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Chair

The Honourable Paul DeVillers

Standing Committee on Justice, Human Rights, Public Safety and Emergency Preparedness

Monday, November 22, 2004

● (1530)

[*Translation*]

The Chair (Hon. Paul DeVillers (Simcoe North, Lib.)): We shall commence this meeting of the Standing Committee on Justice, Human Rights, Public Safety and Emergency Preparedness.

[*English*]

We have before us today four groups of witnesses on Bill C-10, an act to amend the Criminal Code (mental disorder) and to make consequential amendments to other acts.

From the Canadian Bar Association, we have Mr. Allan Manson, chair of the committee on imprisonment and release; and Ms. Tamra L. Thomson, the director of legislation and law reform.

From the Community Legal Assistance Society, we have Daniel Soiseth, a lawyer for the mental health law program.

From the Schizophrenia Society of Canada we have John Gray, the president; and Sheila Deighton, the executive director of the Ottawa chapter.

From the Criminal Lawyers' Association, we have Carol Ann Letman, the assistant secretary.

I'm sure most of you have been here before and you know the procedure. We ask you for an opening statement or brief of approximately ten minutes, and then we'll go to the questions.

We'll start with the Canadian Bar Association, and Mr. Manson or Ms. Thomson.

Ms. Tamra Thomson (Director, Legislation and Law Reform, Canadian Bar Association): Thank you, Mr. Chair. I'll start and then pass the microphone over to my colleague, Professor Manson.

The Canadian Bar Association is very pleased to address the committee today on issues relating to Bill C-10. The Canadian Bar Association is a national voluntary organization representing over 38,000 jurists across Canada. The statement before you today was prepared by the criminal justice section, whose members comprise both crown and defence lawyers, as well as the section's committee on imprisonment and release, of which Mr. Manson is chair. The committee members have particular expertise in the area of sentencing and release matters.

I will hand the microphone over to Professor Manson, who will address the substantive issues within the bill.

Professor Alan Manson (Chair, Committee on Imprisonment and Release, Canadian Bar Association): Thank you.

I hope everyone has a copy of the brief that has been circulated. While we're waiting for that, though, I can give you a little background.

To the Canadian Bar Association, this is a very important area of criminal legislation that doesn't receive the degree of attention it deserves, in our view. It lay neglected for decades, until Parliament passed the 1991-92 amendments that made huge progress on a number of fronts. The next step was the review conducted by this committee in publishing its report in June 2002. A few of the people around the table participated in that, and I'm going to refer to that report from time to time because I think it made some very important findings about this particular area. The report of that committee obviously encouraged the Department of Justice and the Minister of Justice to come forward with these amendments.

Generally, the Canadian Bar Association is very supportive of the amendments. Most of them we consider to be good ideas and properly crafted. In our submission, we address some of the areas that we think are deficient, and I'll speak to them very briefly now. I'll then also come back to some of the omissions, especially some of the areas touched on by this committee in 2002 and touched on by people who appeared in front of this committee that are still being ignored.

The Canadian Bar Association criminal justice section has representatives from every jurisdiction in the country. Our focus is this: impressionistically, we believe too many very sick people are imprisoned in Canada's jails. If that's true—and we don't know because there is no data, and that's one thing this committee recognized and addressed in 2002—then at some point there ought to be a public debate about how to address that situation. I don't claim to come here with specific answers, saying this is the model and this is the answer, but if that impression is true, this is a serious matter that we ought to address seriously.

Let's look at Bill C-10 for a moment, the bill that's in front of you. I'll just touch on some of the recommendations we're making. First, let's look at page 2, dealing with the recommendation in the proposed section 672.121, giving review boards power to order assessments. This was a position put in front of you by review boards in 2002, and we agree completely that it ought to be clear that they have that power. Canadian courts have recognized that they exercise in inquisitorial function; as a result, these boards need good data and good information. There seems to be doubt among some of them as to whether or not they can order an assessment. That means not just the reports that are coming from the hospital where the particular person is held, but a new assessment from an independent source. I think it's appropriate that they be given that power.

Our recommendation is very simple. The phrase in the proposed subparagraph reads that they can order an assessment if “no assessment...has been conducted in the last twelve months”. We suggest inserting the word “adequate”. The board may be faced with a new assessment that is inadequate. They ought to have the power to say they want another one. That's simply our submission, and that's at page 2.

We then move to the question of permanent unfitness. This was an issue addressed by this committee in 2002, when you recognized that there ought to be a mechanism for discharging or releasing someone who is, one, permanently unfit to stand trial, and two, not a risk.

Our Supreme Court, just last spring in the case of R. v. Demers, an appeal from Quebec, concluded that the current regime is unconstitutional in that it doesn't provide a vehicle for someone who is permanently unfit—meaning there is no likelihood they'll become unfit and therefore able to be tried—and poses no significant risk to the safety of the public. It's unconstitutional because there is no scheme for that person to be released from the constraints of the mental disorder regime.

● (1535)

The Supreme Court gave Parliament 12 months to rectify this problem. Bill C-10 responds to that, and in our view there are three deficiencies with the response. First, there is a simple one, shown on page 4. The current bill recommends a process where if the board believes someone meets the test of being permanently unfit and no significant threat, the board then recommends to the relevant court that it consider the issue. Then there's a test that the court has to apply, the result of which may—and I emphasize “may”, because that's the word in the provision—be a stay of prosecution. Our first concern is that after the board makes a recommendation to the court, Bill C-10 says the court must order a brand-new assessment. Our view is the “shall” should be changed to “may”. This is the recommendation at the top of page 5. We ought to trust our superior courts and our appellate courts. If they need a new assessment they will order one; if they don't, there's no reason to engage in the time and the expense of having one. In other words, if there is a full and adequate record to assess the question, they ought to be able to go forward and do that.

The second deficiency we see, also on page five, is access to the process. Under Bill C-10, an individual has no way of raising the question of being permanently unfit and no significant threat. It's done by the board and then on recommendation by the board to the court. Our most important concern is the test, and this is discussed on pages 5 to 7. First, the test at the court level says “the court may” issue a stay of proceedings—it's discretionary—if it's satisfied, first, that the accused remains unfit and is not likely to become fit. We agree completely with that, as does the Supreme Court. Second, the court may issue a stay of proceedings if it's satisfied that the accused poses no threat to the safety of the public. We agree completely with that, as does the Supreme Court. But then there's a third factor, of whether a stay is in the interests of the proper administration of justice. This is followed by a lengthy provision, the proposed subsection 672.851(8), listing all the considerations the courts ought to look to when assessing the proper administration of justice. In our view, this goes far beyond what the Supreme Court of Canada told us was the constitutional issue. The constitutional issue was that it is unfair and disproportionate to continue to constrain a person who is permanently unfit and no significant risk to the safety of the public. This added question of administration of justice is exceeding the threshold provided by the Supreme Court of Canada.

If you read the judgment in R. v. Demers, there is a part where they suggest perhaps there is a balancing to take place, but a balancing between what? The court refers specifically to the public interest in finality. The Canadian Bar Association wonders, in a situation where someone represents no significant risk to the public, why? I can't imagine in what situation a public interest in finality warrants holding someone under constraint, pending some trial that's never likely to happen. Furthermore, if you really are concerned about finality, there are commissions of inquiry or public inquiries that could be conducted after a stay is entered.

Our recommendation is on pages 6 to 7. It says either take the word “may” out and replace it with “shall”, and end the provision with “threat to the safety of the public”, thereby omitting the reference to “proper administration of justice”, or if you can conceive of an example where the interest in finality might outweigh the patient's interest in being freed from constraint—when they're unfit, untried, and no risk—then we offer another rewording that basically says:

> The court shall, on completion of an inquiry...order a stay of proceedings if it is satisfied that the accused remains unfit to stand trial, is not likely to become fit to stand trial and does not pose a significant threat to the safety of the public, unless, in the court's opinion, the public interest in finality outweighs the deleterious effects to the accused of continued subjection to the criminal process.

● (1540)

In other words, that focus is on the only caveat that the Supreme Court offered.

I'm going to stop there, other than to point out our concern at page 9 about the frequency of reviews. We think any efforts to postpone reviews by boards is a mistake. Even if a review is perfunctory, the board ought to have a look at every case every year. These are vulnerable people who often cannot communicate with counsel, and unless I were persuaded that there is a huge cost, the Canadian Bar Association would like to see the board look at each case every year just to confirm that maintaining the status quo is a good idea.

We want to take a minute to speak to you about omissions in Bill C-10. One is an omission to deal with your recommendation from your 2002 report—that is, the concept of being unfit to be sentenced, which to date Canadian law doesn't recognize. Since you've already dealt with that, I won't go into it, but this committee recommended that the code be amended to encompass that concept. Bill C-10 doesn't do it.

The other omission goes right to the heart of the Canadian Bar Association's concern about the growing number of sick people in jails. This goes back to your report in 2002 in which you concluded there was no need to re-examine the scope of section 16. This used to be known as the insanity defence. It's now the defence of being not criminally responsible by reason of mental disorder. Assuming our impression is true that we are witnessing a growing number of very sick people in provincial and territorial jails and federal penitentiaries, it's our position that the only way to respond to this is either to examine section 16 to see whether it ought to be expanded.... And in our brief in 2002 we explained situations where very seriously ill people, paranoid schizophrenics, do not meet the current section 16 test because it's based on cognitive deficiency. It doesn't have a volitional element.

Either you expand section 16, or you look at something like one sees in European countries or in England and Wales, where they have hospital orders where courts can say, “Yes, you've committed an offence, but you are very sick. You are not going into the jail system, you are going into the hospital system.”

In 2002 this committee said, in agreeing that the provision, which has never been proclaimed in force, that would provide for a 60-day hospital order ought to be repealed.... That's not a real hospital order; that's a crisis response. It's not taking you out of the penal system and putting you into the hospital system. In responding to that, this committee said we have a difficult interjurisdictional conflict here, because the Criminal Code is federal and the mental hospitals are run by the provincial governments. That is absolutely true. But it seems to me we can't sit back and say a problem caused by decisions made in 1867 is thereby insoluble. We do discuss and negotiate and make arrangements cooperatively between the various levels of government.

The Canadian Bar Association isn't saying the right answer is to expand section 16 or go the hospital order route of some sort and divide people into a penal or therapeutic regime. What we are saying is this is a serious problem that needs to be addressed.

My final remark is that this committee in its 2002 report—and you see it at page 23 of your report—talks about the need for hard data on these issues. It wasn't presented to you in 2002. It hasn't been collected.

We need the data to generate a public debate, because we're also missing the philosophical answer to how we want to deal with this growing number of sick people in our jails.

● (1545)

So our last position is to recommend to this committee, aside from Bill C-10, that you communicate with the relevant federal ministers —the Minister of Justice, the Minister of Public Security—and ask that they start the process of systematically collecting national data about the number of ill people in federal penitentiaries, at the very least, because they have jurisdiction over those, and communicating with the review boards, getting that hard data about who the review boards are dealing with on an annual basis so that groups like this committee and others can come to grips with the issue we've raised about the growing number of sick people.

Thank you very much. Afterward, I'd be happy to answer any questions.

The Chair: Thank you, Professor Manson.

Now, from the Community Legal Assistance Society, Mr. Soiseth.

Mr. Daniel Soiseth (Lawyer, Mental Health Law Program, Community Legal Assistance Society): Thank you.

I'd like to begin by thanking the committee for this opportunity to share our views. The Community Legal Assistance Society is a Vancouver-based non-profit law firm. There are four different programs. The one I work for is something called the Mental Health Law Program. We have two lawyers, seven legal advocates, and four staff, and we represent clients at review board hearings. This is, of course, after they've already got into the system. There are about 350 hearings each year, so we think we know how these amendments might change our work.

Due to the time limitations, I'm going to focus on just two main areas. I'm not sure if all the members of the committee have a copy of it, but we have submitted a written submission. Hopefully, the members will have a chance to go over it. I'll focus on two main areas in my oral submission.

First is the area of review board jurisdiction. It's our position that review boards should have the power to order parties other than NCR accused to do things, make orders binding other parties, most notably the hospitals that have custody of the accused. We think the board should be able to tell those hospitals what they should do.

The second main point I'll talk about is an appropriate level of victim involvement. This is one of our main concerns with the current Bill C-10.

As it stands, the Criminal Code, as mentioned, doesn't have the power to order a hospital to do anything. This creates, in our view, a practical difficulty, and in effect in some cases it hands jurisdiction over to the hospitals. What I'll try to do is go through one example of a case of how the review board made an order intending one thing, but because of their inability to make an order binding on the hospital, they couldn't give that order effect.

What happened was they discharged a fellow from the hospital. They didn't deem that he was not a significant threat, but they did deem that he was ready to leave the hospital and live in the community somewhere. Upon his discharge, what the hospital did is gave him a ride downtown to an emergency shelter and just dropped him off. His plan, what he was going to do, was get to that shelter and spend the night. He had already made an appointment with a social worker for the next day, and he expected that he would hook up with that social worker and find a more permanent place to stay, and so on.

What happened was that the emergency shelter he went to first was full; there was no space for him. He had to spend a night on the street. The next day he was supposed to have that appointment with the social worker, but through no fault of his own, he couldn't make the appointment. He wound up spending another night on the street. This went on for a couple of more days. What eventually he had to do was find his way back to the hospital and check himself back in.

Now, the reason this could have been avoided by the review board making an order binding the hospital is that the review board could have ordered him discharged, but at the same time, ordered the hospital to do some discharge planning for him. In the vast majority of cases, the hospital's recommendation to the review board is followed. If the hospital is of the opinion that the chap should be discharged, they will do some planning. They have social workers, they have nurses, they do all that sort of stuff, and they get a guy set up before he's into the community.

Now, in this particular case, of course, the hospital wasn't expecting that he would be discharged, so nothing had been done. The effect is that if the hospital chooses not to perform these functions, then the net result is the discharge can't happen properly, can't happen safely.

This is something I hope the committee considers, because really, it's about jurisdiction. If the hospital has de facto jurisdiction, then the intent of the code is thwarted.

Our second area of fairly serious concern is with the amendment proposal to dramatically increase the level of involvement for victims. The most important point I hope to make with the committee is that there has to be maintained this fundamental distinction between “not criminally responsible” proceedings and ordinary criminal proceedings. In ordinary criminal proceedings such as sentencing or parole, what you have is someone who has deliberately done harm to somebody else. In those cases, obviously, I have no qualms with victims becoming involved and having a say in the fate of those who have done harm to them, sometimes grave harm. But NCR proceedings are not like that.

● (1550)

By the time they come to our office, by the time they get into the review board system, the court has already determined that they are not morally at fault. So we see this as a fundamental philosophical issue. NCR proceedings are not really a forum, we don't think, where victim involvement should be increased.

I'll tell you about a couple of situations where victims were involved. I've only personally been involved in two hearings where victims attended and took a role. As the committee members I think would be aware, under the current scheme the victims are entitled to file a victim impact statement and they are also of course entitled to attend hearings as members of the public.

In a case I was involved with not too long ago it was a very serious index offence, a murder, and the victim's family and some close friends attended the hearing. It was a very dramatic, emotional scene in the room, with my client and the other people there. The victims all filed victim impact statements. The board chairman was able to tell the victims to their face that he did have a chance to go over the victim impact statements and that he had appreciated their input.

I came away with the sense that the victims—I didn't speak with them—had a sense of understanding what the process was all about. Of course the review board is there to decide about these twin issues of the accused's liberty and the safety of the public, and I think the victims in that situation came away from the situation realizing that the board did look very closely at these things and did take their concerns seriously. In that way, I think the current set-up in the Criminal Code has been shown to be working reasonably well.

The reason the amendments wouldn't work very well in that case is that, like a lot of hearings we do, especially in a first hearing like that one, where process is basically by consent, the hospital has submitted that the accused should remain in custody in the hospital. We weren't arguing about it. We just wanted to go and get the thing done and have him remain in hospital. If in that case victims were to speak, we're talking about more than doubling the length of the proceedings. There were seven people who could quite justifiably consider themselves victims, such as friends, family members, and so forth, and if each of them takes five or ten minutes to read a victim impact statement, we're talking about more than doubling the length of the hearing. In that way, I think we're talking about a fundamental shift in focus from what it should be, from thinking about the accused's liberty and about the safety of the public, over to what amounts to victim services. I don't think that's an appropriate way for the legislation to operate.

In the second example I'm thinking of, it was another murder situation that occurred quite some time ago, about 12 years ago, and every year the victim's family attends hearings, which is entirely appropriate, of course.

They have filed their victim impact statements, but at this hearing just a few months ago, one of the family members who has a history of attempting to get involved actually tried to become involved. Nobody was calling him as a witness, and the crown didn't see that he had any relevant evidence to give, but it actually appeared that there could have been a physical confrontation at this hearing because the victim was there. Keep in mind that review board hearings in British Columbia, at least, and I'm sure elsewhere as well, don't happen in courtrooms. There aren't sheriffs around, so there is this concern about the safety of all the parties.

If the new amendments were in place at the time of that hearing, that victim would have had an opportunity to obviously make statements and give evidence. Again, it is just not what the focus is. They can't be relevant to the issue of public safety.

The final point I want to make about victim impact statements is that they can be extremely stressful, and you have to appreciate that we're talking about people with very serious mental health issues. Hearings themselves in some cases cause so much stress for my clients that they have a deterioration in their mental state as a result of an approaching hearing. And remember that the mental health of an accused in many ways goes in lockstep with public safety. So if their mental health is better, the public is safer. That's one thing to keep in mind.

● (1555)

With victims attending hearings, that's going to add an enormous amount of stress for the NCR accused. It is very much a potential situation where a victim involvement will lead to a worsening of public safety.

The last point I'd like to make on victim involvement is this. Unless the amendments are crafted in some way that they don't seem to be now, they could well open up victims to cross-examination. I would feel obliged to cross-examine a victim if they made statements that I thought were going against my client. If the committee does want to go ahead with these amendments on victim impact statements, I would suggest perhaps precluding cross-examination, because that obviously would be an extremely traumatic experience for victims. But as the amendment is proposed now, the victims would be open to that, I'm afraid.

I'd be happy to answer questions afterwards. Thank you.

● (1600)

The Chair: Thank you very much.

Now, from the Schizophrenia Society of Canada, Mr. Gray.

Dr. John Gray (President, Schizophrenia Society of Canada): Thank you, Mr. Chair and members of the committee.

I'm sharing this presentation with Sheila Deighton, who is a founding member and also the executive director of the Schizophrenia Society of Ontario.

The mission of the Schizophrenia Society of Canada is to alleviate the suffering caused by schizophrenia. Most of our members have family with schizophrenia or are consumers themselves, and many have had direct experience with the Criminal Code mental disorder provisions. The majority of people, let me remind you, who become involved in the forensic psychiatric system have schizophrenia as the illness.

The Schizophrenia Society of Canada is pleased with most of the proposed amendments in Bill C-10, including the permanently unfit accused, removal of capping, new review board powers, transfer and police amendments. But we want to caution about the victim impact statement amendments, and we also have a very major concern with the absence in the bill of a treatment authorization mechanism for persons found not criminally responsible on account of mental disorder.

While we appreciate that a victim has the same feelings irrespective of whether the perpetrator was criminally responsible or not, the Criminal Code makes a major distinction between the two. We are concerned that introducing criminal-type impact statements may blur this distinction and that this could lead to a trend not to recognize the needs of people whose actions were caused by a brain illness. Victim impact statements for those found guilty and responsible for their crimes are so that the judge can consider the severity of the punishment. The person is given a fixed-length sentence, but he may emerge as dangerous as the day he went in. In contrast, when a person is found NCRMD the disposition is indeterminate. In fact, it could potentially be a lifetime. Unlike the criminal, the NCRMD person can only be released if they do not pose a significant risk to the safety of the public. Thus, victim impact statements, we submit, should be of less importance in review board determinations.

On the other hand, the victims in the majority of NCRMD cases are family members. A number of studies show that over 80% of people involved in NCRMD incidents are family members—as was the Deighton family. It is important that families be involved in decisions that affect their relatives as much as possible, especially if the person is likely to be discharged on a conditional release or an absolute release. We also know that a number of review boards currently allow informal victim impact statements. Therefore, this amendment would perhaps just formalize what in fact happens in some jurisdictions. Nevertheless, we share the concern you've just heard expressed, and we would suggest that if the amendment goes forward as is, the Department of Justice be asked to monitor how those are affecting the victims and also the people who are NCRMD.

Our major concern, however, is not addressed by these amendments. It affects the health and liberty of NCRMD people in some provinces. Whereas the court can order psychiatric treatment under the Criminal Code to restore a person to become fit to stand trial, there is no similar authority to order treatment for a person found NCRMD. Some provinces' mental health acts allow an involuntary patient to refuse the treatment necessary for them to be released. We strongly recommend an amendment to the Criminal Code that would allow the review board to order treatment where the treatment necessary for the person's release is refused.

Sheila Deighton will now give you a family perspective on the effects of untreated mental illness and the effectiveness and importance of appropriate psychiatric treatment.

Sheila.

● (1605)

Ms. Sheila Deighton (Executive Director, Ottawa Chapter, Schizophrenia Society of Canada): Good afternoon, members of the committee.

I am pleased to be here today with my husband of 33 years, Alistair Deighton, who is in the audience. Alistair has a long history of serious mental illness.

In January 1995 Alistair visited his psychiatrist. At that time, Alistair was working as a salesman but had developed paranoid delusions. Alistair's psychiatrist was not treating him with medication but trying to use talk therapy.

On the night of January 30, 1995, tragedy struck our family. Alistair came downstairs with a double-barrelled shotgun and fired at my 18-year-old son Al, killing him instantly. Al had become part of Alistair's psychotic illness. That is what untreated schizophrenia did to my son, did to my husband, did to our other two children, and did to society.

Alistair was so mentally ill that he was found unfit to stand trial, but he took anti-psychotic medications and within about two months of treatment he was found fit for trial, although he was not completely well. Alistair was found not guilty of murdering our son on account of mental disorder. He was hospitalized, and unlike many people with these illnesses, he took his medication voluntarily, made good progress, and was granted a conditional discharge. He did have some relapses but eventually was stable enough to move into an apartment close to our home. Within eight months he returned to live with our family in our home, where he currently resides.

In 2003 Alistair received an absolute discharge. Since then, he has continued to take his medication and have regular appointments with the psychiatrist, and has had no signs of mental illness. He is a wonderful husband and a loving father.

Our treatment success story contrasts with many I hear from families where schizophrenia has precluded loved ones from recognizing they are ill and in need of psychiatric treatment. They therefore refuse treatment. That not only keeps their symptoms going, but it also may result in tragedies like the one we went through. It creates great disruption in their lives and the lives of their families.

I will turn the floor back to Dr. Gray to illustrate what happens because the Criminal Code does not authorize treatment for NCRMD people.

Dr. John Gray: Thank you, Sheila.

The Starson case, a Supreme Court of Canada case that some of you will have heard of, I'm sure, and many others—I've actually listed lots of them in my book—illustrate the effect of the Criminal Code failing to authorize compulsory treatment like it does in most other countries. In most other countries, if a person is found NCRMD, that person is treated, there is no question.

This case involved a Mr. Starson, who was a brilliant man, but he had at least 17 involuntary psychiatric admissions for serious mental illness. He was found not fit to stand trial on charges of uttering death threats. He was ordered by the court under the Criminal Code to take psychiatric treatment and he became fit to stand trial. Mr. Starson was found NCRMD. However, he refused treatment and appealed the Ontario Consent and Capacity Board decision that he was not capable.

This case was appealed all the way to the Supreme Court of Canada, where in a split decision it was found that, under Ontario legislation, the Consent and Capacity Board had erred and that Mr. Starson was capable. The Supreme Court did not rule on the constitutionality of the Ontario legislation, only that in this particular case it had been incorrectly applied.

By refusing treatment, Mr. Starson had already spent five years in hospital—five years. Since his pyrrhic victory in the Supreme Court, he continues to refuse treatment required for his release. He has now spent over a year since the Supreme Court of Canada decision—that's six years—and may well spend many, many more years, perhaps a lifetime, in hospital, despite the fact that his mother and all the people who know him want him treated. The people know he is a brilliant man, and if he were treated, he could actually produce something. At the moment, he's just languishing in a hospital in this city.

This is completely unacceptable to his mother. It is completely unacceptable to the Schizophrenia Society of Canada. It would be unacceptable in most civilized countries in this world where modern psychiatric treatment is available.

The Schizophrenia Society of Canada proposes an amendment to the Criminal Code along the following lines:

> The Review Board may authorize psychiatric treatment where the NCRMD person is not being treated under provincial mental health legislation provided...

I won't go through it all in detail, but in essence it's that the person is involved in the decisions, that there are two physicians involved, and that without treatment the person would continue to be detained with no reasonable prospect of release. That's currently in the New Brunswick Mental Health Act, where their tribunal uses that as a standard to decide whether to provide treatment to a person, that if there's no reasonable prospect of release by not having treatment, then the tribunal in New Brunswick can order treatment under the Mental Health Act.

Without these amendments, provincial inequalities will continue in Canada. A person under the Criminal Code with an advance directive not to be treated will nevertheless be treated in British Columbia because of the legislation, and that person, because of the treatment, will probably be released in a relatively short period of time. However, the same person with the same problems under the same Criminal Code but in Ontario, under the Health Care Consent Act, cannot be treated—like Mr. Starson; he cannot be treated. The person will probably stay suffering and detained for years, perhaps a lifetime.

Just as the Criminal Code does not rely on provincial mental health acts to order treatment for a person found unfit to stand trial—there's a specific chunk in the Criminal Code to do that—the Criminal Code should not rely exclusively on provincial legislation to authorize treatment for NCRMD persons, since in some provinces it is not doing the job.

In closing, the Schizophrenia Society of Canada urges the members of this committee to give careful consideration to the consequences of amending the Criminal Code to permit the oral presentation of victim impact statements. We also urge you to give due consideration to changes recommending that NCRMD persons who are not being treated under provincial mental health legislation be provided that opportunity.

Thank you very much.

● (1610)

The Chair: Thank you very much.

Our final presentation is from the Criminal Lawyers' Association, Ms. Letman.

Mrs. Carol Letman (Assistant Secretary, Criminal Lawyers' Association): I'd like to thank the committee for the opportunity to make a presentation. I have to apologize for having nothing in writing. For a variety of reasons, the notice kind of fell through the administrative cracks in our organization and was only brought to the attention of our legislative committee on Wednesday of last week and didn't allow for the preparation of any written material. I do have some notes and I have copies that can be provided at the end, if necessary, that may be of assistance.

The Criminal Lawyers' Association is largely an Ontario association, although we do have members from across the country, who are all engaged in the private practice of criminal law in some capacity or at some percentage level at various courts throughout the country. Primarily, though, as I've indicated, members are in Ontario and our association is probably the only large organization primarily of defence counsel in the country.

I took the opportunity to review a few of the provisions and will say the bulk of my comments, to some extent, cover the same issue that was covered by Professor Manson in dealing with the permanently unfit. I'd like to start, however, by at least commenting on the issue with respect to assessments being ordered by the review board.

While the organization in large would support the logic of assessments being available and being ordered by the review board, one of the concerns with expanding the power to order assessments is the potential for increased demand on what are already extremely limited resources. Difficulties may arise as to who pays for such assessments, who and where they will be conducted, what resources exist, particularly for the individual who is in the community, as opposed to an individual who is detained in a custodial facility or in hospital.

The issue of resources continues to be a significant problem, particularly in Ontario, as there is a shortage of forensic psychiatrists. That is a growing problem, certainly in Ontario, and I suspect as well in other jurisdictions.

The new amendments did not make use of the recommendation from the former standing committee to expand the class of persons qualified to perform assessments. That was a recommendation by the previous standing committee.

My submission is that that might have been useful where the primary reason for an individual to be assessed is because of fitness issues that are related to cognitive impairment rather than mental illness. Individuals, for example, who are developmentally delayed may be unfit to stand trial, and the assessment of that particular limitation might best be performed, or certainly could be performed, by individuals other than forensic psychiatrists, if that is the operative reason for the individual to be unfit.

Clause 16 is the clause regarding the victim impact statements, and I don't propose to add to the submissions already made on that. I think they were far more eloquent than I can be on the short notice. My only concern in making my notes was that there appeared to be a bit of confusion between subsections 672.5(15.1) and (15.2) as to whether a victim impact statement could be obtained and utilized before the review board where the issue was fitness.

While subsection 672.5(15.2) specifically relates to any evidence being used where the individual has been found not criminally responsible, that appears to have been left open by subsection 672.5 (15.1). A submission that I would strongly advocate is that there is certainly no place for victim impact statements where the individual who is before the review board is there because they are unfit, since in those circumstances it's clear that the presumption of innocence still applies.

I have a very brief comment with respect to clause 19. Subsection 672.52(2) replaced the provision, and the amendment requires that any court that holds a disposition hearing, whether or not it makes a disposition, is required to send material on to the review board. Not questioning the need for material or the appropriateness of the material laid out in the subsection, the question should be asked why material needs to be sent at all to the review board if in fact the disposition that was made was an absolute discharge. Why are we sending on material if an absolute discharge has been made?

Clause 27 is the clause that adds power to the review board to extend the time for a hearing to a maximum of 24 months, either with consent of both crown and the accused, if represented by counsel, or on its own initiative where the accused is detained in hospital under paragraph 672.54(c) and has been found not criminally responsible for a “serious personal injury offence”.

● (1615)

The concern is with the broad definition of “serious personal injury offence”, because in the way that it's defined it basically encompasses any offence involving violence or potential violence prosecutable by indictment. Virtually any offence, from assault to impaired driving to mischief, is presumed to be an indictable offence until the crown elects to proceed summarily. Moreover, all of the offences that I've identified involve violence, potential violence, or injury.

All of the offences also involve “ the use or attempted use of violence against another person”, or“conduct endangering or likely to endanger the life or safety of another person or inflicting or likely to inflict severe psychological damage on another person”. I've used those specific sections as examples because I'm suggesting that the definition is too broad. In fact, as defined, it would allow those offences to be included and would allow that extension to a maximum of 24 months.

I agree with Professor Manson's suggestion that any decision to extend the time is inappropriate under the circumstances. These are vulnerable people in hospitals. While we recognize there may be a shortage of resources in review boards, in the way that the scheme is set out, such an order to extend it becomes a disposition and the route of review becomes an appeal. It becomes a burdensome task for individuals who may not have much of a voice within the system to begin with. The position of the Criminal Lawyers' Association would be that there is no need for the extension position, and it should remain at 12 months, as it currently stands.

I turn now to clause 20 and clause 33, dealing with the issue of the permanently unfit. This concern was raised by Professor Manson, and I raised it when I made submissions in 2002. It has obviously been raised a number of times over the past few years in dealing with the permanently unfit accused. The whole issue of fitness is a complicated issue, in that the scheme under the various provisions of section 672 presupposes that an individual will become fit and will be able to be tried at some point. The reality is that is simply not the case in many circumstances. I have a fairly significant client base that includes individuals who are developmentally delayed and will never be fit.

In 2002 the standing committee recommended that the definition of “unit to stand trial” be revisited to “consider any additional requirements to determine effectively an accused's fitness to stand trial, including a test of real or effective ability to communicate and provide reasonable instructions to counsel”.

The concern was, and remains, that the current concept may be too narrow and may result in some persons who are not actually fit going to trial. This is particularly of concern as issues and evidence become more and more complex in our criminal justice system with various cases.

Charter issues, the right to silence, statement cases, and complex medical expert evidence are a significant portion of many trials before the courts, and yet the current ramifications of a finding of unfit—in other words, the never-ending annual reviews under the current scheme, as long as the crown can mount a prima facie case—may result in fitness currently being hidden. However, no changes were made to the definition, despite the standing committee's recommendation. It seems that it is an issue that should be revisited, and I would strongly urge this committee to consider that again.

However, of more concern is the failure to deal with the recommendation, again from the previous committee and now from the Supreme Court of Canada in the Demers case, for the need to allow a court and/or a review board to impose an absolute discharge for an unfit accused, although it can do so for an NCR accused. What is proposed instead is a complex scheme under proposed section 672.851 to allow a review board to make a recommendation to the court to hold an inquiry as to whether a stay of proceedings should be ordered. The court can also of its own motion conduct such an inquiry.

Under section 672.54 the court or the review board is required to make a disposition that is

> ...the least onerous and least restrictive disposition, taking into consideration the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused.

● (1620)

I was surprised when I saw the opportunity to review the bill, given the recommendations of the previous committee, given the position taken by the Supreme Court of Canada in Demers at paragraph 60 specifically dealing with the issue of whether an absolute discharge should be an amendment to the legislation, that it wasn't there. The same paragraphs (a), (b), and (c) are still there. It still creates the ambiguity that an individual who has been adjudicated responsible for the actions—in other words, an NCR individual—can have the benefit of an absolute discharge, but an individual who is still presumed innocent of the offence under our current Canadian law but is never going to be fit to stand trial cannot have the benefit of an absolute discharge. The only benefit they can have under the scheme that's been devised here is a stay.

The parameters that have been set out and explained in more detail by Professor Manson add a very complicated scheme to this—this element that is not part of section 672.54, that a stay is in the interests of the public perception of justice. I've paraphrased it, and I can find the exact quote. It is concerning that this extra element has been added, which is not part of section 672.54, governing again the NCR accused.

This section then becomes elaborated in the clause 8—I don't have my reading glasses, so I'm not going to try to read all of it—as Professor Manson has already made reference to. It creates what I would respectfully submit is a very elaborate, complex scheme that the individual cannot initiate on their own, that has to be either by the board or by the court of its own motion, and adds a whole other element that was not anticipated by the previous amendments that were put forward in 1993. It seems an unreasonable imposition on an individual, as I've stated before, who is presumed to be not guilty of the offence, who, because of what may be and what frequently is not a mental illness but a cognitive limitation and who is unable to go through the process of trial, should still be caught in a form of limbo. It is, with respect, an improvement—an improvement that was obviously required by the decision of the Supreme Court in Demers—but my submission is it does not go far enough and needs to be revisited.

Subject to any questions, those are my comments.

● (1625)

The Chair: Thank you, Ms. Letman.

Now we'll go to Mr. Toews for the first round of seven minutes.

Mr. Vic Toews (Provencher, CPC): Thank you very much, Mr. Chair. I want to thank the witnesses for coming out today.

First of all, I'd like to thank the Schizophrenia Society of Canada and the Deightons for coming out and making your presentation. It's always helpful to see that insight.

I think, Dr. Gray, you make a very compelling argument for compulsory treatment, especially when we look at the entire issue of increase of transferability of patients between provinces. When you have some provinces being able to compel and others not, it seems to create an anomaly when you can transfer them to certain provinces that have compulsory treatment and others that do not. So I think your argument is a compelling one, and I think the committee should look at it very seriously.

I have two questions . The first I would like to direct to Mr. Manson and the second to Mr. Soiseth.

Professor Manson, on your concern about the test in section 672.851, the stay being in the interest of the proper administration of justice, in fact, doesn't that just parallel the judicial interim release provisions in section 515, where they've added this third ground now? There it was the accused has to appear; it's not against public safety; and the third one now, the proper administration of justice. Indeed, the Supreme Court of Canada in the Hall decision in 2002 said that's perfectly all right in the context of the judicial interim release provisions. So why wouldn't it be proper in this context?

Mr. Soiseth, your suggested amendment to allow the board to order the hospital to do the discharge planning causes me some concern. Why should the hospital be under a legal obligation for the discharge planning? Why shouldn't this be the board's responsibility to carry out this discharge planning? I think there's a real concern here. There's a constitutional issue that I always find surprising in this issue, where the province and the feds meet in this criminal legislation.

How can a federal law order a provincial institution to do anything? Isn't there a significant constitutional impediment to having a federally constituted board order a provincial institution like a hospital to do anything? I'm concerned about that potential constitutional issue.

Perhaps, Professor, we can hear from you first.

Prof. Allan Manson: Sure. I would just point out that with respect to the victim impact statements, the Canadian Bar Association took a position similar to that of the other people around this table, at page 10, and this committee did express concerns about expanding the scope of victim impact statements beyond the question of risk in its 2002 report, at page 14.

But to get to your question, the bail hearing is a very different stage. It is early in the process leading to a criminal trial. What we're talking about here with the permanently unfit is a situation where there is never going to be a trial. There is evidence that the person is unfit, and there is no likelihood the person will become fit. So the question then becomes, if the Supreme Court has said those are the two critical elements, what does it mean to throw in “in the interests of the administration of justice”? Subsection 515(10), you're right, does include a third...There's the primary, the secondary, the tertiary ground, and the tertiary ground is “where the detention is necessary in order to maintain confidence in the administration of justice, having regard to...”, and there's a list.

Look at the list. And the list is important, because when you use a phrase as broad and vague as “the administration of justice”, any lawyer will ask what that means. The list of the relevant factors in proposed subsection 672.851(8) to a great extent defines it for these purposes. And the list is “the nature and seriousness of the... offence”; “the salutary and deleterious effects of the order for a stay”—I'm not sure what that means—“including any effect on public confidence...”—so we're back to that; “the time that has elapsed...”; and “any other factor that the court considers relevant”.

Our position is the Supreme Court has said the only possible issue is the public interest in finality, and as I said in my remarks, that can be addressed through a commission of inquiry, if it's that important. But I can't conceive of a situation where finality would rise to that important level when you have someone who is not going to be tried or triable and who is no threat, no significant threat. That's an important consideration.

So I appreciate your remarks, but I think, number one, there is a very important distinction in the place in the process where they arise. And number two, the Supreme Court has looked at this and has addressed administration of justice and considered it to have only a small role after you've decided on not likely to become fit and no significant threat to the safety of the public.

That second finding is very, very important.

● (1630)

The Chair: Thank you, Professor Manson.

Mr. Soiseth

Mr. Daniel Soiseth: Yes, thank you.

First, talking about the power to order assessments, I want to make clear to the committee, if I didn't do so already, that it's not just discharge planning that we want the board to be able to do; it's to be able to make orders affecting the hospital and other parties as well.

Mr. Vic Toews: I have an example you referred to.

Mr. Daniel Soiseth: Thank you.

We see the board's jurisdiction as being under threat from the hospital's views in certain cases. There are occasions, and this isn't by any means in a lot of cases, where there's a bit of a tug of war going on between what the hospital wants for the patient and what the review board wants respecting discharge or keeping the patient in hospital or whatever.

In some cases it is not safe for accused to get back into the community unless this planning is in place already. If the planning isn't done, they can actually suffer deterioration. Things can get worse for them if they're just plopped out into the street. If the planning is done in advance, then their return to the community can be safe.

They aren't able to do this planning themselves. These are the sorts of details I don't think the review board ought to be involved in. We'd be setting up a pretty big agency if the review board had to do the social work that is currently being done by hospitals.

I should add this is work the hospitals already do in cases where they are of the view that the patient should be discharged. They go ahead and do the discharge planning if they think the patient is going to be discharged at the next review board hearing; they take care of it. In some cases, if they don't think it's appropriate for the patient to be discharged—and that's just a matter of a psychiatrist's opinion—obviously the board has to take its own view of the evidence. If the board believes the person is ready for discharge, then that's their decision. It's a matter of the hospital having de facto control.

Mr. Vic Toews: My concern is that the hospital really isn't a party to these proceedings, and we're asking the hospital to carry out a legal order. That concerns me. It's different when you have, let's say, two parties in a marital dispute and the court orders one to do some thing and the other to do another thing. Here a federally constituted board is ordering a provincially constituted hospital to carry out these responsibilities. I don't know the answer. I'm just wondering if there's some significant constitutional impediment. What if, even if there were legislation in place, the hospital simply said: no, we're not doing that; we don't have the funding to do it, and there's no way you as a board can order this provincial hospital to do it?

● (1635)

Mr. Daniel Soiseth: Frankly, I can't give you too much enlightenment on the constitutional question. My short answer is simply that it can be done constitutionally.

Second, the hospital is a party to the proceedings. It's not a typical criminal proceeding with an adversarial approach. The parties to the hearings—and it's right in the code, in section 672.11—are the accused; the director of the hospital; the crown, of course; and other people can be designated as parties as well. In youth cases, for example, sometimes parents are parties to hearings. We're suggesting that the review board should be able to bind those people as well.

The Chair: Thank you, Mr. Toews.

Monsieur Marceau.

[*Translation*]

Mr. Richard Marceau (Charlesbourg—Haute-Saint-Charles, BQ): Good afternoon. Thank you for having come before us and having made your presentations today.

The first question I would like to ask deals with an issue raised by Mrs. Letman, who mentioned problems about resources, among others the lack of qualified psychiatrists to make assessments. As Mrs. Letman clearly pointed out, the 2002 report of the committee mentioned the possibility of allowing other qualified specialists, psychologists, for example, to make assessments, especially in smaller communities where it is difficult to find qualified psychiatrists to do them. Do the other witnesses agree with this recommendation made in our 2002 report and suggested again today by Mrs. Letman?

[*English*]

Prof. Allan Manson: I think there may be scope for expanding the set of potential assessors to include psychologists. Just as there will be skilled and trained forensic psychiatrists and other doctors who may not have those skills, there will be psychologists who can, in appropriate cases, provide assessment. The Canadian Bar Association doesn't have any trouble with expanding the set of assessors, so long as it's clear that any discipline has to have special expertise.

[*Translation*]

Mr. Richard Marceau: Mr. Soiseth, what do you think?

[*English*]

Mr. Daniel Soiseth: To start off, it's really a matter for concern that we're talking about potentially watering down the level of expertise for people doing assessments. Obviously it's a resources issue; it's not something that can necessarily be dealt with very easily. We don't have a particular problem with it in British Columbia, and we don't have any real problem if there's a broadening of the people who can do risk assessments. “The more information the better” is basically our view on it.

[*Translation*]

Mr. Richard Marceau: Thank you.

You have all been highly critical, I think, of victims rights. You have all categorically refused to allow victims to play a more important role in the process created by Bill C-10.

Mr. Soiseth, you said we should make a distinction between somebody who has been found guilty in a judicial context and people who have been found not criminally responsible. Can you explain to me how allowing victims of criminal offences to make a statement, if they request it, would interfere with the rights of people with mental disorders, who are themselves victims? In the end, how would the rights of a person with mental disorder be curtailed or ignored by allowing victims a greater role in the process?

If other witnesses wish to answer after that, I will be glad to hear them.

[*English*]

Mr. Daniel Soiseth: Hearings typically last about an hour and a half or two hours. They are not very long. It's not like a three- or four-week-long murder trial, at the end of which there's a finding of guilt and a sentencing and so forth. They are very short proceedings. The focus of the hearing has to remain on the treatment of the accused and reintegration into the community. The reason for that is that the treatment and public safety run together: if the accused is well, then the public is safer.

If we're getting into lengthy victim impact involvement—and it can't help but be lengthy as a percentage of the time spent at hearings—that will shift the focus to simply where it does not belong. The focus has to remain on treating the accused and getting them well. That's where it works for public safety.

● (1640)

[*Translation*]

Mr. Richard Marceau: Professor Manson, do you wish to answer too?

[*English*]

Prof. Allan Manson: Let me refer back to what this committee said in 2002. It's at pages 13 and 14 of the committee evidence. It may be it wasn't presented properly to the committee by those interested in victim impact statements, but since 1999, the Criminal Code does permit the filing of written victim impact statements. This doesn't seem to have been understood fully, but this committee, keeping in mind the question "should there be victim statements?", said this, at page 14:

> At this stage of the criminal justice process, the accused has been determined to be not criminally responsible by reason of mental disorder.

Or unfit, and that's another category, but as one of my colleagues pointed out, the current proposal doesn't distinguish and would permit the oral statements in unfit cases as well.

> The concern of the court or the Review Board is the risk posed by the accused, should there be an absolute or conditional discharge.

The oral statement to be made by the victim should therefore be limited to this issue. The code doesn't so limit it. This is incorporated in the new proposal when it says "in accordance with subsection (14)". The current subsection 672.5(14) permits the written statements to talk about "harm done" or "loss suffered". In the very first instance, aside from my colleague's comments about concerns about the vulnerability of the accused person and security concerns in the context, our major concern is what's the point? The issue here is relevance.

The concern for the board is first, mental disorder—that's a question for expert evidence in the hospital—and second, risk. If the victim has something to say that pertains to future risk, that's relevant. If a victim wants to talk about his or her experience, which I can appreciate has a lot of value to the victim, it's not relevant to this question of future risk, or is not necessarily relevant.

This is the major reason why we think there has to be a big distinction between sentencing in the criminal process, which is about gravity—gravity includes considerations both of blameworthiness and harm done—and this stage, where the issues are set out in the code: it's about whether this person is not criminally responsible where he's in mental disorder, or whether this person is unfit, and then about risk to public safety. These are not matters where the victim can necessarily help.

The Chair: Merci.

Maybe just before going to the government side, I would ask Dr. Gray what the position is of the Schizophrenia Society of Canada vis-à-vis victim statements.

Dr. John Gray: The point we were making was that we share the concerns that these may, in essence, be misapplied. The victims frequently are the families, though I think the code, as currently written, does provide for a family to make the points to the review order.

I agree with the important point made, which is that the issue is future risk; the issue is not past risk. You heard the story here about the horrendous things that happened in this family, and then there's the man sitting over there. Things have just changed completely because this man had an illness, which has now been treated. It is not the same as a person with a life-long criminal career.

The Chair: Thank you.

Now, for seven minutes, Mr. Macklin.

Hon. Paul Harold Macklin (Northumberland—Quinte West, Lib.): Thank you for appearing before us today.

You certainly have given us a lot to think about, and you certainly addressed a lot of fine points, but we seem to have picked up on the area of victim impact statements.

Clearly, these do cause some concern, and particularly with respect to you, I believe, Mr. Soiseth. You commented about the harm being done and that this is a stressful process, but how do you generalize that this is stressful on the NCR accused? I'm curious as to how you draw that conclusion. To me, I find that's something I have difficulty in understanding.

● (1645)

Mr. Daniel Soiseth: I don't want to overemphasize that, and I certainly don't mean to say that in all cases these amendments are going to make my clients less well or worsen their mental health. I'm mostly concerned about the potential for that. I guess you have to bear in mind the nature of the illness of the people I work with; it's just one of those things that stress is a greater concern with them. Frankly, I don't know if this is true of people with schizophrenia generally, or if we're just talking about the particular brand of schizophrenia I deal with, but stress is a major concern. It's one of the risk factors the experts look at when they perform those risk assessments, and it can cause deterioration in mental health. That's just a fact of psychiatry.

Hon. Paul Harold Macklin: Did you want to comment on that?

Ms. Sheila Deighton: In our particular case, my husband had no knowledge of what he had done until hours later, so you can imagine the trauma for him in coming to terms with the fact he had just killed his son. As I said earlier, after spending two and a half months in jail waiting for a bed for a psychiatric assessment, by the time he got to hospital he was so ill that he wasn't fit for trial. It took years of therapy. He was in hospital for a total of two years, and it took years of therapy to help him come to terms with the trauma he suffered.

As we know, 80% of the victims are family members, and schizophrenics don't appreciate what they're doing. They're very vulnerable to stress, some people more than others. For someone who has been untreated for many years and now, with treatment, comes to terms with what they've done, this can be an extremely stressful event. However, if it's family members who are involved and they are speaking to the need for treatment and support and rehabilitation, rather than being angry and vengeful, there's a different outcome.

So one would have to look at the victim and at how much education was done with that victim to help them understand why this happened to them, that this was as a result of untreated illness. This is not a person who is a criminal; he's a person who is untreated.

Hon. Paul Harold Macklin: In this process of dealing with victim impact statements, though, to some extent to me there is a cathartic process that can go on here as it relates to unrelated third parties, but maybe not within an immediately family situation. This can be helpful to a victim to be able to express, in the presence of this person, the impact of what this has meant to that individual. The whole concept of restorative justice is built on that principle. I'm just surprised to hear that in fact it's harmful for the accused to go through this process. If that stress is going to cause this accused to reoffend, then maybe that accused isn't prepared to be back in society in any meaningful way—at least that's how it strikes me, from what I'm hearing.

Prof. Allan Manson: You raise a very important comparison to a restorative justice approach at sentencing. That is a form of moral discourse, where the victim and the offender participate. We're talking now about a vulnerable group of people who are quite ill. They may be unfit; they may be not criminally responsible by reason of mental disorder. It isn't the same parallel moral discourse that you'd expect in a restorative justice process, as between offender and victim. That parallel doesn't exist here.

I also want to say that when people talk about stress, they're not talking about reoffending. In fact it's a huge myth, and a very unfortunate one, that mentally disordered people are dangerous. Compared to the rest of the community, they are much less disposed to committing violent acts. So no one was really talking about that. I think they were talking about an immediate effect on the well-being of the individual—as in the example Mrs. Deighton gave—because of the stress of confronting the past now that they're well.

● (1650)

Hon. Paul Harold Macklin: Although you don't get the full discourse, as you express it, at sentencing, surely in certain cases the victim impact opportunity is helpful to the person who was the victim. I think that's what we're trying to do, and I believe in this particular instance we were attempting to bring forward that opportunity.

Prof. Allan Manson: The question always becomes, at what cost to other interests, because it is different from the sentencing process. I think that's the position.

Hon. Paul Harold Macklin: I agree it is likely not as wholesome or fulsome as it would be in a normal sentencing process, with someone who was found guilty and was held criminally responsible.

Going back to Daniel Soiseth, you indicated in one of your recommendations that you share the concern of the B.C. review board chair, regarding the precise amendments proposed, that the power to order assessments is defined too narrowly, and the review board should be empowered to order assessments for other purposes.

What should the limitations be on the board itself? Shouldn't there be limitations placed upon boards as to what sorts of assessments they are able to order? If there are no limitations, who is going to pay for this?

Mr. Daniel Soiseth: I can't answer who's going to pay for it, of course.

Hon. Paul Harold Macklin: But resourcing is a relevant part of this entire problem when we're dealing with federally defining the responsibility, and then trying to work with provincial authorities to in some way reach an accommodation where we can work together. I think some of these issues have been left off the table because there are still ongoing conversations and discussions at the FPT level to try to determine how we interrelate on a national basis, so we get proper resources to deal with these issues.

Can you tell me what you're suggesting here, in terms of wanting to broaden the definition? What sort of definition are you suggesting be there? What other assessments do you think would be appropriate to have on the agenda of assessments that a review board could order?

Mr. Daniel Soiseth: The difficulty with the particular amendment proposed is that it envisions situations where assessments could be ordered. As Mr. Bernt Walter points out in his letter of May 31, the situations posed in the amendments don't arise in British Columbia —I can't speak for other parts of the country. That amendment is really not going to change anything, and there aren't going to be any additional assessments in B.C. as a result of this particular amendment.

We do think their assessment power has to be broadened, for a couple of different reasons. I support Professor Manson's comment earlier that sometimes assessments come along that simply aren't very helpful. In my experience, some clients have been in hospitals for years and years. They've had the same psychiatrists for years and years, who write the same pro forma page-and-a-half risk assessment every year. They just don't get a real new risk assessment.

In a situation where the hospital, in our view, isn't fulfilling its duty of performing ongoing assessments, the review board should be able to redress that by ordering the hospital to conduct another assessment by another psychiatrist—a more detailed assessment, or something like that.

The Chair: Thank you.

Mr. Thompson is next, for three minutes.

Mr. Myron Thompson (Wild Rose, CPC): Thank you, and welcome to everyone.

I've been listening with great interest. Mr. Marceau pretty well covered one of the questions I was going to ask about victims, and so have others. That's always a major concern when you're dealing with justice, crime, and problems.

I'm not a lawyer, and I don't understand a lot of the technical stuff, but I was a principal of a high school for a number of years. In that particular school, we had two cases of schizophrenia in the young people. That was an eye-opener for me, because I thought it happened to older people; I didn't know it happened to kids. In both cases they were very violent episodes that took place—very frightening. Had it not been for fast feet and kids able to move quickly, one of the fellows would have certainly killed some people with his vehicle. As it was, he destroyed a lot of other vehicles and missed a kid, which was a blessing to all of us. That was a real eye-opener.

Then we had another case that was equally violent. They underwent treatment and eventually, after a few years, returned to the situation they were once in. They recognized what they had done, and were regretful and remorseful. But the onus was on the school to make absolutely certain that the medications required to continue this good process were in the hands of the school for an eight-hour or six-hour period. I thought all along that was putting a lot of onus on people who were there to educate kids. But the Charter of Rights and Freedoms came in, and you couldn't refuse to accept these people. To try to eliminate fear in the hearts of other students... It was a difficult time. So I can understand all of that.

I hope the day will come when they can get a cure. I don't know if they actually have a cure; I think it's treatment that must continue. That's probably true in so many of the cases. This is what worries me about what I think the professor said earlier—that so many people are incarcerated because of mental disorders, and we need to get them out. How can we be certain—I'm not talking about reoffending—the illness does not take charge of their actions once again and create a very dangerous situation?

I was shocked in the mid-1990s, when I travelled across the country to many maximum security penitentiaries, by the number of people they had behind double-cell doors. If they had to go in and do anything, it took at least six people to deal with any one of them because of their severe violence and strength—absolutely out of it. I was surprised by the huge number of them. So where do we draw the line? Where do we as legislators say we have to protect society? God bless those poor sick people, but we have to protect society.

If I'm the principal of the school, it's my job to protect the students. Where do individuals out there in the rest of the world, who maybe aren't as intelligent as lawyers and others who try to interpret legislation, who just know that something has to be done... Do you ever approach anything from that point of view? It's a frightening experience, and I'd like some response.

● (1655)

Prof. Allan Manson: Can I answer that, please?

Mr. Myron Thompson: Yes, you can.

Prof. Allan Manson: I think my comments were misunderstood. When I said that the Canadian Bar Association is concerned about the growing number of very sick people in jails, I wasn't suggesting that the response ought to be to release everyone to the community. What I was suggesting was that sick people ought to be in hospitals.

I've just come back from a research trip. Two weeks ago today, I was at Broadmoor in the United Kingdom, where they have the most difficult, most dangerous prisoners, but it's a hospital. I've been in those maximum security institutions, and the super maximum security institutions, and the regional treatment centres in our penitentiary system. They are not hospitals, they're jails. They're run with a penal culture and a penal ethos.

It was extraordinary to me the different feel inside Broadmoor. It has an extremely secure unit, but you're not always hearing the sound of the barriers every time you walk six feet. You're not seeing what we see at the regional treatment centre at Kingston Penitentiary. When a patient there refuses to take medication, they bring in the emergency response team, the Darth Vaders, six men, to make sure....

When I raised this with them a year and a half ago, and said I was outraged, they said, “You're making like it happens every day; it only happened 15 times last year.” I have that document in my briefcase, if you want to see it. I was shocked to find out that 15 times the Darth Vader teams were brought in.

You don't see that in a hospital. That's our point. We have to make some hard decisions about this very serious problem.

The schizophrenia group has raised a difficult question, that of compulsory treatment. I'm not here, on behalf of the Canadian Bar Association, to address that, but that's the kind of philosophical issue that needs to be addressed. Do we or do we not as a country, as a culture, accept compulsory? Do we or do we not accept the difference between punishment and a therapeutic response?

So I wasn't suggesting that doors be opened from jails for sick people. What I was asking is why are they in jails rather than in hospitals? If they have to be in a secure hospital because they're dangerous, that's tragic, but so be it. But it ought to be a hospital, not a jail.

● (1700)

Mr. Myron Thompson: Do we have any in Canada?

Prof. Allan Manson: Oh, yes; we have eleven in Ontario. The maximum security one is at Penetang. Do they have adequate resources? Do they have enough psychiatrists? Absolutely not. At Broadmoor they have 25 psychiatrists and 25 forensic psychologists on their staff. You go up to Penetang and see how many they have. They have professional health care workers who work very hard. It's a tough job. But you won't see 50 of them.

The Chair: Dr. Gray, a response to Mr. Thompson?

Dr. John Gray: I would like to congratulate you on that principle, on taking the right approach in that difficult situation. The right approach is that people need their medication when they're in that circumstance. They need other supports as well, but if they don't get the fundamental medications and get their brain chemistry right, then you will have problems.

You asked whether we have a cure. No, we don't have a cure, but we do have better medications probably than the ones involved in the cases you were involved in. It's a bit like diabetes, in the sense that for many of these illnesses you must take medications for the rest of your life. If Mr. Deighton takes medications, he's well; if he doesn't take medications, he will become ill.

The issues have been well put in terms of the distinction between prisons and hospitals. We want to keep mentally ill people out of prisons, out of courts. We have mental health courts being developed in some parts of the country, which I think is a very positive thing. In some of the forensic systems, they are working reasonably closely with the prisons, although not well enough. Some initiatives like that are very helpful.

The bottom line is that you have to have services. In terms of the legislation we've been talking about today, unless we have services to make it happen, it isn't going to happen.

The Chair: Thank you.

Monsieur Marceau?

Questions from the government side?

Mr. Thompson.

Mr. Myron Thompson: I'm still curious about something. I understand what you're talking about in terms of helping these people, but I don't know if some of these Kingston Penitentiary people who you're talking about can ever be helped. I don't know that, and neither does anybody in society know that. But I know one thing about society, having worked in the various places I have: there is a certain amount of fear about their personal safety.

I'm asking you, with input from people like you, what legislation could we put together on this Hill to best give people the security and safety that they feel they deserve? Maybe things have improved an awful lot since 1994 or 1995, when I was visiting these penitentiaries. It's been 10 years...

They haven't improved? Well, that frightens me. I know that these people need help. I hope these hospitals that you're talking about are very, very secure, because to transfer them to a hospital just doesn't make sense to me. Like, confinement just appears...

I'm an ordinary guy. I'm not the intelligent guy who runs around drawing up legislation and everything else. I'm the guy who lives on the street and packs his lunch and wonders why somebody who has committed a crime is free. Irrespective of the reason, why aren't they being cared for in some other manner?

God bless those boys who were affected by this disease, but fear lived in the hearts of the kids who were going there everyday: is anything like this going to happen again, and is it going to occur by either one of these individuals?

What do you do about that?

● (1705)

The Chair: Professor Manson.

Prof. Allan Manson: First, as I said before, there is a very unfortunate myth about the dangerousness of mentally disordered people. I think it behoves people like those in this room, and government officials, people with authority, not to generate fears unnecessarily. Fearmongering doesn't help anyone. I think Dr. Gray is quite right, there are a lot of responses therapeutically available for a lot of mental disorders.

Our point is simply that there needs to be a serious debate about why we have so many sick people in jail. Unless they're there for life, which most of them are not, they will be released and they will be released sick, untreated. I'm not here to say, here's the math, do this, do that. We're saying, how many sick people are in our penitentiaries and our prisons? Why don't we have better data on that? Are the boards doing what the Supreme Court directed them to do in the Winko case?

Let's get the relevant ministries—and I'm not saying they have to do it tomorrow, or next month—to collect the data. In the United Kingdom, every year you get a report called “Mentally Disordered Offenders in the Criminal Justice System”. It's about 30 pages long, and it gives you all the data you need to come to grips with what kinds of policy decisions ought to be made. We don't have that data in Canada. We haven't had that kind of philosophical and policy debate that really needs to be done if we accept the proposition that jail is not a good place for sick people.

Mr. Myron Thompson: You're telling me the treatment's not there?

Prof. Allan Manson: I'm telling you it's a complex issue.

Mr. Myron Thompson: The treatment's not available in jail, that's what you're telling me.

Prof. Allan Manson: For the most part, no.

Mr. Myron Thompson: Then it appears to me that it's our job to see to it that it is. If these are sick people who need to be treated, then why isn't the treatment occurring?

I'll ask the question and just leave it at that, because I don't know why. I can't give you an answer, and I'm sure you can't give me an answer.

The Chair: A brief response, Mr. Soiseth.

Mr. Daniel Soiseth: Perhaps I could add, on that very same point, that we're still talking about improving public safety when we're talking about treatment. The comments you heard today might be seen as things that might have some potential ramifications for the provincial governments, and might be seen as costly, or this or that. But everything we talked about today are the sorts of things, I think, that are likely to increase public safety. It's not necessarily a tug-of-war between public safety and proper treatment and so on. They work together.

The Chair: Thank you.

Ms. Neville, do you have a question?

Ms. Anita Neville (Winnipeg South Centre, Lib.): I do, thank you.

Thanks to all of you for appearing here today. I was not part of the first go-round of this bill, so I'm learning. I've found the discussion this afternoon fascinating. I have a couple of quick questions.

First, I understand that this is complex, depending on where a mentally ill person is, but can you comment on recidivism among the mentally ill?

Second, to Mrs. Deighton, I listened to your comments about victim impact and how it affected your family. Can you comment on when a victim impact statement before the board might be more effective than a written one? Are there instances when it could be helpful?

The Chair: Professor Manson, do you have the information?

Prof. Allan Manson: I will give you some data about recidivism, but I can't point to any from Canada. I don't know that it exists.

Going back to the U.K. *Statistics of mentally disordered offenders 2002*, table 17 gives the re-conviction rates of what are called "restricted patients". These are patients who were found to be suffering from a mental disorder and sent to hospital rather than jail when they were convicted. For those who were discharged, and this goes back to 1985, the persons re-convicted since first release, the biggest number is seven for those released in 1992. For the most part, it's one or two offences each year, including very grave offences.

I didn't prepare to talk about the recidivism rate. I'd have to look through this document. It is very small. These are people who spent their sentence, or longer or less, depending on the kind of order in a mental health facility, even though it might be a secure one—they have maximum security, medium, etc.—who received treatment, and who eventually were conditionally discharged into the community either by the Home Office or the Mental Health Tribunal and later given probably an absolute... So these are people in the community.

I can refer you to this document. It's published by the Home Office and is entitled *Statistics of mentally disordered offenders, 2002, England and Wales*. If you look at table 17, there are notes that accompany it that will give you the percentages. The recidivism rates are quite small and support the view that it is a myth that mentally disordered people are exceptionally dangerous. They are not.

● (1710)

The Chair: Thank you.

Ms. Deighton, you were asked for a reaction by Ms. Neville.

Ms. Sheila Deighton: In terms of the victim impact statements, I was at my husband's board hearings annually and often was given the opportunity to make a statement. For myself, I found it was an opportunity perhaps to educate members of the board as to the struggles we endured as a family in order to try to get treatment for my husband and my son who died. He was displaying symptoms of illness. But under our Ontario Mental Health Act, even though he had made a suicide attempt, a serious one, he was not considered certifiable. We struggled as a family with two individuals who were seriously ill and untreated. Why? Because of the legislation governing care.

I found it therapeutic for myself because the support we had gotten from the forensic program at the Royal Ottawa Hospital had provided me the education. That's why I say it's very important for the victim to have education so that they can try to understand how this happened. Why is someone who is so ill living among us in our community? How can somebody go untreated today, at this time? So for myself I found it therapeutic, and in fact I think for my husband it was of help to him because he realized that even though he was seeing a psychiatrist, he was not being treated properly.

On the other hand, I've heard of situations where the victim is not connected to the accused and there is not that education, there is not that understanding. They really don't understand the complexities of the illness and how someone can do this. I have to stress that there would need to be some education done with those victims to help them have some closure as well, because I don't think they necessarily get that at a hearing, which is very structured.

Ms. Anita Neville: Thank you.

The Chair: Thank you.

Are there any further questions?

Mr. Macklin.

Hon. Paul Harold Macklin: I have a couple of small points, Mr. Chairman. First I'd like to ask Mr. Soiseth something.

I'm informed that the B.C. Court of Appeal, in a case called, I believe, Mazzei, indicated that the review board itself cannot bind a hospital. Is that a fair comment?

Mr. Daniel Soiseth: Yes.

Hon. Paul Harold Macklin: So that whole question is wide open then in terms of where we go with that. I misunderstood. I thought you basically said that in British Columbia it could be ordered.

Mr. Daniel Soiseth: No, I'm sorry, I didn't.

Hon. Paul Harold Macklin: So that's a wide open question.

Secondly, with respect to Ms. Letman, you made a distinction in referring to NCR and unfit to stand trial in terms of saying that an absolute discharge didn't apply in both cases, but a stay would apply in an unfit, right?

Mrs. Carol Letman: Yes.

● (1715)

Hon. Paul Harold Macklin: Why do we make the distinction between an absolute discharge and a stay? Is there a major concern you have as to why the stay isn't at a level that you feel is appropriate, that the absolute discharge is something that goes beyond a stay? I just want to know, what is the substantive difference that you're trying to make between the absolute discharge and the stay?

Mrs. Carol Letman: There isn't a substantive difference, other than by allowing the court to make it at first instance. For example, after a finding of unfitness a judge can make the determination in certain circumstances that the individual is permanently unfit. Given that a judge can make a disposition, or a review board can make a disposition, if a judge in the case of someone who is NCR makes an absolute discharge because the individual is not a significant risk to the community, that ends the process. The person never has to go to the review board. I'm suggesting that the same could apply if the individual is unfit to in effect keep it out of the hands of the review board in those circumstances. Procedurally there really is no difference in the sense of distinguishing between the absolute discharge or the stay proceedings.

My larger concern was this whole protocol that's been set up, because I think it's extremely complex the way it's been done. And the previous committee and the Supreme Court in Demers both seem to be advocating that the court be able to grant an absolute discharge, which I think would be a shorter and faster method than going through this complex procedure.

Prof. Allan Manson: I have to apologize, but I have to catch a train.

The Chair: We'll be concluding, in any event.

Thank you very much to all of our witnesses, including Sheila Deighton, who has come here today.

I will suspend for five minutes. I would ask the committee members to stay with us while our witnesses take their leave and we'll go over future business very briefly.

[*Proceedings continue in camera*]

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