RJR-MacDonald Inc. v. Canada (Attorney General)\footnote{Supra note 577.} emphasizes that "the protection of 'health' is one of the 'ordinary ends' served by the criminal law, and that the criminal law power may be validly used to safeguard the public from any 'injurious or undesirable effect'."\footnote{Ibid at 23.} The Court adds that criminal legislation aimed at the protection of health must "contain a prohibition accompanied by a penal sanction and must be directed at a legitimate public health
In my view, the above-mentioned decisions make clear that "health" is not a matter specifically assigned to the provincial or federal competence under the Constitution Act, 1867. Thus, each level of government may legislate with respect to health but only within the scope of its legislative powers. For example, the provincial government may validly legislate regarding hospitals or general health matters which are local in nature, and the federal government may validly legislate where there is a national dimension to the health problem or to protect the public under the federal criminal law power.

In my opinion, the decision of C.(J.) v. British Columbia (Forensic Services Commissioner) is applicable to the current mental disorder provisions of the Code. Based on R. v. Swain and a number of other cases, I argue that the pith and substance of the mental disorder provisions is the protection of the public from dangerous persons. This argument is also supported by the wording of section 672.54 of the Code which requires the Review Board to consider the need to protect the public from dangerous persons when making a disposition. To achieve the protection of the public,

601 Ibid.
602 Supra note 253.
603 Supra note 570. Though this case arose prior to the coming into force of the current mental disorder provisions, the issue of whether a Charter challenge should be brought against the federal or provincial government remains applicable.
604 See Swain supra note 17 and RJR-MacDonald supra note 577.
605 See Davidson supra note 23 at 277 and 279 and Winko supra note 17 at 58.
section 672.54 of the Code authorizes a Review Board to make a disposition either
detaining an accused person or setting the conditions of that detention. If an accused
person is not a significant threat to the safety of the public, a Review Board must grant an
absolute discharge.

Furthermore, I contend that the administration of the mental disorder provisions is
given to the provincial Minister of Health by the following provisions: section 672.1 of
the Code states that a hospital means “a place in a province that is designated by the
Minister of Health for the province” for the custody, treatment or assessment of an
accused person under a disposition; under section 672.38 of the Code, the Review Board
is established and the appointments to the Board are made by the Lieutenant-Governor in
council, and the Board is treated as having been established under the laws of the
province;\(^606\) and under section 672.56 of the Code, the person in charge of a hospital has
the obligation of implementing the order if the Review Board delegates to her or him the
power to do so.\(^607\)

I suggest that valid federal legislation may impose an administrative burden on
provincial governments as ruled in Reference re: Goods and Services Tax (Alta.).\(^608\) In
this case, the Attorney General of Canada argued that “there is nothing impermissible in
valid federal legislation imposing administrative burdens upon provincial governments.

\(^606\) Members of a Review Board are remunerated by the province.

\(^607\) As discussed in chapter 2, the Review Board delegates to the person in charge
the implementation of a disposition.

provided that these are necessarily incidental to the operation of a valid federal scheme of taxation.\textsuperscript{609} The Supreme Court of Canada accepts this submission though it does not rule on the limits of the federal government to impose administrative burdens on the provinces. La Forest J. adds that

\begin{quote}
It by no means follows, however, that an administrative duty reasonably placed by Parliament on a province in the course of enacting a scheme falling squarely within federal power will be invalid because the performance of that duty will in consequence require some expenditure by the province.\textsuperscript{610}
\end{quote}

I also argue that treatment is only peripheral to the mental disorder provisions in that subsection 672.55 (1) of the \textit{Code} prohibits the ordering of treatment in a disposition under section 672.54 of the \textit{Code}. However, a disposition may include a condition regarding treatment where the accused person consents and the Review Board considers it reasonable and necessary in the interest of the accused person.\textsuperscript{611} There are no sections regarding the provision of treatment or other mental health services relating to accused persons in Part XX.1 of the \textit{Code}. I suggest that this is due to the existence of complementary provincial mental health legislation. For example, in Ontario, section 25 of the \textit{Mental Health Act}\textsuperscript{612} specifies that an accused person who is detained “may be admitted to, detained in and discharged from a psychiatric facility in accordance with the

\begin{footnotes}
\item[\textsuperscript{609}]	extit{Ibid} at 77.
\item[\textsuperscript{610}]	extit{Ibid} 84.
\item[\textsuperscript{611}] The only other provisions regarding treatment are sections 672.58 to 672.62 of the \textit{Code} which authorize the court to order treatment in the case of unfit accused persons prior to a disposition being made under section 672.54 of the \textit{Code}.
\item[\textsuperscript{612}]	extit{R.S.O.} 1990, c. M.7.
\end{footnotes}
law.” In addition, under subsection 5(2) of the Mental Hospitals Act,613 the Lieutenant-Governor in Council may make regulations “regarding the care, treatment and maintenance of patients” which would include accused persons. Section 7 of the Mental Hospitals Act614 states that a person in charge of an institution has control and charge of the institution for which she or he is appointed. These Acts govern the treatment and the psychiatric facilities in which the treatment is generally provided.615 In British Columbia, the Forensic Psychiatry Act provides that one of the functions of the commission is “to provide forensic psychiatric services” for accused persons.616 The administration of psychiatric facilities and the provision of mental health services are under the jurisdiction of the provincial mental health ministry. At present, the federal government does not provide any mental health services to accused persons, it does not administer any health facilities, and does it not provide funding for the mental disorder provisions of the Code.617

b) Jurisdiction of federal government

However, an argument can be made that the federal government should be


614Ibid.

615Mental health services may also be provided in psychiatric units of general hospitals under the Public Hospitals Act, R.S.O. 1990 c. P.40 and by psychiatrists and physicians under the Health Insurance Act, R.S.O., 1990 c. H.6.

616See subparagraph 5(b)(ii) of R.S.B.C. 1996, c. 156.

617Under the Canada Health Act R.S.C. 1985, c. C-6, the federal government shares with the province the cost of health services in general.
providing adequate mental health resources to accused persons. First, Parliament could validly enact treatment provisions within Part XX.1 of the Code. The Supreme Court of Canada in Swain finds that

It should be noted that while “treatment” in a narrow sense falls under provincial heads of power, Parliament may have competence over certain subjects which may appear to be “treatment” in certain aspects. For example, no one disputes that criminal law sentencing may deal with considerations of rehabilitation. The criminal law power authorizes Parliament to provide for conditional discharges just as well as unconditional discharges, even though some of the conditions may involve a treatment program. If Parliament chooses to respond to conduct proscribed by the Criminal Code in a manner more sensitive to rehabilitation concerns, it does not thereby lose its legislative competence. In addition, the Supreme Court of Canada in RJR-MacDonald v. Canada (A.G.) emphasizes the “plenary nature of the criminal law power” and in R. v. S. (S.) the Supreme Court of Canada states that “this court has held repeatedly that the legislative power over criminal law must be sufficiently flexible to recognize new developments in methods of dealing with offenders.” In R. v. S. (S.), one of the issues was whether section 4 of the Young Offenders Act, which empowered a provincial Attorney General

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618 Supra note 17 at 1007.
619 Supra note 577.
620 Ibid at 28.
622 Ibid at 294.
623 Ibid.
to establish alternative measure programs, was *ultra vires*. The Court concludes that section 4 is an attempt to deter young offenders from criminal activities and is within Parliament's power over criminal law. This suggests that treatment of accused persons could be within the scope of the federal criminal law power under which the mental disorder provisions are enacted. The federal government should provide adequate mental health resources to implement the mental disorder provisions because the administration of the disposition sections does not appear to fall to the provincial Attorney General under the administration of justice power (section 92(14)) of the *Constitution Act, 1867 (U.K.).* Rather, it is a health matter.

Second, treatment of accused persons is the means of attaining the object of the mental disorder provisions. The Supreme Court of Canada in *Swain* states

> The *objective* of the legislation is to protect society and the accused until the mental health of the latter has been restored. The objective is *to be achieved by treatment* of the patient in a hospital, rather than a prison environment. (Emphasis in the original)

It follows that the federal government should fund adequate mental health resources to ensure that the objective of the mental disorder provisions is attained so that accused persons receive the least onerous and least restrictive disposition or that a disposition is implemented. These arguments would form the basis for seeking a declaration of rights against the federal government for the provision of adequate mental health resources.

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625 *Supra* note 253.

626 *Supra* note 17.

627 *Ibid* at 1005.
c) Stronger case respecting provincial jurisdiction

In my view, a stronger case can be made that the provincial government is the government against which to seek a Charter remedy under subsection 24 (1) for the provision of adequate mental health resources. First, historically, the provinces have provided mental health resources to accused persons. Second, on the basis of Swain and C.(J) v. British Columbia, the provision of treatment under the mental disorder provisions of the Code has been determined to be a provincial health matter while the federal government has the responsibility of protecting the public by authorizing the detention of accused persons who present a significant threat to the safety of the public. Third, the federal government may legislate within its sphere of competence and may impose the administrative burden of implementing the federal legislation on provincial governments. In summary, while acknowledging that a Charter challenge might be made to the disposition sections of the mental disorder provisions, in particular section 672.54 of the Code, I reiterate that the stronger argument is that the mental disorder provisions of the Code are not constitutionally suspect because they balance the rights of accused persons and the protection of the public. The Court of Appeal cases refer repeatedly to the requirement in section 672.54 of the Code that a Review Board must make the least onerous and least restrictive disposition after considering the factors set out in this section. This requirement affords substantive protection to accused persons

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628 Swain supra note 17 and C(J) supra note 570. Furthermore, the other cases, supra note 524, dealing with the matter of “health” have declared that the provincial government had competence in “health” matters of a local nature or regarding the establishment of hospitals as discussed above.
and guarantees the least intrusion “possible into the lives and liberty of those who are
unfortunately afflicted.” Where the legislative scheme has run aground is in cases
where inadequate mental health resources have resulted in accused persons either not
receiving the least onerous and least restrictive dispositions or receiving an appropriate
disposition order but experiencing lengthy delays in the implementation of dispositions.
In my opinion, the Review Board would grant the least onerous and least restrictive
disposition if the lack of resources was not an issue. Furthermore, the *McGillis* case
which held that, if there was no suitable accommodation in the community, the Ontario
Review Board should have ordered his detention in custody order, would not have any
application, if there existed adequate resources. Presumably also persons in charge of
hospitals would implement dispositions if they had enough resources. Arguably, the
current situation in which some accused persons find themselves will not be remedied
unless the necessary mental health resources are allocated to accused persons.

I reiterate that the stronger argument with respect to jurisdiction is that the federal
government has validly enacted the mental disorder provisions, and has delegated the
administration of the disposition sections to the provincial Minister of Health and persons
in charge of hospitals. The mental disorder provisions deal with the custody and release
of an accused person and are silent on the provision of mental health resources. The
provision of mental health resources, including treatment, is done under provincial health

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629 *Supra Winko* note 17 at 41.
630 *Supra* note 16.
legislation. *Swain and C(J) v. British Columbia*\(^{631}\) support this argument.

Given that I argue that the *Charter* infringement relates to provincial legislation, *Eldridge* suggests that the provincial legislation should be examined to determine whether *Charter* infringement results from the legislation or the actions of delegated decision-makers acting under the legislation. On reviewing the following legislation in Ontario: *Mental Health Act*,\(^{632}\) *the Mental Hospitals Act*,\(^{633}\) and the *Ministry of Health Act*\(^{634}\) and *Savings and Restructuring Act, 1996*\(^{635}\) and in British Columbia: *the Forensic Psychiatry Act*,\(^{636}\) *the Ministry of Health Act*\(^{637}\) and the *Health Authorities Act*,\(^{638}\) in my opinion this legislation is silent on the question of the provision of mental health resources. Therefore, in keeping with the approach in *Eldridge*, this legislation can be read as being constitutionally valid; thus the *Charter* breach arises out of the discretion exercised by the delegated decision-makers. An accused person should seek a remedy under section 24(1) of the *Charter* against the provincial government for the provision of adequate mental health services on the grounds that the impact of inadequate mental

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\(^{631}\) *Supra Swain* note 17 and *C(J)* note 570.


\(^{635}\)*S.O.* 1996, c.1.

\(^{636}\)*R.S.B.C.* 1996, c.156.


health resources is greater on accused persons than persons with mental disabilities in general. This greater impact results from the fact that accused persons are detained under the mental disorder provisions and that their release from detention is linked with the adequacy of resources, as argued in chapter 2. Therefore, I propose that accused persons raise the following constitutional questions:

1. In Ontario, do the decisions taken by public officials under the Mental Health Act, the Mental Hospitals Act, and the Ministry of Health Act and by the Health Services Restructuring Commission under the Savings and Restructuring Act, 1996 which affect the administration of the mental disorder provisions of the Code infringe the rights and freedoms of accused persons under section 7 and subsection 15 (1) of the Charter by not providing adequate mental health resources to accused persons?

In British Columbia, do the decisions taken by public officials under the Forensic Psychiatry Act or under the Ministry of Health Act or by the British Columbia Mental Health Society and Health Authorities which affect the administration of the mental disorder provisions of the Code infringe the rights and freedoms of accused persons under section 7 and subsection 15 (1) of the Charter by not providing adequate mental health resources to accused persons?

2. If the answers to the above are yes, is the infringement demonstrably justified in a free and democratic society pursuant to section 1 of the Charter?

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639 Supra note 632.
640 Supra note 633.
641 Supra note 634.
642 Supra note 635.
643 Supra note 636.
644 Supra note 637.
645 Supra note 638.
Part 2 - The Proposed Charter Challenge

A) Application of the Charter

As determined in Eldridge 646, the Charter applies to the actions of a decision-maker delegated to carry out government policy under provincial legislation and I argue that the Charter would apply to the actions of a decision-maker delegated to carry out provincial government policy made pursuant to federal legislation where the administration of the federal legislation is delegated to the provincial government. In the case of accused persons, the proposed Charter challenge would not be brought against either the provincial legislation governing mental health services or the disposition sections of the mental disorder provisions of the Code, but against the exercise of discretion by government departments or agencies or psychiatric hospitals under the provincial and federal legislation. In Ontario, at present, a number of entities are involved in the provision of mental health services and might therefore be the target of a Charter challenge: one, the province, because it directly administers the provincial psychiatric hospitals under the Mental Hospitals Act,647 two, the Health Services Restructuring Commission, established under the Savings and Restructuring Act, 1996,648 has decision-making regarding the restructuring of psychiatric and other hospitals; and three, the Minister of Health has the overall responsibility respecting the provision of

646 Supra Eldridge note 38 at para. 20.
647 Supra note 633.
648 Supra note 635.
health services under the *Ministry of Health Act*⁶⁴⁹ In British Columbia, at present, the Forensic Psychiatric Services Commission, established as an agent of the government under the *Forensic Psychiatry Act*,⁶⁵⁰ is responsible for providing forensic psychiatric services to accused persons. However, as discussed in chapter 2, *The 1998 Mental Health Plan*⁶⁵¹ proposes to integrate forensic services with mainstream mental health services and to transfer the governance of the British Columbia Forensic Psychiatric Institute to the British Columbia Mental Health Society and the forensic clinics to the different health authorities.⁶⁵²

The text of section 32 of the *Charter* has been interpreted as applying to all activities of government. La Forest J. in *Eldridge* states

In *Douglas* and *Lavigne*, the argument was made that even if the entities in question were generally part of 'government' for the purposes of s.32, the *Charter* should not apply to the 'private' or 'commercial' arrangement they engage in. In each case, the Court rejected this contention, holding that when an entity is determined to be a part of the fabric of government, the Charter will apply to all its activities, including those that might be thought of as 'private'. The rationale for this principle is obvious: governments should not be permitted to evade their *Charter* responsibilities through the vehicle of private arrangement.⁶⁵³

However, prior to the *Eldridge* case, it was unclear whether the *Charter* applied to an entity such as a public hospital, the Health Services Restructuring Commission, the

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⁶⁴⁹ *Supra* note 634.

⁶⁵⁰ *Supra* note 636.

⁶⁵¹ *Supra* note 3.

⁶⁵² *Supra* note 638.

⁶⁵³ *Supra Eldridge* note 38 at para. 40.
British Columbia Mental Health Society or the Health Authorities in British Columbia which may be construed as private actors. The Supreme Court of Canada held in Eldridge that the Charter applies "to a private entity ... found to be implementing a specific governmental policy or program" (emphasis in the original)\(^654\) Professor Pothier comments that

> Although this principle had been alluded to in passing before, Eldridge is the first concrete application of that principle in the Supreme Court of Canada. Whereas previously the focus had been only on governmental actors. Eldridge shifts the focus to the quality of acts, though with ultimate reference back to the primary governmental actor whose policy or program is being implemented.\(^655\)

Therefore, the Charter would apply to any decision-maker implementing mental health policy under provincial health legislation and in administering the mental disorder provisions of the Code. It is clear that the Ministry of Health sets mental health policy as discussed in chapter 2.\(^656\) In all the various reports on mental health reform, the Ministry of Health retains the responsibility for setting mental health policy though different proposals have been made on who and how this policy is to be implemented.

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\(^654\) *Ibid* at para. 43.


\(^656\) For example, in *The 1998 Mental Health Plan British Columbia supra* note 3 at 21, it states that the ministry of health is responsible for "maintaining the policy, legislative and organizational framework for health services; funding the health care system; defining core programs and services to be provided.. Another example is the statement in Ministry of Health, Ontario, *Putting People First: The Reform of Mental Health Services in Ontario supra* note 26 at 20 that "[t]he ministry must accept and fulfill its responsibility to establish provincial policies and to manage the system effectively." Other examples are cited in chapter 2 in the discussion on health care reform.
B) Section 7 of the Charter

i) Deprivation of Liberty

In *R. v. Swain*, the Supreme Court of Canada stated that, to invoke section 7 of the *Charter*, "an individual must establish an actual or potential deprivation of life, liberty or security of the person" and show that the deprivation of liberty or security was not in accordance with the principles of fundamental justice. To address the first part of section 7 of the *Charter*, the mental disorder provisions clearly provide that accused persons are subject to restrictions on their liberty following the verdict of NCRMD until they are determined not to be a significant threat to the safety of the public. As Williams J.A., with whom the rest of the Court of Appeal was in agreement on this point, noted in the *Winko* case

It is common ground that s.672.54 deprives a person in the position of the appellant ... of his liberty... He is immediately subject to restrictions on his liberty, and will remain under those restrictions until it can be shown that he is 'not a significant threat to the safety of the public.'

I argue that to this restriction of liberty mandated by the *Code*, there is added the actual or potential deprivation of liberty or security that results from lack of adequate mental health resources. Examples of this include:

the case of an accused person whose disposition authorizes a transfer from a maximum secure psychiatric facility to a medium secure psychiatric facility, but whose transfer is delayed because of a lack of psychiatric beds; the delay in the transfer of an accused person from a medium secure facility...

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657 *Supra Swain* note 17.

658 *Ibid* at 969.

659 *Supra Winko* note 17 at 38.
unit or hospital to a minimum secure unit or hospital because of a lack of psychiatric beds; a delay in a transfer to the community, or the refusal by the Review Board to authorize such a transfer because of lack of appropriate housing or other adequate resources to support, resulting in an accused person being detained in custody in hospital.

I suggest that all these scenarios result in accused persons being deprived of their liberty in that they do not benefit from less restrictive environments and are unable to exercise any additional liberties that result from a less restrictive form of detention.660

Furthermore, these delays may also result in lengthier detentions for accused persons. If the accused persons do not have an opportunity to be reintegrated into the community because of inadequate mental health resources, neither the accused persons nor any other party may be able to marshal the evidence that the accused persons are not a significant threat to the community. Therefore, the Review Board may be unable to form the opinion that the accused person is not a significant threat to the safety of the public and will not grant an accused person an absolute discharge. The link between the liberty of an accused person and treatment as a result of the mental disorder provisions needs to be reiterated to demonstrate the manner in which inadequate mental health resources result in lengthier detentions for some accused persons.

The object of the mental disorder provisions (as was the case of its predecessor, the insanity provisions) is the protection of society. This can only be achieved by means

660One illustration of my point is that in Ontario, an accused person in a maximum secure psychiatric hospital is not given even escorted access to the community while one in a medium secure psychiatric facility is given such access. These situations are discussed in chapter 2.
of providing treatment to accused persons as determined in Swain661, Davidson662, and Winko.663 In addition, the McGillis case664 clearly links the availability of mental health resources with the type of disposition a Review Board may grant an accused person. In that case, the Ontario Review Board grants the accused person a conditional discharge which could not be implemented because no appropriate housing was available. The Court of Appeal of Ontario finds that, in such a situation, the Review Board should have granted a custodial disposition because the evidence before the Ontario Review Board was that the appropriate housing did not exist in the community. The Court of Appeal determines that a disposition granting a conditional discharge was illegal because the accused person had to remain in hospital given the lack of appropriate housing.

Furthermore, the British Columbia Court of Appeal emphasizes in Winko665

[T]he legislative scheme of the new provisions governing the detention and release of those found NCRMD attempts to balance protection for the public with the early return to conditional or unconditional liberty of these patients.666

In addition, the Court of Appeal in Winko and Lepage,667 states that the legislative scheme is meant to restrict the liberty of the accused person no more than is needed to meet the

661 Supra Swain note 17 at 1004 & 1005.
662 Supra note 23 at 277.
663 Supra Winko note 17 at 58.
664 Supra note 16. The effects of this decisions are discussed in detail in chapter 2.
665 Supra Winko note 17 at 50.
666 Ibid.
667 Supra Winko and Lepage note 17.
objective of the legislation. However, without adequate mental health resources the return to liberty is not possible. The result is lengthier detention of some accused persons.

These situations are analogous to those in the prison context involving transfers from a prison with a lower security rating to one with a higher one, except in reverse. The change in conditions of imprisonment that result from such a transfer in prisons

[M]ay affect the ... residual liberties [of the offender]. More specifically, there is a negative effect on the liberty of an offender when the conditions imposed are more restrictive and severe. According to the notion of ‘a prison within a prison’ the remaining rights of incarcerated individuals—that it is to say their residual liberties—will be negatively affected.

In another case, administrative segregation was judged more restrictive because it restricted the mobility and activities of an offender as well as the offender’s contact with other offenders. The courts have determined that the following were restrictions on residual liberties: “a heavier atmosphere, frequent investigations and more limited access to recreational services”

ii) Deprivation of liberty in accordance with the principles of fundamental justice

The second component of section 7 of the Charter, that any deprivation of liberty must be in accordance with the principles of fundamental justice, raises two interpretation issues, one respecting the meaning of the principles of fundamental justice and the other

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668 Ibid Lepage at 20 and 21.
669 Supra note 481 at 9-64.
671 See supra note 481 at 9-64.
whether “liberty” should be given a broad or narrow meaning. The case in which the Supreme Court of Canada first examines the meaning of the expression “principles of fundamental justice” is Reference re s. 94(2) of the Motor Vehicle Act (British Columbia). Lamer J. for the Court states that “[t]he principles of fundamental justice ... are not a protected interest, but rather a qualifier of the right not to be deprived of life. liberty and security of the person.” Lamer J. clearly states that the expression “principles of fundamental justice” in section 7. is broader than the concept of “natural justice.” He adds that the principles of fundamental justice “are to be found in the basic tenets of our legal system,” but the exact parameters of these principles are to be determined by the courts. Furthermore, Lamer J. in Reference re s. 94(2) of the Motor Vehicle Act (British Columbia) makes clear that section 7 extends to substantive as well as procedural justice.

The Supreme Court of Canada states that a vague law violates a principle of fundamental justice because it “offends two values that are fundamental to the legal

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672 Reference re s. 94(2) of the Motor Vehicle Act (British Columbia) supra note 480.

673 Ibid at 500.

674 Ibid at 503.

675 Ibid.

676 In Singh v. Minister of Employment and Immigration supra note 478 held that section 7 includes a a requirement of procedural fairness where a decision-maker has the power to make decisions which affect the life, liberty or security of the person. See also supra note 481 at 9-49-9-53.
system.\" The values as explained by Lamer J. in *Reference Re Criminal Code*\textsuperscript{678} are that a law must give a reasonable warning to individuals so that they know what is prohibited and so they may act accordingly; and that a law must "sufficiently outline the discretionary power of authorities which are in charge of applying the law"\textsuperscript{679} so that they do not act arbitrarily. Lamer J. concludes that a law whose provisions include possible sanctions which deprive a person of her or his liberty or security must not be of an "unacceptable degree of vagueness."\textsuperscript{680} Similarly, in *R. v. Nova Scotia Pharmaceutical Society*,\textsuperscript{681} the Supreme Court of Canada reiterates that, as a principle of fundamental justice under section 7 of the *Charter*, laws may not be too vague. A law will be unconstitutional if it is so vague that it provides no guidance for judicial debate.\textsuperscript{682}

A law which is overbroad also violates the principle of fundamental justice. In *R. v. Heywood*,\textsuperscript{683} the Supreme Court of Canada states that the concept of overbreadth and that of vagueness are different concepts which are sometimes related:

\begin{quote}
[T]he meaning of a law may be unambiguous and thus the law will not be vague; however, it may still be overly broad. Where a law is vague, it may
\end{quote}

\begin{itemize}
\item \textsuperscript{677} *P. W. Hogg*, *supra* note 457 at 1045.
\item \textsuperscript{678}[1990] 1 S.C.R. 1123.
\item \textsuperscript{679}See *supra* note 481 at 9-54 for discussion of the vagueness doctrine which is a principle of fundamental justice.
\item \textsuperscript{680}*Supra* note 678 at 1157.
\item \textsuperscript{681}*Supra* note 519.
\item \textsuperscript{682}See *supra* note 481 at 9-58 & 9-59 for a discussion of other cases which deal with the principle of vagueness. See also P. Mecklam et al. *supra* note 457 at 956-958.
\item \textsuperscript{683}*Supra* note 518.
\end{itemize}
also be overly broad, to the extent that the ambit of its application is
difficult to define. Overbreadth and vagueness are related in that both are
the result of a lack of sufficient precision by a legislature in means used to
accomplish an objective. In the case of vagueness, the means are not
clearly defined. In the case of overbreadth the means are too sweeping in
relation to the objective.

Overbreadth analysis looks at the means chosen by the State in relation to
its purpose. ... If the state, in pursuing a legitimate objective, uses means
which are broader than is necessary to accomplish that objective, the
principles of fundamental justice will be violated because the individual’s
rights will have been limited for no reason. The effect of overbreadth is
that in some applications the law is arbitrary or disproportionate.\textsuperscript{684}

Another issue is whether “liberty” should be given a narrow interpretation— to
mean protection from interference with physical liberty— or a broad one to include all
forms of liberty. For the most part, the courts restrict the meaning of “liberty” in section
7 to the protection of physical liberty.\textsuperscript{685} However, in the \textit{Morgentaler} case,\textsuperscript{686} Wilson J.
broadens the concept of liberty to include the right to dignity— an individual’s right to
personal autonomy over important decisions affecting their private lives. Furthermore,
courts in reviewing changes in the conditions of detention of a prisoner, have determined
that these changes correspond to a deprivation of liberty.\textsuperscript{687}

Now, I examine whether the deprivation of liberty of accused persons resulting

\begin{footnotes}
\item\textsuperscript{684} \textit{Ibid} at 792.
\item\textsuperscript{685} See the cases cited by P. Garant, \textit{supra} note 481 at 9-13.
\item\textsuperscript{686}[1986] 2 S.C.R. 388.
\textit{Balian v. Canada (Regional Transfer Bd.)} (1988) 62 C.R. (3d) 258 (Ont. H.C.), and \textit{Hay
\end{footnotes}
from inadequate mental health resources is in accordance with the principles of fundamental justice. As argued previously, a disposition order that is not the least onerous or the least restrictive as a result of inadequate mental health resources is illegal because it exceeds the powers of the Review Board, even though the Review Board may have held a hearing in accordance with the mental disorder provisions. I contend that the resulting deprivation of liberty would not be in keeping with the basic tenets of our legal system in that the accused person does not receive any notice of the deprivation and has no opportunity to be heard regarding the deprivation of liberty. In addition, a lengthier or more restrictive detention resulting from a delay in implementation or the non-implementation of a disposition due to inadequate mental health resources is not a deprivation of liberty in accordance with the principles of fundamental justice for the following reasons. Where a disposition is made but not implemented, the person in charge of a hospital who is responsible for implementing the disposition does not give the accused person notice of the reasons for the delay in implementation. The accused person does not have any right to question the decision of the person in charge of a hospital to delay the implementation of the disposition or not to implement it. In addition, the accused person is denied the benefit of a hearing before the Review Board under paragraph 672.81(2)(a) of the Code because, where the disposition is not implemented or the implementation delayed, the person in charge of the hospital has not increased the restrictions on the liberty of the accused person. Rather, the accused person has not had her or his liberties increased as permitted by the disposition. The detention is unlawful
and results from the non-implementation of lawful dispositions. In *R. v. Miller*, the Supreme Court of Canada states that “a prisoner has the right not to be deprived unlawfully of the relative or residual liberty permitted to the general population of an institution.” Therefore, in prisons, offenders have the following procedural guarantees in cases of transfers:

>[T]he right to be notified that a transfer will be proposed and to be informed of the specific reasons behind this decision; the right to contest in writing this decision and to take into account the reasons behind the offender’s contestation; and the right to have this decision transmitted to him.  

Furthermore, the Court of Appeal of British Columbia in *Davidson* and *Winko*, clearly held that section 672.54 of the *Code*, as interpreted within the context of Part XX.1 of the *Code*, does not infringe section 7 of the *Charter* because there are procedural and substantive safeguards such as notice, annual hearings, the right of an accused person to be present at the hearing and to question witnesses, provisions for early reviews, criteria for making a disposition and the right to receive a copy of written reasons on which the disposition is based.  

Therefore, I conclude that some accused persons, in Ontario and in British Columbia and in any other province where a similar lack of adequate mental health resources exists, are deprived of their right to liberty contrary to section 7 of the *Charter*. In addition, the potential exists for other accused persons to be deprived as well. The

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688 *Ibid* *Miller*.

689 *Ibid* at 637.

690 *Supra* note 481 at 9-64 & 9-65.
deprivation of liberty arises from a more restrictive or lengthier detention and is not in accordance with the principles of fundamental justice. Although I argue that accused persons are deprived of their liberty contrary to section 7, the question remains as to whether the violation is saved under section 1 of the Charter, which is discussed below.

C) Equality rights of accused persons

a) Scope

In subsection 15(1) of the Charter, the emphasis is on equality before and under the law and equal protection and benefit of the law without discrimination as affirmed in Andrews v. Law Society of British Columbia. The Supreme Court of Canada in Andrews adopts a contextual approach to subsection 15(1) of the Charter, whereby the courts must inquire into the personal characteristics of the claimant and the resulting discrimination. However, the inquiry must place the individual in the broad societal context and consider the effects of stereotyping and historical disadvantage on the individual and the group in determining the effect that the impugned legislation has on the individual or group. McIntyre J. adopts the words of Hugessen J. who stated

The inquiry [to determine whether there exists discrimination], in effect, concentrates upon the personal characteristics of those who claim to have been unequally treated. Questions of stereotyping, of historical disadvantage, in a word, of prejudice, are the focus and there may even be a recognition that for some people equality has different meaning than for others.

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692 Ibid.

693 Ibid at 16.
McIntyre J. emphasizes that a substantive and purposive approach must be taken to subsection 15(1) because

The promotion of equality entails the promotion of a society in which all are secure in the knowledge that they are recognized at law as human beings equally deserving of concern, respect and consideration. It has a large remedial component.694

Furthermore, in R. v. Turpin,695 the Supreme Court of Canada reiterates and expands the approach to subsection 15(1) set out in Andrews. It rules that in determining whether discrimination exists a court must not only analyze the impugned legislation but also the "larger social, political and legal context".696 In later cases,697 the Supreme Court of Canada rules that while "it is not necessary to show membership in a historically disadvantaged group in order to establish a s. 15 (1) violation, the fact that a law draws a distinction on such a ground is an important indicium of discrimination."698 Furthermore, as La Forest J. states in the Eldridge case699 "[w]hile this Court has not adopted a uniform approach to s.15(1), there is broad agreement on the general analytic framework"700 which the Supreme Court of Canada applies to equality claims. This

694 Ibid at 15.
696 Ibid at 1331.
698 Ibid Eldridge at para 54.
699 Ibid Eldridge.
700 Ibid Eldridge at para.58 and Vriend at para. 73 & 74.
framework of analysis is reiterated in the Vriend case.701

b) Equality Claim Of Accused Persons

The next step is to analyze the equality claim. McIntyre J. states in Andrews v. Law Society of British Columbia702 that

[D]iscrimination may be described as a distinction, whether intentional or not, but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits and advantages available to other members of society.703

This is a two-step approach. An accused person must first establish that, due to the actions of a decision-maker implementing mental health policy under provincial health legislation and in administering the mental disorder provisions of the Code, a distinction has been drawn between accused persons and others based on personal characteristics and that this distinction has resulted in a denial of equality before the law, equality under the law, equal protection of the law or equal benefit of the law. Secondly, the accused person must establish that the denial constitutes discrimination on the basis of one of the enumerated grounds listed in s. 15(1)—mental disability.704

701 Ibid Vriend.

702 Supra note 691.

703 Ibid at 18.

704 See Eldridge supra note 38 and Vriend supra note 38 for a discussion of differences in approach to an equality claim. However, in both these cases the Supreme Court of Canada held that the two-step approach was sufficient and did not address the differences.

See Eldridge supra note 38 and Vriend supra note 38 for a discussion of differences in approach to an equality claim. However, in both these cases the Supreme Court of Canada held that the two-step approach was sufficient and did not address the differences.
i) Distinction results in a violation of equality

As in Eldridge, the issue is one of funding and the provision of services within the health care system and the impact on persons with disabilities. I suggest that the allocation decisions of entities implementing mental health policy under provincial health legislation and in the administration of the mental disorder provisions of the Code do not result in an adequate supply of psychiatric beds and adequate inpatient or community mental health resources. Furthermore, inadequate mental health resources have a different impact on accused persons in comparison to other persons with mental disabilities. Where a person with mental disability is detained under civil committal legislation, the person is discharged from involuntary detention by hospital authorities when the person no longer meets the committal criteria, which is generally when the person is no longer a danger to herself or himself or others. Whether the person will once again become a danger to herself or himself or others is not considered. In this situation, the decision is based on the mental condition of the person at the time of discharge. However, the release from detention of an accused person is governed by different factors.

Without adequate mental health resources, an accused person remains longer under the jurisdiction of the mental disorder provisions of the Code. As emphasized previously in chapter 2, an accused person can regain her or his liberty only if evidence

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705 Supra note 38.

706 Civil committal criteria varies across Canada. For a more detailed discussion see G. Robertson, Mental Disability Law in Canada, supra note 133 at 367-437.
can be placed before a Review Board that she or he is not a significant threat to the safety of the public. Under section 672.54 of the Code, when a Review Board is determining whether an accused person is a significant threat to the safety of the public, it considers the mental condition of the accused person:

The significance of the accused’s mental condition to that determination will depend on many variables, including the nature of the mental disorder (disability), if any, from which the accused suffers at the time of the inquiry, the available treatment, the accused’s understanding of his mental condition, and the accused’s willingness to conform to any proposed course of treatment.⁷⁰⁷

Furthermore, the Review Board considers the future risk that an accused person will present to the public. These variables come into play when a Review Board is considering a disposition other than an absolute discharge. Since the majority of accused persons suffer from a serious mental illness, the availability of treatment and other mental health resources has an impact on the mental condition of the accused person. Without adequate mental health resources, the liberty of some accused persons is being restricted unduly and their detention lengthened, which is contrary to the spirit and object of the mental disorder provisions of Part XX.1 of the Code and which results in a distinction that violates the equality rights of accused persons. Furthermore, I cite C.(J) v. British Columbia⁷⁰⁸ in support of the argument that the allocation decisions of the provincial decision-makers violate the equality rights of accused persons. McKinnon J. states that

⁷⁰⁷ Supra Lepage note 17 at para. 69.
⁷⁰⁸ Supra note 570.
J.C., the accused person, is subject to a provincial statute, the *Forensic Psychiatry Act*.\textsuperscript{709}

which regulates her confinement and

While there is no specific 'law' prohibiting J.C.'s move to the cottages, the administration of the provincial statute operates to exclude her. It is this action of the authorities that brings her within the jurisdiction of the court and a review of s.15.\textsuperscript{710}

McKinnon J. concludes that this action results in a violation of the accused person's equality rights.

\textbf{ii) Distinction results in discrimination and imposes burden}

The analysis of the claim of discrimination of accused persons under subsection 15(1) of the *Charter* must be conducted within the broader social, legal and political context, as determined in *Andrews*\textsuperscript{711} and *Turpin*.\textsuperscript{712} Accused persons fall within a category enumerated under subsection 15(1) of the *Charter*—the mentally disabled. A compelling account of the discrimination, exclusion and subordination of persons with disabilities is rendered by M.D. Lepofsky.\textsuperscript{713} He notes that though persons with disabilities number over four million in Canada, they are "over-represented among the poor," "under-represented among those persons who have graduated from post-secondary educational institutions," "under-served by the legal profession" and "they are daily

\textsuperscript{709}R.S.B.C. 1979, c. 139 now at R.S.B.C. 1996, c. 156. This Act remained basically unchanged in the intervening period.

\textsuperscript{710}Supra note 570 at 396.

\textsuperscript{711}Supra note 691.

\textsuperscript{712}Supra note 695.

\textsuperscript{713}See supra note 159 at 270.
impeded by a barrage of pejorative, inaccurate stereotypes which pervade public perceptions of them."\textsuperscript{714} Specifically regarding discrimination against persons with mental disabilities, Lamer C.J., for the Court, stated in \textit{R. v. Swain}\textsuperscript{715}

The mentally ill have historically been subjects of abuse, neglect and discrimination in our society. The stigma of mental illness can be very damaging. The intervener, C.D.R.C., describes the historical treatment of the mentally ill as follows:

For centuries, persons with a mental disability have been systematically isolated, segregated from the mainstream of society, devalued, ridiculed, and excluded from participation in ordinary social and political processes.

The above description is, in my view, unfortunately accurate and appears to stem from an irrational fear of the mentally ill in our society.\textsuperscript{716}

He concluded that "[t]here is no question that the mentally ill in our society have suffered from historical disadvantage, have been negatively stereotyped and are generally subject to social prejudice."\textsuperscript{717} This finding was reiterated in \textit{Battlefords & District Co-operative Ltd. v. Gibbs}.\textsuperscript{718} Most recently this was reaffirmed in \textit{Eldridge}, wherein La Forest J. stated that "disabled persons have not generally been afforded the 'equal concern, respect

\textsuperscript{714}\textit{Ibid} at 266-272. A similar picture of prejudice, high unemployment, poverty and educational and employment segregation is found in L. Legault, \textit{L'Intégration au travail des personnes ayant des incapacités} (Montreal: Wilson and Lafleur, 1996) at 11-67.

\textsuperscript{715}\textit{Supra} note 17.

\textsuperscript{716}\textit{Ibid} at 973-974.

\textsuperscript{717}\textit{Ibid} at 994.

and consideration’ that s.15(1) of the Charter demands.”719 Accused persons are further stigmatized by the underlying assumption of the mental disorder provisions that society must be protected from dangerous persons. This assumption can be traced back to the adoption of the Criminal Lunatics Act, 1800, as discussed in chapter one. that it is reasonable to assume that some accused persons will pose a threat to society.”720 As one author has argued, this assumption is based on a psychiatric myth that “there is a higher rate of violence among people who have been diagnosed as mentally disordered than among the general public, and therefore mentally disordered offenders present a greater risk to the public than other offenders.”721 Therefore, they may be refused access to programs or housing based on being stereotyped as dangerous.722

719 Supra Eldridge note 38 at para 56. Though Mr. Justice La Forest made this statement in the context of persons with physical disabilities it is even more applicable to persons with mental disabilities because as noted by M. D. Lepofsky that “our history is sadly replete with instances of persons with mental disabilities being treated worse than persons with physical disabilities” in “A Report Card on the Charter’s Guarantee of Equality to Persons with Disabilities after 10 Years - What Progress? What Prospects?” supra note 159 at 331.

720 See Swain supra note 17 at 1005 and 1014.


722 An example of such prejudice is found in a document produced by the Institutional Health and Community Services, Mental Health Programs and Services, Ministry of Health of Ontario, Backgrounder: The Provincial Forensic System, dated April, 1997 (unpublished) at 9. It states that even when an accused person no longer needs specialized forensic services there “appears to be a reluctance to accept forensic patients into general programs. Some hospitals have had exclusionary criteria that essentially dictated that forensic patients will always remain with forensic units” rather than be integrated into the general population.
The next step is to determine whether decisions regarding allocation of mental health resources discriminate against accused persons. These decisions do not appear to discriminate directly against accused persons; however, I suggest that the decisions result in adverse effects discrimination against accused persons. La Forest J. in *Eldridge v. British Columbia (A.G.)*\(^{723}\) for the Court reiterates the concept of "adverse effects" discrimination which was first dealt with in *Ontario Human Rights Commission v. Simpson-Sears Ltd.*\(^{724}\) He cites McIntyre J. who stated:

A distinction must be made between what I would describe as direct discrimination and the concept already referred to as adverse effect discrimination in connection with employment. Direct discrimination occurs in this connection where an employer adopts a practice or rule which on its face discriminates on a prohibited ground. For example, 'No Catholics or no women or no blacks employed here.' ... On the other hand, there is a concept of adverse effects discrimination. It arises where an employer for genuine business reasons adopts a rule or standard which is on its face neutral, and which will apply equally to all employees, but which has a discriminatory effect upon a prohibited ground on one employee or group of employees in that it imposes, because of some special characteristic of the employee or group, obligations, penalties, or restrictive conditions not imposed on other members of the work force.\(^{725}\)

La Forest J. reaffirms the principle set out in the *Andrews* decision, wherein McIntyre J. declared, that the "equality principles developed by the Court in human rights cases are equally applicable in s.15 (1) cases."\(^{726}\) The *Egan case*\(^{727}\) also adopted the *Simpson-Sears*

\(^{723}\) *Supra* note 38.


\(^{725}\) *Supra Eldridge* note 38 at para.63.

\(^{726}\)*Ibid.*

\(^{727}\) *Supra* note 697.
definition of adverse effects discrimination in the context of section 15(1) of the Charter.

With respect to adverse effect discrimination, the Supreme Court of Canada in

*Eldridge v. British Columbia (A.G.)*\(^{728}\) held that

[S]ection 15(1) of the Charter protects against this type of discrimination ... a discriminatory purpose or intention is not a necessary condition of a s. 15(1) violation. It is sufficient if the effect of the legislation is to deny someone the equal protection or benefit of the law.\(^{729}\) [Emphasis in the original]

In addition, La Forest J. reiterates that the Supreme Court of Canada has held that where the state does provide a benefit "it is obliged to do so in a non-discriminatory manner."\(^{730}\)

Furthermore, La Forest J. declares that discrimination will result from a "failure to take positive steps to ensure that disadvantaged groups benefit equally from services offered to the general public."\(^{731}\)

Under subsection 15(1) of the Charter, the provincial government has to take into account that its decisions may impact on individuals differently. La Forest J. in *Eldridge* endorses the approach espoused by Lamer C.J. in *Rodriguez v. British Columbia (Attorney General)*\(^{732}\) wherein he stated that "to promote the objective of the more equal society, s. 15(1) acts as a bar to the executive enacting provisions without taking into

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\(^{728}\) *Supra Eldridge* note 38.

\(^{729}\) *Ibid* at para. 61 & 62.

\(^{730}\) *Ibid* at para. 73.

\(^{731}\) *Ibid* at para. 78.

\(^{732}\) *Supra* note 495.
account their possible impact on already disadvantaged classes of persons.\textsuperscript{733}

On the basis of the above discussion, I conclude that accused persons are discriminated against on the basis of their mental disability. The provincial government has failed to take into account the adverse impact that its decisions respecting the allocation of mental health resources and delivery of mental health services have on these persons. In addition, I cite \textit{C(J) v. British Columbia}\textsuperscript{734} in support of this argument. Although in that case the discrimination was on the basis of gender, it raises the same issues regarding allocation of resources and the impact on an accused person. The evidence before the Court indicated that “but for budget restrictions, provisions could be made for the accommodation of female patients in cottage.”\textsuperscript{735} McKinnon J. finds that

\textit{[A] policy restricting participation in a rehabilitative program based entirely on gender is discriminatory... J.C. by most accounts needs the benefit of the cottage program to make the transition into the community. She has been denied that program because of her gender and for no other reason.}\textsuperscript{736}

In this case the provincial Attorney General argues that J.C.’s denial to the program was motivated solely by financial considerations. McKinnon J. reiterates the ruling of the Supreme Court of Canada in \textit{McKinney}\textsuperscript{737} that this fact does not alter the fact that the

\begin{itemize}
\item \textsuperscript{733}\textit{Supra Eldridge} note 38 at para 64.
\item \textsuperscript{734}\textit{Supra} note 495.
\item \textsuperscript{735}\textit{Ibid} at 394.
\item \textsuperscript{736}\textit{Ibid} at 397.
\item \textsuperscript{737}\textit{Supra McKinney} note 473. See also \textit{Andrews} supra note 691; \textit{Rodriguez} supra note 495 and \textit{Simpson-Sears supra} note 732.
\end{itemize}
action is nonetheless a denial of equality and discriminatory under section 15(1).

I conclude that the equality rights of accused persons are violated, but the question remains whether the violation is justified under section 1 of the Charter.

D) Section 1: Limits to Charter Rights and Freedoms

a) Positive or negative Charter rights

Whether the Charter imposes positive or negative duties on government impacts on the outcome of the analysis under section 1 of the Charter. A succinct explanation of the different conceptions of positive and negative duties and the Charter and their implications is given by H. Lessard et al. They state:

A purely negative definition of rights and freedoms would ensure that the Charter benefits only those individuals with the means to exercise and enforce their rights. Such a conception of rights is closely allied with the abstract individual of classical liberal theory, for the pretense of guaranteeing fundamental rights and freedoms equally to all can only be maintained if the individual circumstances and context that may effectively hinder or block access to those rights are repressed or ignored. Incorporating positive state obligations into various Charter rights on the other hand, entails some recognition of the connection between freedom and equality of condition in order to put Charter rights within the grasp of Canadians of all classes. Thus, a positive conception of rights is closely allied with the contextualized individual of pluralist liberal thought; a consideration of the linguistic, cultural, economic and other differences that mark individuals in society reveals the inadequacies of a purely negative conception of rights.\textsuperscript{738}

Some Charter rights are seen as imposing a mix of negative and positive obligations on governments such as “the denominational school rights, language rights, aboriginal treaty

rights, the right to a fair trial and the right to vote." The courts determine whether the 
Charter imposes a negative or a positive duty in the context of each right or freedom.

The issue becomes whether the Charter right or freedom in question

guarantee[s] simply negative freedom, that is the right to be free from state interference with individual freedom or does the Charter also impose positive obligations on the state to extend benefits or to create the conditions necessary for the meaningful exercise of rights and freedoms by all citizens?740

For example, in Mahe v. Alberta,741 the Supreme Court of Canada finds that section 23 of the Charter [right to minority language education] imposes a positive obligation on government to permit minority parents the care and control of the schools where their children are taught. Another example is R. v. Tran742, where the Supreme Court of Canada determines that section 14 of the Charter (the right to an interpreter for a party or witness in any proceedings where the person does not speak or understand the language of the proceedings) imposes a positive obligation on government. However, in R v. Prosper743 and R. v. Matheson,744 the Supreme Court of Canada states that paragraph 10(b) of the Charter (the right to retain and instruct counsel on arrest or detention) does not impose a positive duty on government to provide state-funded duty counsel on arrest or detention.

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739 Ibid at 100.
740 Ibid.
741 Supra note 558.
With respect to section 7 of the Charter [the right to life, liberty and security of the person], the theory of negative rights would interpret the purpose of this section as being “absence of all coercion vis-à-vis the person. Under the other approach, the objective is the imposition of positive obligations on the state with a view to protecting and, indeed, even promoting these rights.”\textsuperscript{745} However, the courts have not given any precise answer in favour of one theory or another with respect to section 7.\textsuperscript{746}

With respect to subsection 15(1) of the Charter [the right to equality], the Andrews decision made it clear that section 15(1) of the Charter is intended to ensure “equality in the formation and application of the law”\textsuperscript{747} and does not constitute a “general guarantee of equality.”\textsuperscript{748} In \textit{R. v. Schachter},\textsuperscript{749} the Supreme Court of Canada held that subsection 15(1) is a hybrid of positive and negative obligations and that “[i]n some contexts it will be proper to characterize section 15 as providing positive rights.”\textsuperscript{750} The Supreme Court of Canada has limited the positive duty of government to existing legislation or programs.\textsuperscript{751} However, when a government provides a benefit, it must do so without discrimination against disadvantaged groups or must not impose a burden that

\textsuperscript{745}Supra note 481 at 9-6.

\textsuperscript{746}Ibid at 9-7.

\textsuperscript{747}Supra Andrews note 691 at 15 and Swain note 17 at 992.

\textsuperscript{748}Ibid Andrews at 9.

\textsuperscript{749}Supra note 497.

\textsuperscript{750}Ibid at 702.

\textsuperscript{751}See Brooks v. Canada Safeway Ltd. [1989] 1 S.C.R. 1219; Schachter supra note 497 and Egan supra note 697.
results in discrimination on such groups.\textsuperscript{752} In \textit{Thibaudeau v. Canada},\textsuperscript{753} L'Heureux-Dubé J. states that

Although section 15 of the \textit{Charter} does not impose upon governments the obligation to take positive actions to remedy the symptoms of systemic inequality, it does require that the government not be the source of further inequality.\textsuperscript{754}

In \textit{Eldridge v. British Columbia (Attorney General)}\textsuperscript{755} and \textit{Vriend v. Alberta}\textsuperscript{756} the Supreme Court of Canada states that it will not decide whether subsection 15(1) imposes a positive obligation to remedy systemic inequality, since the issue is not raised in these cases.\textsuperscript{757} However, one author argues that in \textit{Eldridge} and \textit{Vriend} “the court is resisting the implications of its own analysis” and that in these cases the Supreme Court of Canada does place a positive obligation on governments under subsection 15(1) to implement programs to ameliorate disadvantage and a duty to legislate protections.\textsuperscript{758} The result is that the Supreme Court of Canada has not made any definitive ruling on whether subsection 15(1) imposes a positive obligation on government to remedy or ameliorate disadvantage. As one author notes, “[t]he Court’s treatment of the issue of positive

\begin{itemize}
\item \textit{Ibid} \textit{Thibaudeau}.
\item \textit{Ibid} \textit{Thibaudeau} at para.37.
\item \textit{Supra Eldridge} note 38.
\item \textit{Supra Vriend} note 38.
\item \textit{Supra Eldridge} note 38 at para. 73 and \textit{Vriend} at paras. 63-64.
\end{itemize}
obligations has been peripheral and indecisive."^{759}

b) Framework for analysis

*R. v. Oakes*^{760} sets out the framework for analysis for the justification of the limits on a right or freedom under section 1 of the *Charter*. The *Oakes* test suggests "a relatively stringent view of s.1. one that cedes the protection of rights and freedoms only in rare circumstance."^{761} However, in cases subsequent to *Oakes*, courts adopt a "more deferential, flexible, reasonableness-based approach to the various strands of the *Oakes* test."^{762} The *Egan* case^{763} restates this framework which is cited with approval in *Eldridge v. British Columbia (A.G)* and in *Vriend v. Alberta*

A limitation to a constitutional guarantee will be sustained once two conditions are met. First, the objective of the legislation must be pressing and substantial. Second, the means chosen to attain this legislation must be reasonable and demonstrably justifiable in a free and democratic society. In order to satisfy the second requirement, three criteria must be satisfied: (1) the rights violation must be rationally connected to the aim of the legislation; (2) the impugned provision must minimally impair the *Charter* guarantee; and (3) there must be proportionality between the effect of the measure and its objective so that the attainment of the legislative goal is not outweighed by the abridgement of the right.^{764}

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^{759} *Ibid* at 73.

^{760} *Supra* note 492.

^{761} See P. Macklem et al. *supra* note 457 at 638.

^{762} *Ibid* at 643. The authors state that *Edwards Books and Art Ltd. v. the Queen* [1986] 2 S.C.R. 713, and *Irwin Toy Ltd. v. Quebec* [1989] 1 S.C.R. 927 introduced a more flexible approach to section 1.

^{763} *Supra* note 697.

^{764} *Supra Eldridge* note 38 at para. 84 and *Vriend* note 38 at para. 108.
In *Oakes*, the Supreme Court of Canada states that "a legislative objective would not count as a justification if it was not sufficiently important to override a Charter right."\(^7^6^5\) The Court adds that the legislative objective must be consistent with the values of a free and democratic society and be directed to "the realization of collective goals of fundamental importance."\(^7^6^6\) These statements would appear to require a court to scrutinize closely the legislative objective. However, the Supreme Court of Canada has been easily persuaded that

[W]hen the Parliament or Legislature acts in derogation of individual rights, it is doing so to further values that are acceptable in a free and democratic society, to satisfy concerns that are pressing and substantial and to realize collective goals of fundamental importance.\(^7^6^7\)

The Court has been deferential to the legislature’s choice of objective, “especially if the legislation can be characterized as having a social justice agenda.”\(^7^6^8\) In addition, in *Vriend*, the Supreme Court of Canada notes that, on the first condition, the jurisprudence is "somewhat divided with respect to the proper focus of the analysis at this stage."\(^7^6^9\) The Court states that the focus of the analysis must be on the objective of the impugned

\(^7^6^5\) *P. W. Hogg*, *supra* note 457 at 872.

\(^7^6^6\) *Supra* note 492 at 136.

\(^7^6^7\) *P. W. Hogg*, *supra* note 457 at 870.


\(^7^6^9\) *Supra Vriend* note 38 at para. 109. The Court explains that "some authorities have examined the purpose of the legislation in its entirety (see e.g. Miron, *supra*; Egan, *supra*), others have considered only the purpose of the limitation... (see e.g. RJR-Macdonald Inc. v. Canada, [1195] 3 S.C.R. 199, per McLachlin J.; McKinney, *supra*)."
limitation, but that the limitation cannot be understood in isolation and consideration must be given to the purpose of the legislation as a whole.\textsuperscript{770}

The next step is to determine whether the law is rationally connected to the objective of the law. In making this determination, the law is scrutinized to assess "how well the legislative garment has been tailored to suit its purpose."\textsuperscript{771} The law should not be "arbitrary, unfair, or based on irrational considerations."\textsuperscript{772} According to one author,\textit{Oakes} is the only case where the Supreme Court of Canada has found that a law was not rationally connected to its objective.\textsuperscript{773}

Under the requirement that, in order to be justified under section 1, a provision must have a minimal impact upon the \textit{Charter} guarantee, courts have adopted the more deferential approach to legislative choices in cases "where the government has acted to balance competing rights; to otherwise protect a socially vulnerable group; to balance the interests of various social groups competing for resources."\textsuperscript{774} As reiterated in \textit{Eldridge}

\textsuperscript{770}Supra \textit{Vriend} note 38 at paras. 109-111.

\textsuperscript{771}P. W. Hogg, \textit{supra} note 457 at 875.

\textsuperscript{772}Supra note 492 at 139.

\textsuperscript{773}P. W. Hogg, \textit{supra} note 457 at 877.

\textsuperscript{774}See P. Macklem et al., \textit{supra} note 457 at 643. See also \textit{P. W. Hogg, supra} note 457 at 877-882 where he states that the Supreme Court of Canada was willing "to defer to the legislative choice on the basis that the choice was within a margin of appreciation, a zone of discretion in which reasonable legislators could disagree while still respecting the Charter right. The result makes for an unpredictable jurisprudence." at 882. The question of deference of the courts to the legislature will be discussed more fully later in this chapter.
and Vriend 775 "although this Court has recognized that the Legislatures ought to be accorded some leeway when making choices between social interests... judicial deference is not without limits." 776

The element of proportionality requires a balancing between the effects of the Charter infringement and the legislative objective; the question is "whether the Charter infringement is too high a price to pay for the benefit of the law." 777 In order for the legislative objective to be justified under section 1, the legislative objective must outweigh the Charter violation. However, according Professor Hogg, "this step has never had any influence on the outcome of any case." 778 He adds that it is redundant because it is a restatement of the first step, that the objective of law is sufficiently important to justify the override of a Charter right.

c) Justification of infringements of section 7 and subsection 15(1) of the Charter

Given that I have argued that an accused person's liberty interests are limited in a way that infringes on section 7 and that an accused person has been denied equality in contravention of subsection 15(1), then the issue becomes whether this restriction of liberty or denial of equality can be justified under section 1. It is interesting to note that in Eldridge v. British Columbia (A.G) 779 La Forest J. states that

775 Supra Eldridge note 38 and Vriend note 38.
776 Ibid Eldridge at para. 86 and Vriend at para. 126.
777 P. W. Hogg, supra note 457 at 883.
778 Ibid.
779 Supra Eldridge note 38 at para. 52.
It is not necessary to consider each of these elements [in the analytical framework for section 1] in this case. Assuming without deciding that the decision not to fund medical interpretation services for the deaf constitutes a limit ‘prescribed by law’, that the object of this decision – controlling health care expenditures – is ‘pressing and substantial,’ and that the decision is rationally connected to the objective, I find that it does not constitute a minimum impairment of s.15(1).780

He adds that the “Court has also held that where the legislation under consideration involves the balancing of competing interests and matters of social policy, the Oakes test should be applied flexibly.”781 As one author comments, the issues that La Forest J. assumes

[A]way were not without substance. Given the complete absence of any statutory discretion, it might have seriously doubted that the decisions not to fund language interpretation were ‘prescribed by law. On the pressing and substantial element, Justice La Forest was accepting without explanation the submission that the objective had to relate to the limiting measure (here non-funding of sign language interpretation) and not, as had been done in previous cases, the objective of the statutory scheme as a whole.782

However, I apply the framework for the analysis set out in R. v. Oakes783 to answer the question of whether the restriction of liberty or denial of equality can be justified under section 1.

780 Ibid at para. 84.
781 Ibid at para. 85.
782 Supra note 655 at 274.
783 Supra note 492.
i) Objective test

In *McKinney*, Wilson J. discusses the meaning of the word “law” in the *Constitution Act, 1982* and the different interpretations that the case law has attributed to the word. Wilson J. declares

These two definitions of ‘law’ are obviously quite different. Their difference springs from the fact that s. 1 of the *Charter* and s. 52 of the *Constitution Act, 1982* serve two very different purposes. Section 52 is animated by the doctrine of constitutional supremacy. As such, a wide view of ‘law’ under that provision is mandated so that all exercises of state power, whether legislative or administrative, are caught by the *Charter*. Section 1, on the other hand serves the purpose of permitting limits to be imposed on constitutional rights when the demands of a free and democratic society require them. These limits must, however, be expressed through the rule of law. The definition of law for such a purpose must necessarily be narrow. Only those limits on guaranteed rights which have survived the rigours of the law-making process are effective.

As determined in *C(J) v. British Columbia*, the legislation in question is the mental disorder provisions of the *Code* which provide for the detention of an accused person and which the province administers and the following provincial health legislation: in Ontario, the *Mental Hospitals Act*, *Savings and Restructuring Act, 1996* and the

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784 Supra note 473.

785 Supra note 453.

786 See Wilson J. in *McKinney* supra note 473 at 82-83.

787 Supra note 570.

788 Supra note 633.

789 Supra note 635.
Ministry of Health Act\textsuperscript{790} and in British Columbia, the Forensic Psychiatry Act,\textsuperscript{791} the Ministry of Health Act\textsuperscript{792} and the Health Authorities Act\textsuperscript{793} which governs the allocation of mental health resources and the provision of mental health services to accused persons.

The question is whether the objectives of this legislation are sufficiently important to warrant the limitation of a section 7 or subsection 15(1) Charter right. In Swain,\textsuperscript{794} the Supreme Court of Canada easily concluded that the objective of the mental disorder provisions, the protection of the public, was pressing and substantial, as did the dissenting judges in Winko and Lepage.\textsuperscript{795} As for the provincial health legislation, it will depend on the manner in which the provincial government argues the case. If it limits argues that the objective of the legislation is to provide mental health services, I suggest that a court would accept that such an objective is pressing and substantial because, as one author comments, the Supreme Court of Canada has dealt summarily with the first part of the Oakes test by accepting that the objective of legislation was pressing and substantial and has been deferential to the legislature's choice of objective.\textsuperscript{796} However, if the provincial government argues that "implicit in the statute[s] is a directive to accomplish those goals

\begin{itemize}
  \item Supra note 634.
  \item Supra note 636.
  \item Supra note 637.
  \item Supra note 638.
  \item Supra Swain note 17.
  \item Supra Winko and Lepage note 17.
  \item Supra note 768 at 3-13.
\end{itemize}
[the provision of mental health resources] within current budget restrictions" as was the case in \textit{C(J) v. British Columbia},\textsuperscript{797} the result might be that the court, as happened in this case, would not find such a directive "to be sufficiently important to warrant the limitation of a constitutional right."\textsuperscript{798}

ii) \textbf{Proportionality test}

1) \textit{Rational connection}

Under this part of the test, at issue is whether the law is designed to achieve its objective and is not arbitrary, unfair or based on irrational considerations. In \textit{Swain},\textsuperscript{799} the Supreme Court found that a rational connection existed between the object of the insanity provisions, the protection of society and the means of achieving the objective, the detention of accused persons. In \textit{Winko and Lepage},\textsuperscript{800} the appellant conceded that a rational connection existed between the means and the objective of the mental disorder provisions. In \textit{C(J)},\textsuperscript{801} McKinnon J. determined that a rational connection existed between the policy which excluded women and the budgetary restraint policy. I suggest that in the case of the provincial health legislation that a rational connection exists between the objective of providing mental health services and the means chosen to provide those services.

\textsuperscript{797}\textit{Supra} note 570.

\textsuperscript{798}\textit{Ibid} at 398.

\textsuperscript{799}\textit{Supra} note 17.

\textsuperscript{800}See \textit{Winko supra} note 17 at 47 and \textit{Lepage supra} note 17 at para. 118.

\textsuperscript{801}\textit{Supra} note 570.
2) Minimal Impairment

With respect to the second component of the proportionality test, minimal impairment, the Supreme Court of Canada has closely scrutinized\textsuperscript{802} whether legislation or decisions that infringe Charter rights constitute a minimum impairment of those rights.

a) Section 7

I argue that the lack of action in funding the appropriate mental health services cannot be said to minimally impair the liberty rights of accused persons since it has the drastic effect of lengthier detention periods for some accused persons. The question becomes whether the state “could easily employ a means which would still meet its objective and yet not limit the appellant’s liberty under s. 7 to such a great extent.”\textsuperscript{803} I contend that the provincial government would be able to achieve the objective of the mental disorder provisions without infringing the Charter rights of accused persons, by allocating additional funds to provide adequate mental health services, ensuring that present mental health resources were directed to accused persons first, or reallocating funds from other health areas to the mental health programs, since the courts do not hold governments “to search out and to adopt the absolutely least intrusive means of attaining its objective.”\textsuperscript{804} However, the provincial government might argue, as it did in C(J) and

\textsuperscript{802}\textit{Supra} note 768 at 3-23-3-30.

\textsuperscript{803}\textit{Supra Swain} note 17 at 1016.

Eldridge,\textsuperscript{805} that it cannot provide additional funds, reallocate funds from other areas or direct mental health services to accused persons first and meet its objectives of providing mental health services to all persons with mental disabilities or general health services given the fiscal constraints on the health budget.

Given the deferential approach of the Supreme Court of Canada to governmental actions under section 1 of the Charter, the Court might find that the allocation decisions of the state respecting mental health services only minimally impair the rights of accused persons. La Forest J. in Eldridge summarized the case law on point when he stated that

It is also clear that while financial considerations alone may not justify Charter infringements (Schacter, supra, at p. 709), governments must be afforded wide latitude to determine the proper distribution of resources in society; see McKinney, supra, at 288, and Egan, supra, at para.104 (per Sopinka J.). This is especially true where Parliament, in providing specific social benefits, has to choose between disadvantaged groups; see Egan, supra, at para.104 (per Sopinka J.). ... In the present case, the failure to provide sign language interpreters would fail the minimal impairment branch of the Oakes test under a deferential approach.\textsuperscript{806}

Furthermore, in Prosper and Matheson\textsuperscript{807} where the liberty of a person could be jeopardized by the lack of access to legal aid counsel on arrest, the Supreme Court of Canada refused to extend a benefit. In these cases, the issue was whether the right to counsel set out in paragraph 10(b) of the Charter obliged the state to provide legal advice on arrest or detention. In Nova Scotia and Prince Edward Island respectively, where these cases arose, legal aid advice was unavailable after hours. This service was available

\textsuperscript{805}See C(J) supra note 570 and Eldridge supra note 38.

\textsuperscript{806}Ibid Eldridge at para. 85.

\textsuperscript{807}Supra Prosper note 743 and Matheson supra note 744.
in the other provinces. The Court ruled that the right to counsel was not breached even though these persons had no financial means of obtaining legal advice. Lamer C.J. in

R. v. Prosper clearly advocated "fiscal prudence"\(^{808}\) when he stated:

...[I]t would be a very big step for this Court to interpret the Charter in a manner which imposes a positive constitutional obligation on governments. The fact that such an obligation would almost certainly interfere with governments allocation of limited resources by requiring them to spend public funds on the provision of a service is, I might add, a further consideration which weighs against this interpretation.\(^{809}\)

In addition, L’Heureux-Dubé J., who agreed with the majority position, "stated that whether the poor would be able to exercise the constitutional right to counsel set out in section 10(b) was a matter of legislative policy."\(^{810}\) In addition, in Eldridge v. British Columbia (A.G.)\(^{811}\) La Forest J. emphasized that the cost of the service, sign language interpretation, was $150,000 or .0025 % of the health care budget of British Columbia at that time, therefore

In these circumstances, the refusal to expend such a relatively insignificant sum to continue and extend the service cannot possibly constitute a minimum impairment of the appellants’ constitutional rights.\(^{812}\)

\(^{808}\)This term is used by the authors of Developments in Constitutional Law: The 1994-95 Term supra note 738 to describe the Supreme Court’s rationale “to relieve the state of an obligation to provide the means to exercise freedom of expression and right to counsel in NWAC and Prosper surfaced again in Sopinka J.’s decisive swing judgment in Egan.” at 105.

\(^{809}\)Supra note 743 at 267.

\(^{810}\)Supra note 738 at 105.

\(^{811}\)Supra note 38.

\(^{812}\)Ibid Eldridge at para. 87. In C(J) supra note 570 at issue was access to a rehabilitation program for at least 5 women and at most 17.
However, in the case of mental health services, we are not dealing with insignificant sums. The Ministry of Health of Ontario allocated, in 1997-98, $1.4 billion for mental health services out of a total health budget of 17.9 billions and in British Columbia, the Ministry of Health spent $1.04 billion on mental health services out a total health budget of $6.9 billions in 1996/97. The message is clear in *Eldridge* that if the cost of providing the service had been significant in comparison to the provincial budget, the government might have been justified under section 1 of the *Charter* in infringing the rights of the appellants. La Forest J. stated:

> The government has simply not demonstrated that this unpropitious state of affairs must be tolerated in order to achieve the objective of limiting health care expenditures.

Therefore, based on the above mentioned cases, it seems likely that the Supreme Court of Canada would find that the section 7 infringement was saved by section 1 of the *Charter*. As previously mentioned, in the case of accused persons, not all mental health services are not being denied to them, although adequate and appropriate mental health services are being denied them, nor are they being excluded as a class from receiving a

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814 These figures were taken from a Ministry of Health table entitled *Ministry of Health (Note 1): Summary Level Information on Mental Health Services For Year Fiscal Year 84/85, 89/90 to 96/97*, revised on January 26, 1998, (unpublished ).

815 *Supra Eldridge* note 38 at para. 94.
benefit provided by the state, as was the case in Schachter v. R.,816 Tétreault-Gadoury v. Canada (Employment and Immigration Commission),817 Miron818 and Eldridge.819 In addition, the provincial government might argue that it was attempting to reform the mental health system and to provide additional resources in time.

However, I contend that the Supreme Court of Canada should eschew deferential approach in the case of accused persons because it would not lead to an appropriate outcome. The Court should adopt a purposive approach and focus on the effect that the lack of resources has on accused persons—lengthier detention which is very different from the issues discussed in the above-mentioned cases. Seeing the high value that our society places on liberty, surely the Court would not permit such an infringement on the liberty of an accused person. I argue that the lack of adequate mental resources does more than minimally impair the liberty of accused persons. In support I cite, the Supreme Court of Canada statement in Eldridge v. British Columbia(A.G.)820 which has given governments “wide latitude to determine the proper distribution of resources in society”.821 However, this discretion is not limitless.822 In addition, in Tétreault-
Gadoury, La Forest J. states that

[G]overnment when legislating in these matters [social benefits] ... does not [have] an unrestricted licence to disregard an individual's *Charter* rights. Where the government cannot show that it had a reasonable basis for concluding that it has complied with the requirement of minimal impairment in seeking to attain its objectives, the legislation will be struck down.\(^{823}\)

Even if the court were to adopt a deferential approach based on the declaration of the Supreme Court of Canada in *Schachter v. R.*,\(^{824}\) that "[a]ny remedy granted by a court will have some budgetary repercussions whether it be a saving of money or an expenditure of money",\(^{825}\) a court should find that the lack of adequate mental health resources more than minimally impairs the liberty of accused persons. In addition, the Supreme Court of Canada in *R. v. Askov*\(^{826}\) "appeared to recognize that the use of stays of proceedings to enforce limits on systemic trial delays would require more resources to be devoted to

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\(823\) Supra note 502 at 44.

\(824\) Supra note 497.

\(825\) Ibid at 21.

\(826\) Supra note 822.
backlogged jurisdictions.” However, this did not deter the Court from finding that the Charter infringement was not justified under section 1.

b. Section 15

Additional elements come into play on the justification of a violation of the equality section of the Charter, since subsection 15 (1) focuses on the discriminatory effect of decisions regarding mental health resources. The main issue is whether these decisions constitute a minimum impairment of accused person’s equality rights. In the context of adverse effects discrimination, the issue of minimum impairment becomes a question of whether the state has afforded reasonable accommodation to accused persons. La Forest J. in Eldridge states that the principle of reasonable accommodation is “generally equivalent to the concept of ‘reasonable limits.’” The law is clear that, where adverse effects discrimination is determined under human rights legislation, the obligation to accommodate extends to the point of “undue hardship,” in this context, to the point of placing a severe strain on the health care system. The onus is placed on the government to prove that it has taken reasonable steps to accommodate to the point of undue hardship.

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827 K. Roach, supra note 822 at 3-10.

828 Supra Eldridge note 38 at para. 79.


830 For further discussion of the issues raised the duty to accommodate and its ramifications in the employment context see A. Molloy, "Disability and the Duty to
As emphasized by a number of authors, the duty to accommodate is of the utmost importance for persons with disabilities; it goes “to the very heart of equality.” Such a duty recognizes that, for persons with disabilities, the accommodation of differences is the key to achieving equality. This principle is clearly recognized in both the Eaton and Eldridge decisions. For persons with mental disabilities, the needs of each individual to overcome the impairment or disabling aspect of her or his disability must be accommodated. However, as noted by L’Heureux-Dubé J., the Supreme Court of Canada has held that “economic factors may be relevant in applying the criteria of undue hardship.” In addition, as noted above, in Eldridge, La Forest J. reaffirmed that financial considerations can be argued under section 1 of the Charter. In the case of accused persons, the state may argue that these are times of fiscal restraint and escalating health care costs, and that if it had to allocate additional resources to accommodate accused persons, it would result in undue hardship, by placing a severe strain on the health care system.


831 See A. Molloy, ibid at 26. As well, see M. D. Lepofsky, supra note 159 at 278-283 and D. Pothier, supra note 822 at 537-538.


833 The British Columbia Government in Eldridge supra note 38 argued the if it had to provide interpretation services to deaf persons it would have to provide them to persons who spoke neither English or French and that such a situation would increase the
Columbia spend a portion of their health budget on mental health services, they would argue that they have made reasonable accommodation. In response, I argue that the expenditures required to detain accused persons in hospital and of their longer tenure under the jurisdiction of a Review Board may be more costly to the state than providing adequate community mental health resources and supports and an adequate supply of psychiatric beds. For example, the cost of a forensic bed per day in Ontario ranges from $351.00 to $588.43\textsuperscript{834} and that of a hearing of the Ontario Review Board is $1970.32 in Board costs alone.\textsuperscript{835}

As argued above, the deference shown by the Supreme Court of Canada to government's role in determining legislative policy and allocating government funding has resulted in the Court imposing very few positive obligations on government to extend benefits under existing programs under subsection 15(1). It is clear from the Supreme Court decisions in McKinney, Egan, and Thibaudeau that subsection 15(1) of the Charter cannot be readily used to compel governments to provide benefits. One author declares

program expenses dramatically and place a severe strain on the fiscal sustainability of the health care system.

\textsuperscript{834}These figures are taken from the Mental Health Programs and Services, Ministry of Health of Ontario, Forensic Patient Database: 1996 Annual Report supra note 357 at 33-49.

\textsuperscript{835}This figure is calculated as follows: The estimated cost of the Ontario Review Board for 1997-97 was 2,098,400. as stated in the Ministry of Health, The Estimates, 1998-99 at 142, as distributed by the communications Branch of the Ministry of Health of Ontario was divided by the total number of hearings of the Ontario Review Board of 1065 hearings from April 1, 1997-March 31, 1998. The Board statistics are unpublished and were provided by the Ontario Review Board in a chart dated May 14, 1998. Of note is that the hearing cost figure of $1970.32 does not include the costs of legal counsel to the parties and witnesses.
that Egan and Thibaudeau illustrate that the Supreme Court of Canada is "prepared to manipulate section 15 and/or section 1 to avoid even the limited scope left by Schachter."\(^{836}\) Another striking example of the discrimination that results from this approach to subsection 15(1) and section 1 of the Charter is found in Fernandes v. Director of Social Services (Winnipeg Central).\(^{837}\) In this case, the provincial government had refused a person with a disability an increase in welfare payments for attendant care which would permit the person to live in the community instead of a hospital. The Manitoba Court of Appeal held that Mr. Fernandes' equality rights under subsection 15(1) of the Charter were not infringed since he was treated in the same manner as all other recipients and all his basic needs were being met.\(^{838}\) The Court found that the government was not discriminating against Mr. Fernandes even though as a result of the refusal of the additional allowance Mr. Fernandes had to live in a hospital when his medical condition did not require it. Therefore, the impact of the Court's deference to government in the allocation of government funds "makes large parts of what government does effectively immune from Charter scrutiny in ways that significantly undermine

\(^{836}\) D. Pothier, "M'Aider, Mayday: Section 15 of the Charter in Distress" supra note 822 at 304-305.


\(^{838}\) The Court of Appeal of Manitoba also rejected the appellant's section 7 argument stating that section 7 only applies when a person is detained within the justice system because it is a legal right. The fact that Mr. Fernandes had to live in a hospital did not appear to be considered; the Court stated that "[t]he desire to live in a particular setting does not constitute a right protected under section 7 of the Charter." See ibid at 414.
equality." However, one author states that in *Elrdrige*\(^{840}\) and *Vriend*\(^{841}\)

[T]he Court has provided us with the legal tools to challenge the most important inequalities in society arising from government acquiescence in face of violations of fundamental human rights... In *Vriend* and *Eldridge* the Court has taken an important initiative toward framing a new paradigm of substantive equality.\(^{842}\)

Even if the Supreme Court of Canada were to adopt a deferential approach to the infringement of the equality rights of accused persons, I argue that the government may be unable to demonstrate that it had a reasonable basis for concluding that its allocation decisions infringe the equality rights of accused persons no more than is necessary. This is because of the drastic effect of the discrimination-lengthier detention periods or more restrictive detention for some accused persons. As suggested above, the government would still be able to achieve its goal of containing health costs or providing health care services and not adversely impact on the equality rights of accused persons, by providing adequate mental health services, either by allocating more of the existing mental health resources to accused persons on a priority basis or funding the necessary mental health services and supports.

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\(^{839}\) D. Pothier, "*M'Aider, Mayday; Section 15 of the Charter in Distress*" *supra* note 822 at 305.

\(^{840}\) *Supra* note 38.

\(^{841}\) *Supra* *Vriend* note 38.

\(^{842}\) *Supra* note 758 at 82.
3. Proportionate effect

As mentioned above, although the courts go through this step, it has not been influential in deciding the outcome of a case. This step requires the court to weigh the effects of the law limiting a Charter right against the objective of the legislation and the court has to determine that the object is sufficiently important to warrant the override of a Charter right. I argue that the legislative objective of controlling health care expenditures or to provide mental health services within a limited budget cannot outweigh the drastic effect of infringing the liberty rights of accused persons for the reasons set out above. In addition, as previously argued, the attainment of this legislative objective renders the mechanisms in section 672.54 of the Code, which ensure the protection of the rights of accused persons, inoperative.

E) Charter Remedy

If it can be shown that the Charter rights of accused persons were infringed under either section 7 or subsection 15(1) and that this infringement cannot be justified under section 1, accused persons would use subsection 24(1) of the Charter to seek a remedy in the superior court (in Ontario, in the Ontario Court of Justice (General Division) and in B. C., the Supreme Court of British Columbia). I propose that accused persons should seek a declaration stating that the failure to provide adequate mental health services to

843 P. W. Hogg, supra note 457 at 883.

844 As previously mentioned section 24(1) does not create a court with jurisdiction to grant a Charter remedy, the ability for a court to grant a particular remedy stems from the statute establishing the court or, as is the case with a superior court, its inherent jurisdiction. I suggest a superior court since its jurisdiction is unlimited and this court has exercised a parens patriae jurisdiction in regard to persons with mental disabilities.
accused persons is unconstitutional and directing the provincial government to administer the law in a manner consistent with section 7 and subsection 15(1) of the Charter. In *Eldridge*,

*Supra* note 38. La Forest J. stated that "[a] declaration, as opposed to some kind of injunctive relief, is the appropriate remedy in this case because there are myriad options available to the government that may rectify the unconstitutionality of the current system." The Supreme Court of Canada uses this same approach in *Mahe v. Alberta* because of the complexities of the issues in question and the fact that the provincial government could fulfill its constitutional obligations in different ways. Such a remedy would place the constitutional obligation on government to ensure that adequate mental health services are provided to accused persons so that their detention under the mental disorder provisions of the *Code* is the least restrictive on their liberty.

If the challenge arose in Ontario, the applicants would seek a declaration that the effect of the decisions on mental health services made under the *Mental Hospitals Act*, the *Ministry of Health Act* and the *Savings and Restructuring Act, 1996* is to infringe accused persons' rights under section 7 or subsection 15(1) of the *Charter* and that this infringement does not constitute reasonable limits under section 1 and is therefore unconstitutional. Accused persons would seek an order directing the Government of

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*Supra* note 38.

*Ibid* at para. 96.

*Supra* note 633.

*Supra* note 634 and 635.
Ontario to administer the *Mental Hospitals Act*,\(^{849}\) the *Ministry of Health Act*\(^{850}\) and the Health Services Restructuring Commission under the *Savings and Restructuring Act*. \(^{1996}\)\(^{851}\) including policies and decisions made under these statutes, in accordance with section 7 and subsection 15(1) of the *Charter*. If the challenge arose in British Columbia, the relevant statutes are the *Forensic Psychiatry Act*,\(^{852}\) the *Ministry of Health Act* or the *Health Authorities Act*\(^{853}\) and the direction to comply with Charter rights would be given to the Government of British Columbia and the delegated decision-makers. In essence, the order would require the government to provide adequate mental health resources to accused persons to ensure that they are not detained in a more restrictive environment or in custody when the protection of the public does not warrant it.

**F) Conclusion**

In my view, the lack of adequate mental health resources has resulted in an infringement of the rights of accused persons which is not justifiable in a free and democratic society. Therefore, I suggest that this is the problem that needs to be remedied. An argument can be made that since the mental disorder provisions of the *Code* are not being implemented as intended by the Parliament or in accordance with the legislative scheme as interpreted by the appellate courts, the constitutional validity of the

\(^{849}\) *Supra* note 633.

\(^{850}\) *Supra* note 634.

\(^{851}\) *Supra* note 635.

\(^{852}\) *Supra* note 636.

\(^{853}\) *Supra* note 637 and 638.
mental disorder provisions of the Code, in particular section 672.54, should be challenged under subsection 52(1) of the Constitution Act, 1982. The challenge would be taken against the federal government. If such a challenge were successful, the key section of the mental disorder provisions would be invalid and new disposition provisions would need to be enacted, since in my view, the court is unlikely to use the other techniques of reading down, reading in, severance or constitutional exemption. based on the outcome in R. v. Swain.\textsuperscript{854}

However, a stronger argument can be made that an accused person should bring an application under subsection 24(1) of the Charter, requesting a declaration of rights which would direct the provincial government to act in a manner that does not infringe an accused person’s Charter right and to provide adequate mental health resources to accused persons. As discussed in this chapter, the challenge would be taken against the provincial government since under provincial health legislation it provides mental health services and it has the responsibility of administering the disposition sections of the mental disorder provisions of the Code. Alternatively, an accused person could seek a declaration of invalidity of the mental disorder provisions of the Code under subsection 52(1) of the Constitution Act, 1982 and, if the provisions are determined to be valid, seek a declaration of rights under subsection 24(1) of the Charter.

I subscribe to the position espoused by rights advocates, though some are critical

\textsuperscript{854}Supra note 17.
of the argument of rights advocates,\(^855\) that the "courts should have the last word not only because they are likely to be the strongest guardians of minority interests, but also because the Charter itself provides objective and determinative right answers."\(^856\) In addition, the decisions in *Eldridge* and *Vriend* emphasize the importance of equality rights and provide some of the necessary tools with which to attack the problem of government inaction to adequately fund mental health services in that

> [I]n *Vriend* the Court makes explicit what is implicit in *Eldridge*, that government need not have entered a particular legislative or benefit area in order for a Charter claim to be made with respect to a failure to act to address a need.\(^857\)

As argued by one author, the decisions impose a positive obligation on governments to act because "the majority in *Vriend* makes it clear that section 15 creates broader obligations to protect and promote equality in all areas where the government has the

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\(^855\) For a discussion of the different positions taken on the rights debate in R.F. Devlin, *"The Charter and Anglophone Legal Theory"* (1997) 1 Rev. Const. Studies 1. The author states that there is a debate between those who believe in the utility of a rights discourse, those who do not, and those who resist dichotomous analysis... The dominant intellectual paradigm in Canadian jurisprudence presumes that rights, like law, are both natural and unequivocally desirable... Jurists who subscribe to such a perspective envision the *Charter* as a normative and institutional structure designed to encourage both the courts and legislators to maximize human rights and social justice... Importantly, many rights theorists emphasize that judicial enforcement of rights is grounded in principle, not policy, politics or power... Others however, are unimpressed and advance several arguments against the ideology and practice of the *Charter-*ization of rights. First, critics argue that judicial review is undemocratic because judges are unelected and, therefore, unaccountable." at 35-37. See also M. Mandel, *The Charter of Rights and the Legalization of Politics in Canada* (Toronto: Thompson Educational Publishing, Inc., 1994).

\(^856\) R.F. Devlin, *"The Charter and Anglophone Legal Theory"* ibid at 36.

\(^857\) Supra note 758 at 79.
jurisdiction to act.\textsuperscript{858} Furthermore, in Eldridge, the Supreme Court of Canada adopts a

\[\text{P}urposive approach ... [which focuses] on the inequality which needs to be remedied by the provision of a service or benefit rather than on a question of how the inequality is connected to an existing statute... There is really no requirement of an ‘application of law’ beyond the requirement that it be within the government’s jurisdiction to address the need.\textsuperscript{859}\]

This new approach is important where allocation decisions are in question since

``[d]ecisions not to provide, or failures to act in the face of the need of vulnerable groups. can rarely be pinpointed to one actor within government or to a particular statute.'''\textsuperscript{860}

In addition, the Eldridge decision makes clear that deference to government will not necessarily carry the day where the government failure to provide services does not minimally impair the rights of the claimants.

The Charter remedy is best suited to ensuring that the spirit and intent of the legislative scheme of the mental disorder provisions, which has been reiterated by different Courts of Appeal, are respected. The courts must not permit the lack of adequate mental health resources to render the safeguards of rights of accused persons contained in the mental disorder provisions inoperative. The courts by means of a declaration of rights under subsection 24(1) of the Charter can ensure that accused persons are not detained in more restrictive settings or for any longer than the protection of the public requires since the court can order governments to provide adequate mental health resources to accused persons. This would go a long way towards ensuring that the liberty and equality rights

\textsuperscript{858}Ibid.

\textsuperscript{859}Ibid at 78.

\textsuperscript{860}Ibid.
of accused persons are respected.
CONCLUSION

As argued in chapter 1, in the 19th century, different attempts to provide institutional care and treatment to persons with mental disabilities failed. The initiatives such as providing moral treatment in asylums or bettering the conditions in pauper lunatic asylums were motivated at the outset by humane and compassionate grounds. However, overcrowding and barely minimal living standards were soon the norm and these institutions abandoned all pretense of providing treatment. The pauper asylums became prisons whose inmates were rarely released. The failure of these initiatives has been attributed mainly to the lack of funding of these institutions, and to their use as the “dustbin of society”.

The transformation of the asylums into mental hospitals in the first half of the 20th century does not appear to have changed the living conditions in these institutions. The mental hospitals were for the most part large custodial institutions. As a result of the medicalization of mental illness, somatic treatments were provided which would have certainly inflicted pain and suffering on the persons confined within the hospital. The wave of reform in the 1960s in Canada which advocated the deinstitutionalization also appears to have been motivated by humane and compassionate concerns for persons with mental disabilities. The stated goal was to provide community mental health services and supports to these persons so that they could be re-integrated into the community. Despite these good intentions, however, deinstitutionalization, as argued in chapter 2, has been a failure in that persons with serious mental illnesses have not received adequate mental health services and supports to remain in the community. Instead they have been caught
up in the “revolving door syndrome” with repeated re-admissions to psychiatric units.

The many reports on reform of the mental health system have emphasized that the lack of funding of community mental health services and the closure of psychiatric beds, following the shift in mental health policy from institutional to community mental health services, are the reasons that these persons have not received services. In addition, persons with serious mental illness have become homeless due to the lack of appropriate housing and inadequate income supports. The mental health system has been described as

A non-system ... where a few patients get more than they need, many patients get less than they need and some get nothing at all. Patients may get lost in this non-system and no one feels obliged to look for them. Patients may refuse to follow a program's rules and be terminated from treatment by staff who believe that they had no other choice. Patients are moved from the community into hospital and from the hospital back into the community such that the hospital, the community, the patient, and the family all feel mistreated.861

Accused persons under the jurisdiction of the mental disorder provisions generally suffer from serious mental illness. As a result of committing an offence and being found not guilty on account of mental disorder, an accused person is placed under the jurisdiction of a Review Board who determines whether she or he is a significant threat to the safety of the public, as discussed in chapter 2. The principal aim of the mental disorder provisions is to protect the public from dangerous persons. However, in making a disposition, a Review Board must also consider the re-integration of the accused person

into the community and the other needs of the accused person. Only a few accused persons are given an absolute discharge after their initial disposition hearing. The others are detained in custody at a hospital or given a discharge on condition and placed under the supervision of a person in charge of a hospital.

The lack of mental health resources has additional consequences for accused persons. While persons under civil committal are released from a psychiatric unit when considered no longer dangerous to self or others or no longer suffering from a mental illness, in order to receive an absolute discharge, accused persons have to contend with the additional requirement (under the mental disorder provisions) that they will not pose a significant threat to the safety of the public in the future. Without adequate mental health resources, an accused person cannot obtain her or his liberty because she or he will be unable to convince the Review Board that they do not pose a significant threat to the safety of the public. In fact, for a number of accused persons, inadequate mental health resources render the mental disorder provisions virtually inoperative.

The Charter remedies suggested in chapter 3 are aimed at identifying ways of forcing governments to fund the mental health system and other support services to ensure that adequate resources are available to accused persons. These resources are necessary to ensure that the mental disorder provisions are truly the least onerous and least restrictive and do not infringe the liberty and equality rights of accused persons.

I suggest that governments should avoid litigation and direct the necessary resources towards accused persons. This goal may be achieved by reforming forensic services "to ensure that action is taken to increase accessibility to both inpatient and
community-based forensic services"862 and to mainstream mental health services.
Governments should reallocate or enhance funding to increase community-based mental
health services and supports prior to any downsizing of psychiatric beds, as outlined in
the 1998 Mental Health Plan863 in British Columbia and as recommended by the Health
Services Restructuring Commission in Changes and Transition. As noted by one health
economist, "[w]hen the cost of mental illness is tallied, a massive reinvestment in
community supports makes economic, not just humane, sense."864 Therefore, the
implementation of the suggested changes should be accelerated. As stated by the
executive director of the British Columbia Division of the Canadian Mental Health
Association "[w]e know what the right things to do are, but there are never, ever the
resources to do it."865

Furthermore, two documents can serve as useful guides to governments to
enhance services and supports. The first is contained in A Provincial Strategy To

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862 Health Services Restructuring Commission, Change and Transition: Planning
Guidelines and Implementation Strategies for Home Care, Long term Care, Mental
Health, Rehabilitation, and Sub-acute Care. supra note 3 at 55.

863 Supra note 3.

864 Dr. W. Gnam, psychiatrist and health economist affiliated with the Clarke
Institute of Psychiatry in Toronto, Ontario as cited in T. Boyle and D. Vincent, "Madness:
Seven parts on how we're failing the mentally ill," The Toronto Star, January 10 to
16, 1998, Part 7 "What are the answers?" on January 16, 1998 supra note 1 at 5. In this
article Dr. Gnam explains that in a study he conducted in 1990 he found that the cost of
clinical depression was $476 million in Ontario.

865 C. McInness, Victoria correspondent, "How the system failed a troubled mind:
Case of a schizophrenic who killed his mother highlights cracks in mental-health care,"
supra note 1 at A2.
Coordinate Human Services and the Criminal Justice System. The aims of the strategy are twofold. One is to attempt to stem the tide of persons with mental disabilities coming into conflict with the law since these persons “frequently fall through the cracks in service delivery.” The strategy identifies two main points at which persons with disabilities can avoid falling into the criminal justice system: crime prevention and diversion out of the criminal justice system of persons with mental disabilities. Diversion programs are directed at persons who commit minor offences. If fewer persons with mental disabilities enter the criminal justice system, there is less likelihood that they will come under the jurisdiction of the mental disorder provisions. This would decrease the pressure on the mental health system to provide forensic services. However, unless there are community services and supports in place for persons with mental disabilities, neither prevention nor diversion can happen.

The other aim of the provincial strategy referred to above is to coordinate services to persons with mental disabilities who are in conflict with the law. This would ensure cooperation between ministries providing services to these persons and promote savings in the long term to government by eliminating duplications and identifying gaps in services. As noted in A Provincial Strategy To Coordinate Human Services and the

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866 Supra note 42.

867 Letter of deputy ministers of health, community and social services, and corrections and deputy attorney general and deputy solicitor general of Ontario undated accompanying A Provincial Strategy To Coordinate Human Services and Criminal Justice systems in Ontario, ibid.
Criminal Justice System\textsuperscript{868} accused persons and persons with mental disabilities serving sentences "consume a disproportionate amount of services throughout the health care, social services and criminal justice systems."\textsuperscript{869}

The second document which offers government a useful guide in implementing mental health reform is the discussion paper, \textit{Best Practices in Mental Health Reform}.\textsuperscript{870} The strategies suggested in this document are based on "proven and promising approaches for providing individual supports, inpatient/outpatient care, crisis response, housing, employment and self-help."\textsuperscript{871} However, the authors of the discussion paper emphasize three points. The first is that without political will and reallocation of resources to support reform, it cannot be achieved. The second point is the importance of "defining and protecting the budgets that are allocated for persons with severe mental illness."\textsuperscript{872} The third point is the establishment of mental health authorities to administer the mental health system for a particular geographic area.

Since the mental disorder provisions of the \textit{Code} result in the deprivation of liberty for an accused person, the safeguards set out in the provisions to ensure that accused persons regain their liberty must be respected. If an accused person does not receive the least onerous and least restrictive disposition because of a lack of adequate

\textsuperscript{868}Ibid.

\textsuperscript{869}Ibid at 1.

\textsuperscript{870}Supra note 41.

\textsuperscript{871}Ibid at 6.

\textsuperscript{872}Ibid at 21.
mental health resources or if the disposition is not implemented, the safeguards are meaningless. It is of utmost importance that adequate mental health resources be provided so that the legislative scheme of the mental disorder provisions of the Code can be implemented as intended and the liberty interests of accused persons are truly balanced against the protection of the public.
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