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Chair

The Honourable Paul DeVillers

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

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● (1620)

[*English*]

The Chair (Hon. Paul DeVillers (Simcoe North, Lib.)): I call the meeting to order.

We have witnesses before us. First, from the Psychiatric Patient Advocate Office we have Mr. Riis and Mr. Simpson, and from the Empowerment Council, Ms. Chambers.

We would ask you to make a presentation in approximately 10 minutes. That would allow us then to go to members for questions.

Perhaps the Psychiatric Patient Advocate Office would want to go first.

Who will be doing the presentation, or are you going to share it?

You will share it. Okay, go ahead.

Mr. David Simpson (Program Manager, Ministry of Health and Long-Term Care (Ontario), Psychiatric Patient Advocate Office): Good afternoon, Mr. Chair and members of the committee. I'd like to thank you for the opportunity today to meet with you to talk about this very important bill.

My name is David Simpson. I'm the program manager of the Psychiatric Patient Advocate Office. With me is Nils Riis, who is legal counsel for the Psychiatric Patient Advocate Office.

I want to just give you a quick history about the Psychiatric Patient Advocate Office, and then I'll turn it over to Nils.

The Psychiatric Patient Advocate Office was established in 1983 in Ontario to protect the legal and civil rights of in-patients in the 10 current and former provincial psychiatric hospitals. Since that time our mandate has expanded to include the provision of rights advice in 50 of 55 Schedule 1 or general hospitals in Ontario that have mental health units. That means we're doing rights advice to approximately 20,000 clients per year and providing service to 4,500 individual instructed and non-instructed advocacy issues and about 75 systemic advocacy issues across the province of Ontario.

The forensic programs in Ontario are predominantly located in the facilities where we provide service. That's both our interest in this bill and our expertise, that our 12 advocates for Ontario do a lot of work with and on behalf of forensic clients.

We have an interest in the work of the committee for a couple of reasons. The first is to advance the legal and civil rights of our clients. The second is to ensure that the forensic system has an empowerment and recovery focus to assist clients in their reintegration into the community, that there's an appropriate balance between care and treatment and safety and security, and that there is a balance between public interest and client interest; to combat stigma and discrimination, because often our clients will say that once they are forensic clients, they are always forensic clients—and that forensic label can have devastating consequences for our clients in terms of being reintegrated into the community—and last of all, to remind the system that our clients are patients, not inmates, and are sent to a hospital for care and treatment, not sent to a correctional facility for incarceration and punishment. They're sent to hospital because of their illness.

Our last interest in this is to make sure the forensic system is accountable to the people it provides service to.

I'll turn it over to Nils, who will go through some of the points in our submission.

Mr. Nils Riis (Legal Counsel, Ministry of Health and Long-Term Care (Ontario), Psychiatric Patient Advocate Office): Thank you, David.

Mr. Chair, committee members, thank you very much for this opportunity.

Because I don't have much time, I'm going to divide my presentation into four parts. In the first part I'll talk about guidelines and enforcement; in the second part, about victim impact statements; in the third part, about annual reviews and mandatory attendance at hearings; and finally, I'd like to talk briefly about treatment orders.

Many of our clients have complained to us that review boards will have a disposition that authorizes placement in the community—for example, where there's 12-hour supervision—but because of a lack of community resources, they will only have eight-hour supervision in that particular community. What happens is the client will languish in hospital because they don't have the appropriate resources in the community. Not only is that costly to the system, but it violates the principles of the code that clients should be in the least onerous and least restrictive environment.

They also complain that a lot of emphasis is placed on their index offence, which could have happened ten or twenty years ago, and also on behaviours that stem from incarceration, from detention. Clients complain it's very hard to be perfect. If you get upset once, it's on your permanent record, and at your next annual review it's going to come up. Rather than focusing on current clinical presentation and current level of risk, people are focused on the wrong things.

We are recommending, first of all, that timelines be introduced into disposition orders, and that review boards be given power to enforce their dispositions, because right now they don't have that power. We also recommend that dangerousness be defined in the code specifically to exclude undesirable behaviour or inappropriate behaviour.

Another concern clients have voiced is that if there is a significant restriction on their liberties for seven days, under section 672.56 of the code hospitals are supposed to advise the review board that there's been a significant restriction, and there needs to be a hearing. Not only do facilities fail to do that; some facilities refuse to do it. What can the board do? It doesn't have the power to force facilities to comply with the law, so clients languish in a state of increased detention.

We recommend that the code clarify the phrase “restriction on liberty“ so that facilities know when they have to advise the board that they need a hearing, and again that the boards be given power in the code to enforce their dispositions.

We also recommend that the code specify that a forensic client's rights are not altered unless specifically stated in the disposition order or in the Criminal Code, because for many of them, their freedom of speech is restricted, their freedom of employment is restricted, their freedom of communication is restricted, without any clear guideline as to whether this constitutes legal behaviour.

I know victim impact statements—I'm on number two now—have been discussed at length. The PPAO respects that victims deserve recognition and deserve to have a voice; however, we emphasize this has to be done in the appropriate forum. Review board hearings are not the appropriate forum for this sort of statement to be made. Historically, victim impact statements are used once a person has been found guilty and is being sentenced. This process doesn't take place with our clients. They are not found guilty, and they are considered patients as opposed to criminals.

We think the provincial, federal, and territorial working group could discuss an appropriate forum for victims to be recognized and to have their voices heard, but not in a system designed for rehabilitation and reintegration.

The PPAO recommends that the clauses relating to permitting victim impact statements be repealed and that a more appropriate forum be found for those people.

Concerning the recommendation that some clients only have hearings every 24 months, the PPAO does not feel that is appropriate. People whose liberties have been severely restricted, we feel, are entitled to annual reviews, first of all to make sure that the disposition order is being followed, and second, to make sure they are living in the least restrictive and least onerous environment.

● (1625)

The other thing that happens with 24-month reviews is that their use appears to put a presumption of dangerousness on the accused, which the Supreme Court of Canada has clearly articulated is inappropriate.

The PPAO is also opposed to compelling the attendance of clients before the board. Many clients do not wish to participate and would rather send a lawyer on their behalf; others would like to attend but not give evidence. We feel the proposed change is somewhat paternalistic and we ask the committee to recommend that forensic patients retain the right to choose how they wish to participate in these hearings.

Finally, turning to treatment orders, there is no more important principle in law and in medicine than treatment with consent. I believe Mr. Walter, the chair of the B.C. review board, indicated that if you're in B.C. and are a forensic client, you are deemed to consent to treatment. However, if you are in Ontario, you have totally different rights that comply with the charter. That sort of variation across Canada not only is inappropriate, but we feel it may violate the charter.

We ask the committee to recommend the treatment disposition section in the code, section 672.58, be repealed and that a model of consent-based treatment be adopted similar to the law as it exists in Ontario today.

We thank you for your willingness to hear our submissions, and we look forward to any questions from the committee. Thank you.

● (1630)

The Chair: Thank you very much.

Ms. Chambers.

Mrs. Jennifer Chambers (Coordinator, Co-Chair, Mental Health Legal Advocacy Coalition, Empowerment Council): In Canada, as in the rest of the world, people considered mentally disordered are subject to extreme social prejudice and scorn. Appalling assumptions go unchallenged. “Dangerous” and “lunatic” are considered synonymous, and the people most feared and despised are the so-called criminally insane.

Instead of providing education and leadership to address the public's ill-founded fears, legislators all too often adopt and even inflame those fears—for example, naming legislation that affects thousands of people in the mental health system after a man who was killed by a single mentally disturbed individual.

The U.S. National Council on Disability has concluded that one of the reasons public policy concerning psychiatric disability is so different from that concerning other disabilities is the systematic exclusion of people with psychiatric disabilities from policy-making. With that in mind, we'd like to thank you very much for inviting us here today.

The Empowerment Council and the Mental Health Legal AdvocacyCoalition represent people with direct experience in the psychiatric system, including the forensic mental health system. Our members have intervened in four Supreme Court of Canada cases affecting the rights of people in the psychiatric system: Winko,Pinet, Tulikorpi, and Starson.

The report that you have is co-authored by me and Randy Pritchard of the Mental Health Legal Advocacy Coalition.

In our brief we outline our positions on the proposed amendments. In a separate section we detail our non-legislative recommendations, citing research and experience supporting our recommendations on the amendments. So we beseech you to read both of those sections.

In the appendix you'll find the preliminary results of the only survey we know of that asks people in the forensic system what they themselves think of the system. That was a project funded by the court challenges program that the Mental Health Legal Advocacy Coalition is conducting.

A number of amendments seem to be based on misconceptions. For that reason, we offer the following information, with the corresponding evidence offered in our submission.

Mentally disordered people are no more violent than other members of the same community. Most people in the forensic system have not committed acts causing bodily harm. For statistics, I refer you to the Centre for Addiction and Mental Health's 2002 submission to this committee. In fact, even for those registered as having caused physical harm it is a greatly exaggerated number where, for example, a person spitting on someone is recorded as having assaulted them.

Mentally disordered people of all kinds do recover. A significant percentage can recover without psychiatric medications. The research evidence is supplied in our brief.

Evidence has shown that recidivism is less likely for mentally disordered offenders than non-mentally-disordered offenders. Evidence shows that, for offenders at lowest risk, supervision, detention, and treatment actually increase the risk of violence.

The majority of the time, being found NCR or unfit generally has a worse result on the person's liberty interests than being found guilty of a crime. People have a great misconception that this means getting off somehow, when in fact the experience of penalty is usually far worse.

A large percentage of people in the forensic system are survivors of abuse, and many people report abuse in the forensic system, reports that are confirmed by others.

Our position on the amendments is that we recommend an additional reason for ordering an assessment, which is to seek reasons to discharge absolutely in order to better comply with Winko. We oppose the withholding of assessment reports from the individual concerned, as well as the already existing potential exclusion of individuals from their own disposition hearings. A therapeutic relationship is impossible under such circumstances.

It is also critically important that the accused be allowed to see and therefore correct errors in the report. Errors of great significance are not unusual. For example, someone was found delusional because he thought he was magic. In fact, all he had ever said to the psychiatrist was that he's able to perform a few magic tricks.

We also know of cases in which, for example, a person said he was judged psychotic because he said he was a police informant, when it later turned out that he was in fact a police informant.

Victim impact statements have no place in disposition hearings, which are a non-adversarial venue where the Supreme Court has been clear that the NCR-accused is not to be punished. If someone had a heart attack that resulted in their driving their vehicle into a pedestrian, they would not be considered criminally responsible for the commission of that act, because there was no intent to commit the crime. Would it be appropriate for the victim suffering to have that reread to them on an annual basis? The person is not supposed to be punished. What purpose would that serve?

● (1635)

The same is true of people found NCR. There was no criminal intent; that's what NCR means. Victims suffer and want acknowledgement of that suffering. That is understandable and it should happen, but not before a body that is deciding what should happen to someone who is not criminally responsible.

We do not agree with giving anybody the power to extend time between review board hearings. It is simply not possible to predict an individual's state of mind two years into the future, and current state of mind is what is supposed to be considered when determining detention, supervision, or discharge.

Setting criteria so broad as “likely to inflict severe psychological damage” creates a standard that is both excessive and arbitrary and has no possible foundation in evidence. This section strips away procedural safeguards that, taken in their totality, protected the charter rights of NCR accused.

We concur with the Supreme Court and this committee's recommendation to grant the power to absolutely discharge an unfit accused. We commend you for your attention to the plight of the person who is found unfit, whose liberty is lost for a lifetime simply for an inability to comprehend the judicial process.

The current forensic system does not offer what it should in a just society such as ours. People should not have to live in what has been described as a "regime of state-mandated segregation and degradation". It is worth remembering that with great ill fortune, any of us could be there.

Thank you.

The Chair: Thank you very much, Ms. Chambers.

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

Mr. Warawa.

Mr. Mark Warawa (Langley, CPC): Thank you, Mr. Chairman.

Mr. Riis, you shared some interesting information here. I have a question regarding the review boards. How often do you find yourself attending or involved with review board hearings?

Mr. Nils Riis: At present, because of my position, it would be a conflict of interest for me to present before review boards, but I have in the past.

Mr. Mark Warawa: You have in the past.

Mr. Nils Riis: Yes.

Mr. Mark Warawa: Okay, and it would have been fairly often in the past?

Mr. Nils Riis: It would have been five or six times.

Mr. Mark Warawa: Of those five or six times, how many times did you have a victim impact statement?

Mr. Nils Riis: None.

Mr. Mark Warawa: Have any of the witnesses today been involved with a victim impact statement? Yet you all believe they're not valuable, based on what criteria?

Mr. Nils Riis: Actually, I believe they are valuable; however, what I wanted to emphasize is that they're only valuable if they are provided in the appropriate forum. With all due respect, I believe review board hearings are not the appropriate forum for the victim and are not the appropriate forum for the NCR accused to have to listen to it.

I wish we could offer some other ideas, but I believe that's what the working group could sit down, discuss, and figure out—what is the best place for these to take place.

Mrs. Jennifer Chambers: If I may answer, the victim impact statements are not some type of restorative justice. They're used generally in the criminal process as part of sentencing—which isn't appropriate in a process in which it has been made quite clear that the accused is not supposed to be punished.

Mr. Mark Warawa: Ms. Chambers, you're with mental health from Ontario, is that correct?

Mrs. Jennifer Chambers: Yes.

Mr. Mark Warawa: What percentage of victims would have a mental disorder as a result of being a victim of an NCR accused?

Mrs. Jennifer Chambers: There's a broad interpretation of mental disorder. I think you'll find that when properly examined, anyone can qualify as having a mental disorder. So I couldn't offer that information.

I can tell you that in some of the cases I mentioned, the victims included people who saw men urinating out of doors, who five years ago received a threat; and that the majority of people in the forensic psychiatric system have not experienced bodily harm. So I think it's important to keep that in mind when talking about the population as a whole.

Mr. Mark Warawa: The next question is on resources. What percentage of resources are focused on the NCR accused as opposed to the victims?

You're all with the province of Ontario—is that correct?—so I guess it would be from an Ontario perspective.

● (1640)

Mrs. Jennifer Chambers: I'm not involved in resource allocation, but I'm sure it's an unequal distribution. I think there should be more money going to the victims. In fact, the money that goes to the NCR accused—something we pointed out in our submission—is wrongfully allocated. It's not sensibly allocated in a way that would have the best results for both prevention and recovery.

Mr. Mark Warawa: Okay.

Mr. Nils Riis: I unfortunately don't have access to any information about resource allocation either. I think another expert would be better able to answer that.

Mr. Mark Warawa: You're here today as an advocate for the forensic clients?

Mr. Nils Riis: Yes.

Mr. Mark Warawa: Thank you.

Mr. David Simpson: If I could just add something to what Nils has said here, our patient advocates are independent from the facilities in which we work. We're also a partisan advocate for the client. Our job is to protect the client in the system.

Do we provide service to the victims? No, we don't. Our job is actually to provide service to in-patients of current and divested provincial psychiatric hospitals who find themselves in our facilities and who have had their legal status changed or are potentially in the forensic system, including the Oak Ridge site of the Penetanguishene mental health centre. We have two advocates who provide service at Penetanguishene, and they do provide service to the clients at Oak Ridge, which is Ontario's only maximum-secured facility.

Mrs. Jennifer Chambers: I can offer a resource-related question.

It costs over $500 a day to keep someone in the forensic system. When you consider some of the trivial offences that keep people in there for five or six years, something they would have gotten time served for, that is money that certainly could be better spent in many different ways.

Mr. Mark Warawa: Thank you.

The Chair: Thank you, Mr. Warawa.

Mr. Comartin, do you have a question?

Mr. Joe Comartin (Windsor—Tecumseh, NDP): Mr. Riis, I'm not clear if this is a typo or if this is a different way, but I assume your second last recommendation on the last page is the one that corresponds with paragraph 6 on page 5. You used differently terminology. In one you used a model of consent-based treatment, and in the other you used a model of substitute decision-making.

Are you equating those two phrases?

Mr. Nils Riis: Yes. The way the legislation in Ontario is drafted, those are intertwined in the sense that the first principle is that you cannot treat without consent. In Ontario everyone is deemed capable of making treatment decisions. If a physician finds, after an assessment, that you are not capable, the physician still needs consent, so they have to go to a substitute decision-maker. That decision-maker has to first consider any prior capable wishes that the incapable person had. If they have none that apply in the circumstances, they have to go to what's in the person's best interest. This is all laid out quite categorically in Ontario's Health Care Consent Act. After going through that process, the substitute decision-maker will give or withhold consent to treatment, based on the principles outlined in the law.

What is difficult for a lot of people to grasp is that some substitute decision-makers will go through that process: Is there a prior capable wish—no. What is in the person's best interest? In some cases, treatment that does not involve psychiatric medication may be what is actually in the person's best interest. That will be the consent given to the physician, and the physician is obligated to act on that consent.

Mr. Joe Comartin: Who normally plays that role of substitute decision-maker?

Mr. Nils Riis: The law has a list of people, in order, who should make those decisions. Some people will refuse to make those decisions.

Mr. Joe Comartin: I am from Ontario, but for those people who aren't, those tend to be family-related individuals.

Mr. Nils Riis: For instance, in terms of family, the first person the physician would turn to would be a spouse. Sometimes the spouse is tired of dealing with the illness, and they'll say I'd rather give that responsibility—which is a very serious responsibility—to the son or daughter. If they're okay with it, that'll be documented, and the physician will go to that family member to get consent for all treatment until the patient, perhaps, regains capacity and can make their own decisions again.

All we're asking for is that considering this legislation affects all Canadians, regardless of where they live, there should be consistent policies with respect to treatment and making sure that fundamental human rights are respected instead of imposing treatment on people—who may be capable—against their will.

● (1645)

Mr. Joe Comartin: Which is the B.C. model.

Mr. Nils Riis: Yes.

Mr. David Simpson: If I could just add to that, if the client doesn't have anybody on the list who can act as their substitute decision-maker, then that responsibility goes over to the public guardian and trustee, and they have a substitute decisions unit that would then step in and become the person's substitute decision-maker.

Mr. Joe Comartin: But if there is a personal care power of attorney—

Mr. Nils Riis: That would trump it. That would be the first thing you'd look to, yes.

Mr. Joe Comartin: Thank you, Mr. Chair.

The Chair: Thank you, Mr. Comartin.

Mr. Macklin.

Hon. Paul Harold Macklin (Northumberland—Quinte West, Lib.): Thank you, Mr. Chair.

I wanted to go back a moment just to get your testimony into perspective. How many of you are there in this psychiatric patient advocate office?

Mr. David Simpson: We have actually two programs. In the program that provides service in the 10 current and divested provincial psychiatric hospitals, we have a staff of about 25 across the province: 12 advocates, 10 rights advisers, and the rest are secretaries.

In the community-based rights advice program—this is where we go in and provide rights advice in general hospitals that have mental health units—we probably have about 70 part-time, on-call staff. They carry a pager, and we'll say a patient at this hospital needs to see you; a patient at that hospital needs to see you. We have about 70 people in that category who provide service in the other 50 hospitals.

So it's a very small staff considering that we have a provincial mandate.

Hon. Paul Harold Macklin: Again, so I can understand how these recommendations were arrived at, when you prepared your brief for us, how did you arrive at the conclusions that you've placed in your brief? Did you canvass your membership? How did this happen?

Mr. David Simpson: We have advocates in each of the forensic programs across the province who provide service in each of the forensic programs. So the advocates are continually talking to me, as the program manager, about the issues they're seeing, the trends they're seeing, the environmental scanning they're seeing—the issues, in fact, that the clients are bringing to them for assistance with.

So we're fairly close, as the partisan advocate for our clients, to be getting this information first-hand. And I don't know if you've looked at our website, but we also have done a lot of systemic advocacy work about making change at a systems level to improve the quality of care and quality of life of all of our clients, not just forensic clients.

One of the things we see in the forensic system is the lack of a hopeful future orientation that tomorrow is going to be better than today. A lot of our clients just feel they're going to be there for an indefinite period of time, and they're not getting much out of the experience. The fact that their bedroom door has bars on it makes it seem like they're in a correctional facility and not a hospital. Those are some of the issues we hear about frequently.

The other thing we've done in the last few years is we've also had standing at inquests where forensic clients have died—or attempted to get standing, because we're not always successful—so that we can bring up some of those issues that clients are talking to us about.

Hon. Paul Harold Macklin: That, then, brings me back to the victim impact statement recommendation that you have within your proposal before us. You suggest there may be a more appropriate forum for such statements, yet we have witnesses...or at least evidence before us that suggests that it's very important for certain victims to be there and have an opportunity to appear before a review board and make their case as to why, as they see it, the individual ought to be retained within the system and not given freedom outside of the system.

If that's the case, if we have a strong feeling that this should be there within this system, what method would you suggest? Are you suggesting possibly that we consider that the individual who is appearing before the board on their own behalf in a hearing be in some way screened or protected from the person, or should the evidence be given separately from the person—the patient, in your terminology?

How do you see that this could happen in the context of a review board hearing about the situations that resulted from this patient's behaviour?

● (1650)

Mr. Nils Riis: I'd like to ask the committee to go back to those and review the testimony of Mr. Walter from the B.C. review board. We're basically taking a similar position, but taking it a baby step further. If I understand Mr. Walter's evidence properly, he failed to see how these statements would add to the proceeding beyond the first year, and I believe that was his position.

We fail to see how they will add at all, because the review board looks at things more in a futuristic component as opposed to a historical component, and they're there to look at what the person's clinical condition is today: Do they constitute a significant risk to public safety? If they do, what is the least onerous and least restrictive environment in which to place them? That is the sole purpose of the review board.

Victim impact statements would tend to divert the board's interest from what is relevant and cogent and in the code to other things that may not be of importance to the board. Not only do we think it may be very untherapeutic for our clients, it could potentially be untherapeutic for the witnesses who may be misled about what they may get out of this process. There's controversy as to whether victim impact statements are effective in the criminal justice setting where people are criminally responsible—they knew what they did. I know there's social science evidence that questions whether victims get enough out of that process.

Taking it into this arena that is fundamentally different to the criminal justice system, we fail to see how it would be effective for anyone, and it's in that spirit that we recommend an alternative forum. We didn't have much time to prepare these submissions given the late notice, but we're confident the working group could come up with something.

Mr. David Simpson: Perhaps I can just add to that too. Many of our clients in fact at the time they're found unfit or NCR are actually at the low point of their illness, and that is why the court in its wisdom has said this person requires hospitalization versus incarceration.

Many of the families that talk to us about their loved one being now in the forensic system talk to us about their being victims too. How many times did we try to get this person help? How many times did they get turned away from the emergency room? How many times did we approach the community saying we need help as a family? Nothing came through, and then the person goes out and commits a crime, is found NCR or unfit, and ends up in this system with long-term consequences for them and the family.

I was at a forensic conference in October in London where three families came forward and said they wanted to talk to me about their experience with the forensic mental health system, and it was absolutely heart-wrenching, because here they are now with their sons in their early twenties who are probably going to remain in the system for an extended period of time.

I don't think we're saying to exclude victims from the process. The crown attorney is there to usually make the argument about why the person should be detained in the long term. I guess what we're saying is that we don't have the answer about where that should happen. But again, many of our clients have done these things at the low point of their illness, and then every year for the next *x*number of years for them to be reminded of that as they start to get well and start to focus on recovery and reintegration, the potential for a therapeutic setback is very great.

● (1655)

Hon. Paul Harold Macklin: But if we assume for the moment that some evidence we hear would lead us to believe there is some value in victim impact statements, can you give us any concrete advice, as advocates for the patients, as to how we ought to have that introduced in a review board hearing? We're not really discussing other venues. How do we do it within that hearing format?

Mr. David Simpson: I'll let the lawyer answer that.

Mrs. Jennifer Chambers: What would be the purpose?

Hon. Paul Harold Macklin: Well, we've heard purposes. What you're advocating is exclusion. We would like to hear, or at least I would like to hear, how could we do it in a way that would, from your point of advocacy, meet your needs and yet allow us to do that.

Mrs. Jennifer Chambers: I'm asking about the purpose because I think it results in different answers. I think there's never been a restorative justice approach taken, for example, in the forensic system. That wouldn't be the right approach to take in many cases, but there are some cases in which it might be an approach that could benefit the victim and the accused, as restorative justice does.

Hon. Paul Harold Macklin: Do you think, therefore, we should have, shall we say, some limits as to where a victim impact statement could go if it had a restorative tone to it?

Mrs. Jennifer Chambers: I don't think we should confuse the two. I think they're very different processes. Both people have to consent to restorative justice. I don't think there is a way that victim impact statements are justifiable at the review board because the victim can't possibly know the person's current state of mind. The review board is not there for the purpose of healing the victim. It's there for the purpose of evaluating the accused, who is not guilty of a crime, and evaluating their current state of mind. I think there need to be far more services in our society for victims. Many of the people who entered the forensic system were victims themselves and could have used some help also.

The Chair: Thank you, Mr. Macklin.

Are there any further questions?

Mr. Comartin, and Mr. Warawa next.

Mr. Joe Comartin: I'd like to follow this up, because I think Mr. Macklin is struggling with the same thing as I am. I actually can see occasions where a victim impact statement would have some benefit. What if we were only to use them.... We've heard some evidence that the victims rarely come, but for those who want to, what if we had a two-step system? At the stage where in fact the board was seriously considering allowing the person to leave the institution, then at that stage the victim impact statement would be allowed.

I'm going to give you the fact situation that I'm dealing with, because it's one that came out of my home town. There was ongoing contact. I don't think that's unusual, Ms. Chambers. I've heard a number of cases over the years where the victim was a family member and the accused continued to have contact with that victim because of the blood relationship, the family relationship. They have ongoing contact, ongoing knowledge of the person, ongoing knowledge of what it's going to mean when that person gets out of custody. That was the situation in Windsor recently in the last year or so. The siblings of the accused who had killed the father were quite concerned and were very much involved. The victim impact statements in that sense did have some impact at the level of the decision-making because he was getting close to the point where he was going to be released.

I guess the comment I would like to have from you, if you have any, is would you consider that it would be appropriate in those circumstances with a two-step process? I think the last thing we need is for victims to be constantly showing up at hearings and then having them adjourned over to the next year and spend 20 years coming back and back out of a sense of obligation—they have to do it. Would a two-step have any merit?

Mr. David Simpson: I won't answer the question directly, but just state that the Ontario review board process is an open process. When you look at some of the cases you've just talked about, they ended up being splashed across the front page of *The Windsor Star* day after day, both the lead-up to the annual Ontario review board hearing and then in that period until the decision actually came from the board. That's difficult for a family too, because once the story is out there, every detail about their life and everything that's discussed at that hearing potentially the media may put it in print, which has happened in your riding a couple of times. That's really tough on the family too because they don't get a sense of closure and year after year these same details are trotted out.

We have other cases where victims have picketed out front of an Ontario review board hearing, or the facility where it's being held, because of the circumstances. There are other situations where an Ontario review board, because such a large crowd has shown up to hear the evidence, has actually had to move it to an auditorium-style room where several hundred people can be in attendance. There is a process, and as I say, the crown attorney's office is there to argue why this person should be detained based on the evidence, based on the prognosis, based on their current treatment, and based on their progress. Some of these things are already in place.

Does the two-tiered thing work? I don't know.

● (1700)

Mr. Nils Riis: Mr. Comartin, one example that I would be concerned about in a two-step process is when, in the first example, there's no victim who wants to take part in this process.

Mr. Joe Comartin: Then I wouldn't advise it.

Mr. Nils Riis: What would happen in that case is that the NCR accused would go to the hearing. The Crown would be there, the hospital would be there, and they would present their case to the board. They would be complying with the relevant sections of the Criminal Code. What's their clinical presentation today? Are they a significant risk? Where's the best place to put them?

It's a very complicated process. The board comes up with the disposition that they've complied with the test they have been asked to do under the Criminal Code, and this is where the person should be for the next 12 months.

My concern is that in a two-part step, in a two-part test or system, that's the rational way in which the system should work. If a victim impact statement is introduced after the board has made that determination—

Mr. Joe Comartin: It's not the scenario that I would see happening. On a preliminary basis, the board knows the recommendation is coming from the hospital and the experts. Then there would be a preliminary determination made. This one appears as if there's a reasonable chance that we're going to do that, so that's the only test we'd have to meet. It would be preliminary, before the hearing. At the time of the hearing, the victim would then be allowed to be present and provide a statement.

Mr. Nils Riis: My scenario still doesn't change, because in that scenario, the rational thing would be to have this person housed in this place and in this community, if there was no victim involved. By introducing the victim impact statement, instead of putting the person where they should, to maximize rehabilitation and to maximize reintegration into society, they may be brought back a step because of the victim impact statement. Something that happened 10 years ago, or maybe 20 years ago, has no bearing on the clinical presentation today.

Mr. Joe Comartin: The reason certainly has a bearing on the victim.

Mr. Nils Riis: It absolutely does. With all respect, I'm trying very hard not to discount what victims go through. All I'm saying is that I think the introduction of that will distort the entire process to the point where it may be unconstitutional. Review boards won't be complying with the legislation and the intended purpose of the mental disorder provisions of the Criminal Code.

The Chair: Thank you, Mr. Comartin.

Mr. Moore, and then Mr. Maloney.

Mr. Rob Moore (Fundy Royal, CPC): I guess I've been listening to your testimony and trying to balance things. It sounds very clinical. I know that's part of your job. You talk about prognosis and treatment and progress.

The victim impact statement has been kind of the focus of discussion and questions, but I guess I'm not convinced by your arguments, and I want to go back to it. What's missing a bit is that we're taking away the humanity. By excluding victims, we would be excluding the humanity of what has happened in a situation.

I note that you've gone to lengths to distinguish the difference between when someone is NCR versus a criminal process. I understand that, and I understand that those are different processes. But to my mind, to a victim it's the same scenario. I'd be interested in getting your feedback on that. I just can't see the victim being as concerned whether someone, once that determination is made, is NCR, or whether they go through the criminal process, when they appear as a witness; they have been victimized.

You've mentioned, Ms. Chambers, that there are trivial cases. I think we all recognize that. But there are also some very serious cases where someone has been traumatized. Those can stick with people for the rest of their lives. I recognize what you're saying about an impact statement concerning something that happened 10 or 20 years ago, but for the victim this is an ongoing thing.

I note the guidelines here from Winko: protection of the public from dangerous persons, the mental state of the accused, the reintegration of the accused into society, and the other needs of the accused. So there's a lot of focus on the accused there, but as to protection of the public....

I think a person who could give great input on the danger or the threat this person poses, or at least posed at one time, is the victim. By excluding the victim, I think we're taking away a bit of the humanity. In our system, one of the overriding factors, whether it's through the criminal justice system or through this system, is that protection of society is paramount. And that's recognized in that decision. But we have to know what we're protecting society from. Only by listening to the victim do we know what this person was capable of.

I know what you're saying, that a prosecutor can make a very clinical argument. However, only by listening to the victim do we have the humanity of the situation. I know we've been talking about this, but maybe you have some comments on what I've said.

The other thing you mentioned was the possibility of the victim having to go to these hearings year after year. I would throw that back and ask, why then can we not extend the period? If there's been no change in the person's situation, why then, maybe for the victim's sake, the annual review? Why could that not be extended, unless there's some indication that there's been some change?

● (1705)

Mrs. Jennifer Chambers: I'll reply to some parts of what you said.

For a victim, I know it is the same, but the recognition in the law is that there is a difference between people who intended to commit a crime and people who did not. Other than the example I used of someone having a sudden physical disability, the law judges people who did something because of a mental disability as having not intended to commit the crime. Therefore, a very different system of justice is applied. It's not a system of retribution, it's a system based on the current state of mind of that person.

All people who are mentally disordered, as you know, do not end up in the NCR system. What's judged is the actual intent of the person and whether they actually intended to commit a crime. If it's judged that they did, they wouldn't be found NCR.

Unless we're going to overhaul the entire criminal justice system, so that retribution according to the victim is the basis on which justice is meted out, I don't think it would be fair to impose it on people who are considered mentally disabled.

Mr. Rob Moore: I appreciate that comment. I don't think we're taking about retribution according to the victim, although I think it's interesting to hear what the victim has to say. It's getting a perspective on what this person was capable of doing. I think only the victim can provide that perspective.

I'm not talking about the victim saying what the term should be, or whether this person should be kept in for another year. That's not what I'm talking about. I'm talking about just an impact on what that person did to another person, whether they were criminally responsible or not.

Mrs. Jennifer Chambers: The danger of the victim impact statement as well is that it creates uneven justice. It's based on the victim, on how they present themselves and on whether they are able to present themselves. So there are some inherent dangers in the entire process.

Mr. Nils Riis: Mr. Moore, perhaps I could add a couple of things.

I read Ms. Chambers' submission before I came here, and I think the example she gave the committee is really important. It also is really hard to grasp. When someone with a mental illness is charged with a criminal offence but found not criminally responsible, it means they had no idea what they were doing at the time. I'd like the committee members to remind themselves, if I had a heart attack, drove my car into a bus stop, and injured someone, would it be beneficial to society if, for the next 20 years, the person whose leg I broke appeared before me in public and annually reprimanded me for having a heart attack? It serves no purpose.

That is how we see the victim impact statements, in this context. They don't have control of their illness. They had no intent to commit any of these crimes—any of them, anyone in the system—and yet there is a proposal....

I'd like committee members, every time you think of someone with a mental illness committing a crime, to equate that with someone having a heart attack and driving into a bus stop. It's a horrible thing, but that's the distinction we're trying to emphasize here.

● (1710)

The Chair: Thank you, Mr. Moore.

Mr. Maloney, go ahead. And I see that Mr. Cullen and Ms. Neville are interested as well.

Mr. John Maloney (Welland, Lib.): The ultimate goal of an accused going into a facility is that they would be perhaps rehabilitated and returned to the public, but you're advocating treatment only with consent. What happens to those who don't consent? Are they going to heal themselves, so to speak, and are we going to end up perhaps keeping these individuals there and warehousing them until their final hours?

Mr. Nils Riis: Many clients do get better without psychiatric medication. Quite often a traumatic situation can set off an illness. Being fired from your job can set off an illness, with the associated stresses. Once you're in an environment that is safe, that is caring, a lot of symptoms of psychosis can abate. You can be better again and leave without any traditional psychiatric medication.

Mr. John Maloney: Treatment is more than just medical intervention, it's counselling as well.

Mr. Nils Riis: Absolutely.

Mr. John Maloney: Are you suggesting that counselling be excluded as well, if the individual doesn't want to consent to it?

Mrs. Jennifer Chambers: I have some research here—I'll leave it with your researchers—that talks about the most effective types of treatment. The research shows that the treatment that works most effectively is the treatment that meets the self-defined needs of the individual client. That's more effective than meeting the needs as defined by the case manager. More effective than doing anything else is assisting the person with the self-defined needs.

The most unfortunate thing in the psychiatric system in general, including the forensic system, is that often what happens is that needs are defined extremely narrowly, primarily as pharmaceutical. Even when people ask for other types of healing, such as therapy, they don't always get it. They're often offered just the one solution. Properly applied, consent should mean that people actually have the opportunity to access and consent to a range things that they feel would best benefit them. That is indeed what is best supported by the evidence as well.

For example, I was involved in the Starson case. He wasn't refusing treatment, he was refusing one type of treatment. He did want other treatment.

Mr. John Maloney: If medical treatment would expedite his or her rehabilitation, that's a cost, I suppose, over time, but that individual does not stay in that facility. In fact, it's better for them to be returned to society as quickly as is deemed appropriate.

Mr. Nils Riis: One point I would raise with the committee is that it may be safe to assume that everyone at this table at the present time is capable of making treatment decisions. I ask how each one of you would feel if someone imposed on you a treatment that you did not want, that you absolutely did not want, for an indeterminate amount of time. How would you feel if you had that indignity imposed on you?

I'd just ask the committee members to think about that.

● (1715)

Mrs. Jennifer Chambers: To support that parallel, there's actually excellent research evidence showing that the vast majority of people in the psychiatric system are as capable of making decisions about their treatment as other members of the public are.

If I can just speak from my experience, it's extremely rare for someone to say, “I want nothing”. Most people say, “I want this other thing”. What people are offered is usually just too narrow.

Mr. John Maloney: You've indicated that many of the victims haven't experienced physical trauma. You also referred to the many trivial offences a person is put in one of these facilities for. Do you have any percentages for how many have caused physical harm? Perhaps I am also looking for some of your examples of trivial offences.

Mrs. Jennifer Chambers: Yes, I have some statistics. Over 50% of people at the Centre for Addiction and Mental Health or in the forensic system have not committed acts of bodily harm, the last time I looked at the statistics. That statistic, however, is actually exaggerated, because what happens in the forensic system, comparable to the criminal justice system, is that the index offence is never pleaded down, so people are always there with whatever the original charged offence was.

An example would be that there was a man who was out of doors and relieved himself against a building. A woman in a pancake house spotted him doing this. He got on the same bus as her a short time later, and she went to the bus driver and said that the man had sexually assaulted her. The police came, he was arrested and taken away and charged with sexual assault. When the police found out what had actually happened and went to talk to the man, he spat on them and was charged with assaulting police. That man spent six years under the Ontario review board—four years in custody and two years supervised in the community.

Another example I know is of a man who has now spent four years in custody. He had left a pile of newspaper articles on his doctor's doorstep, one of which was an article about someone who killed their doctor. That was interpreted as a threat, and he's been in custody for many years.

There are other examples.

The Chair: Thank you, Mr. Maloney.

Mr. Cullen.

Hon. Roy Cullen (Etobicoke North, Lib.): Thank you, Mr. Chair, and thank you for the testimony.

I'm not a lawyer, so if I don't use the precise language that is required, please correct me.

I was curious, Mr. Riis, when you talked about people who are determined not to be criminally responsible. I know in legal terms that's a fairly black and white thing; I know you have to work within the letter of the law. But I'm just wondering, in real terms, do you ever have any doubt that someone might be considered not criminally responsible and that there might have been some doubt about that? Would that have any bearing on whether a victim's statement might just be useful? It's a leading question in that sense.

Mr. Nils Riis: Well, without disparaging the practice of psychiatry, I think everyone would agree that it's not an exact science. I grant you, there's a possibility that you could have one psychiatrist's assessment of not criminally responsible and another psychiatrist not coming to that conclusion.

The Chair: You would have a finding in a court to that conclusion.

Mr. Nils Riis: Yes, but ultimately there's a recommendation made by the psychiatrist.

Hon. Roy Cullen: I understand that, but you're giving me quite a legal response. That's fair enough; you're a lawyer. But I'm just wondering, if it were all black and white, then the way you'd express it is that the person is not criminally responsible. I think you used some of the examples Ms. Chambers had used; those were good examples. This person didn't have a clue what they were doing, and in a case like that, to my way of thinking anyway, it creates a stronger argument on why we would be looking at victims—because this person didn't have a clue what they were doing. So we're really focused on the accused and trying to reintegrate them back into society.

The other point I wanted to ask about—and maybe you can incorporate the response—is that when you look at why you don't see the value of, let's say, victim impact statements within the context of the review board, are you guided.... I know you're guided by the law, which we all have to be, but we make laws here, so we can change the law. I'm not suggesting we should, but when you look at the criteria, and I think of the Winko case in the Supreme Court, are those pillars something the Supreme Court came out with or are they written in the Criminal Code?

● (1720)

Mrs. Jennifer Chambers: That's the Winko ruling. I'm not a lawyer either, so I couldn't tell you anything about that.

Hon. Roy Cullen: So that's the Winko ruling. Number one is protection of the public from dangerous persons. I suppose you would argue that's really a matter for assessing the mental state of the accused, and it is irrelevant in terms of what this person actually did and the impact of what they did some time ago. I heard your argument that some of these events were quite a bit after this point in time.

If we were guided by principles that placed a little more emphasis on the protection of witnesses, not retribution, could you end up then with a different conclusion? If you're looking at it strictly from the point of view of what is the best solution in terms of the justice system, would you come to the same conclusion, rather than being forced down a certain path because the law and the Supreme Court has written it that way?

Mr. Nils Riis: I guess what we're kind of promoting is sticking to the status quo, to some extent.

I'd like to go back to what I was talking about on the difference between review boards and the criminal courts. When you go to these hearings, of fundamental importance is this person's clinical presentation today. As of today, are they a risk? If there isn't enough evidence to show that the person on that day is a significant risk to public safety, the Winko decision makes it clear there's only one thing you can do: get an absolute discharge. They have the same rights and entitlements as any of us.

Hon. Roy Cullen: I'm not talking about Winko. I realize there are charter issues associated with a lot of this stuff. I'm not a lawyer, but legislators write laws, so we can write laws that could be struck down. Assuming we can do it carefully enough that they aren't, we can write laws that coexist with the charter.

Maybe, Ms. Chambers, you'd like to comment from the point of view of someone who might have a perspective on that as well.

Mrs. Jennifer Chambers: I think perhaps you're operating from the premise that the system is letting a lot of people go. The reality is that the forensic system typically keeps people far longer than the criminal justice system does. So you don't need to broaden it. It's “over-broad”.

I also think the folks you're talking about are in the sort of grey area. That's the area into which mentally disordered offenders in the criminal justice system tend to fall. Someone may be in a position of having a mental disorder, but they are judged responsible for having committed the crime because it seemed that the disorder didn't excuse their criminal act. I think those tend to be the folks to whom you're referring.

The Chair: Thank you, Mr. Cullen.

Ms. Neville—and I think we have five minutes left before we'll start to hear the bells.

Ms. Anita Neville (Winnipeg South Centre, Lib.): Is there a vote?

The Chair: Yes, it's at 5:30.

Ms. Anita Neville: With respect, Mr. Riis, I suggest there's a profound difference between your having a heart attack and breaking someone's leg, and somebody with a mental disorder violently abusing a victim and creating a situation where their recovery is almost impossible.

I'm not a lawyer either, and I'm new to this bill. I'm learning the complexities of it and how difficult it is. But I really believe you are profoundly diminishing the importance of a victim coming forward and indicating how that has changed his or her life, and what the potential is for somebody else's life being altered that way as well.

I don't know whether you want to comment, but that's my view.

Mr. Nils Riis: Again, I've made every effort to not diminish any experience suffered by any victims or any families. I think I'm repeating myself ad nauseam. Their voices need to be heard; they need to have a role. I can't make myself any clearer on that.

All I'm saying is that primarily for the interest of the NCR accused, as well as the victim, it's not the appropriate forum. In the interest of making this a better society in general, getting people rehabilitated and reintegrated, and helping families of victims and victims themselves grieve, I'm urging the committee that a more appropriate forum be found. That's all I'm saying.

● (1725)

Mr. David Simpson: I just want to add a comment here, because I'm thinking as I'm listening to this. In Ontario there's this myth that if you can get your loved one into the forensic system they'll get a gold standard of care. Many families will call the police on their loved ones multiple times until they get charged and sent into the forensic system for assessment, only to later be disappointed by the fact that it isn't a gold standard of care. In fact, the person is then tied up in a legal bureaucracy for years and years, where they get one review board hearing per year. Maybe if the intervention had come earlier, before the person got into the forensic system, they wouldn't be there today.

So I think it is a myth that the forensic system provides a gold standard of care.

Mrs. Jennifer Chambers: If I may respond, the example I used was someone killing a person by driving into them when they were having a heart attack. But what I actually want to address is that I am a victim of violence. Following the experience I had, it just happened to be the time of year when they were having Take Back the Night marches, which frequently have many sort of calls to violence against offenders. I found it extremely disturbing to be in an environment where they were talking about doing harm to someone else, even if it was an offender.

I think our society as a whole is better off if we have compassion for everyone in it. I think that mentally disordered offenders who don't intend to commit crimes fall into that category of people we need to have compassion for.

Ms. Anita Neville: I don't disagree with you, but I disagree with you in that I do believe there is a place for the victim in this process.

The Chair: Thank you, Ms. Neville.

I'm going to thank our witnesses at this point for their attendance and assistance. Obviously there have been some very thought-provoking discussions, so thank you very much.

I'll ask members to stay for a couple of minutes. We'll go in camera and discuss some future business. We've lost some members, but we'll have to do the best we can.

[*Proceedings continue in camera*]

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