

# Hospital Knows Best: Court and Unfit Accused at the Mercy of Hospital Administrators: The Case of R. v. Conception

Suzan E. Fraser

Follow this and additional works at: <http://digitalcommons.osgoode.yorku.ca/sclr>



This work is licensed under a [Creative Commons Attribution-Noncommercial-No Derivative Works 4.0 License](https://creativecommons.org/licenses/by-nc-nd/4.0/).

## Citation Information

Fraser, Suzan E.. "Hospital Knows Best: Court and Unfit Accused at the Mercy of Hospital Administrators: The Case of R. v. Conception." *The Supreme Court Law Review: Osgoode's Annual Constitutional Cases Conference* 71. (2015).  
<http://digitalcommons.osgoode.yorku.ca/sclr/vol71/iss1/12>

This Article is brought to you for free and open access by the Journals at Osgoode Digital Commons. It has been accepted for inclusion in The Supreme Court Law Review: Osgoode's Annual Constitutional Cases Conference by an authorized editor of Osgoode Digital Commons.

# Hospital Knows Best: Court and Unfit Accused at the Mercy of Hospital Administrators – The Case of *R. v. Conception*<sup>1</sup>

Suzan E. Fraser\*

## I. INTRODUCTION

In Canada, an accused will be considered to be unfit to stand trial if he or she is unable, on account of mental disorder, to conduct a defence or to instruct counsel to do so and, in particular, unable on account of mental disorder to

- (a) understand the nature or object of the proceedings,
- (b) understand the possible consequences of the proceedings, or
- (c) communicate with counsel.<sup>2</sup>

In most cases, this occurs at the outset of the trial proceedings although the question of fitness can be considered at any stage of the proceedings before a verdict is rendered.<sup>3</sup>

At the time of making a finding that an accused is unfit to stand trial, a judge may also make a treatment order pursuant to section 672.58 requiring that the accused be treated for up to 60 days and that the accused submit to the treatment. Subsection 672.62(1) provides that a judge may make this order upon receiving the consent of person in charge of the hospital<sup>4</sup> or the person providing the treatment (if treatment

---

\* The writer acknowledges the work of Mercedes Perez, co-counsel with the writer for the Mental Health Legal Committee in the *Conception* case, and co-author of our factum in *Conception*, which assisted with the development of this article.

<sup>1</sup> [2014] S.C.J. No. 60, [2014] 3 S.C.R. 82 (S.C.C.) [hereinafter “*Conception*”].

<sup>2</sup> *Criminal Code*, R.S.C. 1985, c. C-46, s. 2 “unfit to stand trial”, and see also s. 672.22.

<sup>3</sup> *Criminal Code*, s. 672.23.

<sup>4</sup> “Person in charge” is a term used throughout Part XX.1 of the *Criminal Code* but it is not defined. In practice it is often the forensic director of the mental health facility or a person

is to be provided in the community) pursuant to section 672.62(1)(a) and (b) respectively.<sup>5</sup> The Supreme Court of Canada considered the nature and constitutionality of that consent in *R. v. Conception*.<sup>6</sup>

This article analyzes *R. v. Conception*, arguing that the case represents a departure from three decades of legal developments in the sphere of civil and forensic mental health law unified by the principles of restraint and oversight. That is, for the past 30 years, the law regarding the treatment of mentally disordered offenders has developed in a way that mandates, in all approaches regarding the mentally disordered person, the state should employ the least onerous, least restrictive mechanism consistent with public safety. Further, the article suggests that the decision cedes Court and tribunal oversight of the liberty interests of the unfit accused to unregulated hospital administrators, unless the unfit accused can establish a breach under the *Canadian Charter of Rights and Freedoms*,<sup>7</sup> an eventuality which would appear to be legally impossible given that by definition the unfit accused is likely unable to instruct defence counsel. The article asserts that the unfit accused persons, who are to be the subject of treatment orders, are unable legally to advance their Charter rights (having been found unfit). Drawing on the experiences of accused persons found not criminally responsible on account of mental disorder (“NCR accused”), the article suggests the Court’s expectation that the Charter will prevail and judges will maintain control over the unfit accused is unrealistic and practically impossible. Experience demonstrates that mentally disordered offenders will be left at the mercy of the discretion of hospital administrators and resource considerations.

## II. THE TREATMENT ORDER PROVISIONS AND THE UNFIT ACCUSED

### 1. The Statutory Provisions

As noted above, where a Court finds that an accused is unfit, it may also order that the accused be treated for a period of 60 days, if certain

---

designated by the facility to act in this capacity. There are no regulations governing the exercise of the powers of the person in charge.

<sup>5</sup> *Criminal Code*, s. 672.62(1).

<sup>6</sup> *Supra*, note 1.

<sup>7</sup> *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter “Charter”].

criteria are met. Section 672.58 of the *Criminal Code* permits a Court, upon a verdict of unfit to stand trial, to order an unfit accused to undergo treatment for a period not exceeding 60 days:

672.58 Where a verdict of unfit to stand trial is rendered and the court has not made a disposition under section 672.54 in respect of an accused, the court may, on application by the prosecutor, by order, direct that treatment of the accused be carried out for a specified period not exceeding sixty days, subject to such conditions as the court considers appropriate and, where the accused is not detained in custody, direct that the accused submit to that treatment by the person or at the hospital specified.

672.59(1) No disposition may be made under section 672.58 unless the court is satisfied, on the basis of the testimony of a medical practitioner, that a specific treatment should be administered to the accused for the purpose of making the accused fit to stand trial.

(2) The testimony required by the court for the purposes of subsection (1) shall include a statement that the medical practitioner has made an assessment of the accused and is of the opinion, based on the grounds specified, that

- (a) the accused, at the time of the assessment, was unfit to stand trial;
- (b) the psychiatric treatment and any other related medical treatment specified by the medical practitioner will likely make the accused fit to stand trial within a period not exceeding sixty days and that without that treatment the accused is likely to remain unfit to stand trial;
- (c) the risk of harm to the accused from the psychiatric and other related medical treatment specified is not disproportionate to the benefit anticipated to be derived from it; and
- (d) the psychiatric and other related medical treatment specified is the least restrictive and least intrusive treatment that could, in the circumstances, be specified for the purpose referred to in subsection (1), considering the opinions referred to in paragraphs (b) and (c).

Section 672.62(1)(a) prescribes that a treatment order shall not be issued without the consent of the person in charge:

672.62(1) No court shall make a disposition under section 672.58 without the consent of

- (a) the person in charge of the hospital where the accused is to be treated; or

(b) the person to whom responsibility for the treatment of the accused is assigned by the court.

(2) The court may direct that treatment of an accused be carried out pursuant to a disposition made under section 672.58 without the consent of the accused or a person who, according to the laws of the province where the disposition is made, is authorized to consent for the accused.

At issue in *Conception* was the statutory interpretation and constitutionality of the meaning of the consent required from the person in charge of the hospital contained in section 672.62(1)(a).

## 2. Unfit Accused in the Criminal Process

Unfit accused are always vulnerable, commonly psychotic and, by legal determination, unable to understand the nature, object or consequences of criminal proceedings or to instruct counsel.<sup>8</sup> They, like every accused, are presumed innocent with specific legal and procedural rights guaranteed by the Charter.<sup>9</sup> But unlike every accused, because they are deemed to be unfit, the *Criminal Code* permits their detention in hospital and, where statutory criteria in section 672.58 are met, treatment against their will in hospital in order to make them fit (a treatment order sometimes referred to as a “make fit” order).<sup>10</sup>

Having been declared unfit to stand trial, unfit accused have little (or no) control over the legal process through which treatment orders are made. By definition, most unfit accused will not be in a position to instruct counsel on this issue or respecting their appeal rights.<sup>11</sup> Notably, there are no reported cases of an unfit accused appealing from treatment orders.

As discussed further below, unfit accused have been routinely imprisoned while awaiting a hospital bed for the implementation of a treatment order. In Ontario, unfit accused routinely wait in jail — a dangerous, overly restrictive and counter-therapeutic environment — without proper health care, until the State can accommodate them in a

---

<sup>8</sup> *Criminal Code*, ss. 2 “unfit to stand trial”, 672.22.

<sup>9</sup> Charter, ss. 7-14.

<sup>10</sup> *Criminal Code*, s. 672.58.

<sup>11</sup> *Criminal Code*, ss. 2 “unfit to stand trial”, 672.22.

hospital. They are commonly denied bail, being unable to propose a release plan.

In addition, those subject to a treatment order are denied the benefit of provincial health care legislation (and the common law), which would generally prohibit treatment without the consent of the person or a legally authorized substitute decision-maker and which provides a process for challenging treatment incapacity. Treatment without consent may be considered battery and/or assault.<sup>12</sup> Where psychiatric medications are administered by force, the section 7 Charter guarantee to liberty and security of the person is engaged. Courts have repeatedly recognized that “[f]ew medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side effects.”<sup>13</sup>

In contrast, section 672.58 treatment orders require that the accused receive treatment even if he or she is capable and objects. The making of such an order renders the statutory presumption of capacity irrelevant, consent to treatment is bypassed, access to the *Health Care Consent Act, 1996*,<sup>14</sup> the review process of the Consent and Capacity Board (“CCB”) and the broad right of appeal from CCB decisions are denied, and prior capable wishes established through a power of attorney for personal care or otherwise are disregarded.<sup>15</sup>

### III. JUDICIAL HISTORY OF THE CASE

#### 1. Ontario Court of Justice

In April 2010, Brian Conception appeared in the Ontario Court of Justice on charges of sexual assault. His alleged victim was a staff member at the Centre for Addiction and Mental Health (“CAMH”). After

---

<sup>12</sup> *Malette v. Shulman*, [1990] O.J. No. 450, 72 O.R. (2d) 417, at 423-25 (Ont. C.A.); *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A (“HCCA”), ss. 4, 5, 10, 11, 14, 20, 21, 25, 27, 32, 75, 80. Incapable persons can also apply to the Consent and Capacity Board (“CCB”) to appoint a representative of their choice: s. 33 HCCA. Prior capable wishes can be expressed in a power of attorney for personal care, in other written form or orally: HCCA, s. 5 and *Substitute Decisions Act, 1992*, S.O. 1992, c. 30, s. 46(1), (7).

<sup>13</sup> *Fleming v. Reid*, [1991] O.J. No. 1083, at paras. 23-27, 38-40, 4 O.R. (3d) 74 (Ont. C.A.); *Starson v. Swayze*, [2003] S.C.J. No. 33, at para. 75, [2003] 1 S.C.R. 722 (S.C.C.).

<sup>14</sup> S.O. 1996, c. 2, Sch. A.

<sup>15</sup> See, *infra*, note 28.

hearing medical evidence and submissions, the presiding judge found that Mr. Conception was unfit to stand trial. The medical evidence provided to the Court at the time was that the appellant met the criteria for a treatment order. Given that the alleged victim was a CAMH staff member, the Court heard that the treatment would be more appropriately delivered at the Mental Health Centre Penetanguishene — Oak Ridge Division, a maximum secure psychiatric facility, now divested and known as Waypoint Centre for Mental Health Care. However, a bed would not be available for six days.

After hearing of the delay, the presiding judge suggested that it was she who should determine priority, rather than hospital administrators, “observing that she did not make treatment orders lightly”.<sup>16</sup> In the result, she issued a treatment order requiring that Mr. Conception be conveyed to “CAMH or designate (preferably Oak Ridge)” to receive treatment for the purpose of making him fit to stand trial, for a period of up to 60 days. The order also directed that he remain in custody at CAMH or designate and that he “be taken directly from Court to the designated hospital and from [the] hospital directly back to Court. Accused is not to be taken to a jail or correctional facility under any circumstances pursuant to this order”.<sup>17</sup>

Correctional authorities transported the appellant to CAMH, which could not receive him and then onto Oak Ridge, where he was left in a hallway.<sup>18</sup> He was ultimately treated notwithstanding that CAMH successfully sought a stay of the treatment order. In June, 2011, the charges against the appellant were stayed for reasons unknown to the author.

## 2. Court of Appeal for Ontario

CAMH and the Mental Health Centre — Penetanguishene, the two forensic mental health centres, appealed to the Court of Appeal for Ontario and sought an order allowing treatment pending appeal. The Court of Appeal for Ontario appointed *amicus curiae* (*amicus*)<sup>19</sup> who

---

<sup>16</sup> *Centre for Addiction and Mental Health v. Ontario*, [2012] O.J. No. 2253, at para. 15, 2012 ONCA 342 (Ont. C.A.).

<sup>17</sup> *Id.*, at para.18.

<sup>18</sup> A hallway at Oak Ridge is a hallway within the secure perimeter of the maximum secure unit.

<sup>19</sup> From 2000 to 2014, the Court of Appeal for Ontario had a specialized panel of lawyers to act as *amicus curiae* for matters involving mentally disordered accused and offenders. See Larissa Ruderman, “*Amicus Curiae*: Court of Appeal”, *Honouring the Past, Shaping the Future*,

assembled a substantial legislative fact record allowing for a full examination of the issues given that the accused was unfit and he would not have been able to instruct counsel to marshal such a record. The Court of Appeal for Ontario allowed the appeal by the person in charge of CAMH because the trial judge failed to get consent before making a treatment order pursuant to sections 672.58 to 672.62 under Part XX.1 of the *Criminal Code*. The Court allowed the appeal, rejected the section 7 Charter challenge, finding that consent from the hospital included consent to when the order could be carried out. The Court specifically rejected the suggestion that a hospital could not decline on the basis of a bed shortage.<sup>20</sup>

The Court of Appeal opined that the principal function of a section 672.58 order is not medical but legal:

Treatment orders are made for the sole *legal* purpose of making an accused fit to stand trial on criminal charges. They are not intended to be therapeutic or for the medical benefit of the unfit accused in the broad sense.<sup>21</sup>

Further, concerns about hospitals having discretion about the giving or withholding of consent could be answered by the fact that the consent requirement operated within “a broad legislative and regulatory framework that governs the conduct of hospital authorities and medical practitioners in relation to the acceptance and treatment of patients. Examples include the *Mental Health Act*,<sup>22</sup> the *Public Hospitals Act*,<sup>23</sup> the various health professions acts and the regulations under all of these statutes”.<sup>24</sup>

### 3. Supreme Court of Canada

Mr. Conception appealed to the Supreme Court of Canada. The appeal was heard when moot as Mr. Conception had received treatment and his charges were stayed. However, all the parties agreed that the underlying issues required resolution. The main issue on the appeal was whether the Court could make a treatment order directing that the

---

*25th Anniversary Report of the Psychiatric Patient Advocate Office* (Toronto: Queen’s Printer for Ontario, 2008), at 200.

<sup>20</sup> *Centre for Addiction and Mental Health v. Ontario*, *supra*, note 16, at paras. 28, 65.

<sup>21</sup> *Id.*, at para. 61.

<sup>22</sup> R.S.O. 1990, c. M.7.

<sup>23</sup> R.S.O. 1990, c. P.40.

<sup>24</sup> *Id.*, at para. 70.

treatment begin immediately.<sup>25</sup> The Court split 5-4 after a rehearing agreeing on the result but with vastly different approaches.<sup>26</sup>

The majority rejected the appellant's argument that a plain reading of subsection 672.62(1) in the context of Part XX.1 suggests that "consent" relates to the provision of treatment ordered pursuant to section 672.58. The majority held that consent included timing of the order:

As s. 672.58 makes clear, a "disposition" ordering treatment under that section necessarily includes aspects relating to timing: it must set out a "specified period not exceeding sixty days" and it may be made "subject to such conditions as the court considers appropriate", including presumably conditions related to timing. Moreover, a disposition comes into force on the day on which it is made or on any later day that the court specifies: s. 672.63.

All of this makes it clear that a "disposition" under s. 672.58 necessarily has a temporal aspect both as to its beginning and its ending and may include other conditions that the court considers it appropriate to impose.<sup>27</sup>

.....

Given that "disposition" is a defined term meaning the "order made by a court under section 672.58" and the *Code* explicitly requires the hospital's consent to a disposition under that section, we see no possible ambiguity in the text of these provisions. Any possible doubt is dispelled by the clear distinction in s. 672.62 between, on the one hand, the hospital's consent to the "disposition" which is required under s. 672.62(1) and, on the other hand, the accused's consent to "treatment ... carried out pursuant to a disposition" which is not required. We do not see how Parliament could have more clearly expressed its intent that the hospital's consent in s. 672.62(1) relates to all the provisions of the disposition, including when treatment will begin as well as what is to be done.<sup>28</sup>

---

<sup>25</sup> *Conception*, *supra*, note 1, at para. 2 (*per* Rothstein and Cromwell JJ. for the majority) and para. 48 (*per* Karakatsanis J., for the concurring reasons).

<sup>26</sup> The decision was rendered after a video re-hearing by Gascon J., who was appointed after the *Conception* case had been heard and following the successful challenge to the judicial appointment of Nadon J. (*Reference re Supreme Court Act, ss. 5 and 6*, [2014] S.C.J. No. 21, 2014 SCC 21 (S.C.C.)), who had been sidelined at the time of the hearing.

<sup>27</sup> *Conception*, *supra*, note 1, at paras. 18-19.

<sup>28</sup> *Id.*, at para. 24.

On the other hand, Karakatsanis J., after considering the full statutory context, in her concurring reasons, stated:

... before a judge can make a treatment order, the consent provisions under s. 672.62(1) require that a hospital must have indicated it would be willing to administer the specified treatment. When read in their full context, the consent provisions do not permit hospitals to assess the priority of the accused against others on the waiting list — or to withhold consent on the basis of its bed shortages or waitlists. Consent may be withheld only for medical reasons.<sup>29</sup>

She specifically acknowledged “consideration of the significant *Charter*-protected section 7 liberty interests at stake in the regime is ‘built into the [Part XX.1] statutory framework’ at ‘every step of the process’: *Penetanguishene Mental Health Centre v. Ontario (Attorney General)*, 2004 SCC 20, [2004] 1 S.C.R. 498, at para. 53. See also *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625, at paras. 16 and 42.”<sup>30</sup>

The majority found the section did not deprive the appellant of procedural fairness, and that it was not unconstitutionally vague or arbitrary and that the evidence did not establish a *Charter* breach occasioned by the six-day delay.<sup>31</sup> The majority did accept that, in what it considered would be rare circumstances, that the *Charter* rights of the unfit accused could be implicated and that in such circumstances it would be the judge, rather than hospital administrators, who would have the last word.<sup>32</sup> As a result, it is only in those cases where there is a *Charter* breach that a judge can overrule the hospital’s consent on the question of the timing of a treatment order.

In Karakatsanis J.’s concurring reasons, despite disagreeing on the interpretation of the reading of sections 672.58 to 672.62 and finding that the trial judge had jurisdiction to make the order on a forthwith basis, she found that the trial judge erred in so doing. That decision, Karakatsanis J. opined, ought to be based on the specific factors of the case (not out of frustration with the mental health system). These, in her view, include the impact on the offender’s treatment prospects resulting from a delay; the holding conditions in the jail where he would likely be sent to wait; or any possible alternatives to detention while waiting for a bed; whether

---

<sup>29</sup> *Id.*, at para. 125.

<sup>30</sup> *Id.*, at para. 90.

<sup>31</sup> *Id.*, at paras. 41-42.

<sup>32</sup> *Id.*, at para. 43.

the hospital could safely administer treatment immediately, if so ordered; or when safe treatment could be provided, if he was given priority.<sup>33</sup>

The majority appears to have been motivated by a hands-off approach to health professionals because, in its view, the statutory provision was unique “in that it requires an accused to be subject to treatment and authorizes medical personnel to administer it without the accused’s consent”.<sup>34</sup> This reluctance to order an unwilling health professional to treat, appears to have driven the result. However, in making this statement, the Court ignored the evidence before it: consenting to administering treatment was to be presumed. Specifically, as noted above, CAMH’s consent was to be presumed, subject to three days’ notice. This evidence clearly undermines the majority’s reasoning. It was clear to the Court that the hospital’s concern was about timing, not about being asked to do something that it did not want to. Finally, the majority’s reasoning ignores that the Court, under section 672.58 requires evidence from a health practitioner about the treatment to be ordered.

#### IV. CONCEPTION A DEPARTURE FROM PRINCIPLES OF RESTRAINT AND OVERSIGHT

With that history, this article now examines how in reaching its decision, the Court departed from three decades’ work of reform — reform based upon the principle of restraint, emphasized fundamental fairness to the accused and created supervision over the assessment and treatment of mentally disordered persons in the criminal justice system. This portion of the article analyzes that reform and the *Conception* decision in light of it.

##### 1. History of Mental Disorder Provisions and Part XX.1 of the *Criminal Code*

The mental disorder provisions in the *Criminal Code*, including sections 672.58 and 672.62, are located in Part XX.1 of the *Criminal Code* and came into force in February 1992. Prior to this, unfit accused were detained following a finding that they were unfit to stand trial “until

---

<sup>33</sup> *Id.*, at para. 132.

<sup>34</sup> *Id.*, at para. 28.

the pleasure of the Lieutenant Governor of the Province [was] known” and the plea discharged (without prejudice to the accused being tried subsequently). As with the treatment of the then insane acquittees, the Lieutenant Governor was empowered under the *Criminal Code* to maintain the accused in safe custody or, if in the interest of the accused and not contrary to the interests of the public, discharge the accused absolutely or conditionally. As of 1969, the Lieutenant Governors of each province had a statutory discretion to appoint boards of review who were required to review the detention of unfit accused persons within six months of their initial disposition and every year thereafter. The boards had recommendation powers but the ultimate decision to detain or discharge an accused rested wholly within the discretion of the Lieutenant Governor. Thus, prior to the 1992 amendments, the Lieutenant Governor had an unfettered discretion in respect of a mentally disordered offender’s detention whether they were unfit to stand trial or not guilty by reason of insanity. In provinces without boards of review there were no provisions mandating any review of the detention of an unfit accused.<sup>35</sup>

The process of reform of the forensic patient system began with the 1976 report of the Law Reform Commission of Canada entitled *A Report to Parliament on Mental Disorder in the Criminal Process*. The Commission advanced the guidelines for dealing with a mentally disordered individual, in the criminal law process:

1. When dealing with a mentally disordered individual, the criminal law process should be invoked only when it is the best available alternative. Implicit in this guideline is the assumption that increased emphasis will be placed on the pre-trial diversion of the mentally ill.
2. Mentally disordered individuals are entitled to the same procedural fairness and should benefit from the same protections of personal liberty as other persons. In this regard extreme caution should be exercised before there is any deprivation of personal liberty in the form of psychiatric examination or treatment. As well, psychiatric treatment of any kind should only be given after obtaining the consent of the individual, subject only to the limited exceptions outlined later in this report.

---

<sup>35</sup> *Criminal Code*, R.S.C. 1970, c. C-34; *Criminal Code*, R.S.C. 1985, c. C-46, ss. 537 [am. S.C. 1991, c. 43, s. 3], 615-619 [all repealed S.C. 1991, c. 43, s. 3].

3. In those circumstances where some form of detention is deemed necessary, it must be subject to review and in no circumstances should it be indeterminate.<sup>36</sup>

With respect to what order ought to follow a finding of unfitness, the Commission recommended an end to the delegation of power over unfit accused to the provincial Lieutenant Governors stating that the Court was in the best position to consider the situation of the unfit accused. Further, the Commission opined that a judge be entitled to make three different orders: release forthwith for a chronically unfit accused who presents as no danger to self or other; an order for treatment as an outpatient; and mandatory hospitalization for a period of six months to be reviewed including the use of provincial mental health legislation.<sup>37</sup> The Government of Canada's response to the Commission's Report included the formation of a Mental Disorder Project ("MDP"). The MDP was instructed to prepare a set of recommendations that could be used as the basis for amending the relevant legislation. The underlying policy adopted by the MDP is set out in the MDP's Final Report dated September 1985:

A guiding force for the Criminal Law Review is the Government of Canada publication, *The Criminal Law in Canadian Society* (CLCS). While the Law Reform Commission of Canada's 1976 *Report to Parliament on Mental Disorder in the Criminal Process* is a most helpful guide in directing appropriate alternatives for consideration in this area, the CLCS document establishes a blueprint from which much of the philosophy behind the discussion in this paper flows.

The central principle set out in the CLCS document is that the criminal law should be used with restraint. The least restrictive form of intervention in the circumstances should be used.<sup>38</sup>

In terms of the initial disposition and continuing review of those persons found unfit to stand trial, the MDP, in its Final Report, underscored the need for restraint and the use of the least intrusive "intervention":

One of the recurring themes of the *Criminal Law in Canadian Society* (CLCS) document is that the least restrictive form of intervention

---

<sup>36</sup> Law Reform Commission of Canada, *A Report to Parliament on Mental Disorder in the Criminal Process* (Ottawa: Minister of Supply and Services, 1977), at 7; E.A. Tollefson & B. Starkman, *Mental Disorder in the Criminal Proceedings* (Scarborough, ON: Carswell, 1993), at 1-2.

<sup>37</sup> *A Report to Parliament on Mental Disorder in the Criminal Process*, *id.*, at 17-18.

<sup>38</sup> *Mental Disorder Project: Criminal Law Review – Final Report* (Ottawa: Department of Justice, 1985), at 5.

necessitated by the circumstances should be used, and that one must always be mindful of the doctrine of restraint. The principle of using the least intrusive or restrictive mechanism necessary in the circumstances is of particular importance when one considers the matter of the disposition of persons found not guilty by reason of insanity or unfit to stand trial.<sup>39</sup>

In keeping with its underlying theme of restraint and least onerous and least restrictive intervention, the MDP went on to make sweeping recommendations in respect of mental disorders and criminal law. Those recommendations formed the basis for the current forensic system as set out in the *Code*, including the provisions pertaining to review hearings respecting persons found unfit.<sup>40</sup>

As noted above, the policy context for the MDP recommendations was informed by the Government of Canada's 1982 publication entitled *The Criminal Law in Canadian Society* ("CLCS"). The CLCS was published by the Federal Department of Justice for the purpose of setting out the policy of the Government of Canada with respect to the purpose and principles of criminal law in the context of the recently enacted Charter. The CLCS re-affirmed, as a fundamental principle, that criminal law is to be employed with restraint. This fundamental principle, in turn, was premised on the rationale that Canadian society places a high value on freedom and humanity:

Restraint should be used in employing the criminal law because the basic nature of criminal law sanctions is punitive and coercive, and, since freedom and humanity are valued so highly, the use of other non-coercive, less formal, and more positive approaches is to be preferred wherever possible and appropriate.<sup>41</sup>

And further:

The Ouimet Report stated "as a fundamental proposition that interference with individual liberty can only be justified where it is clearly necessary in the interests of society as a whole, and that no greater interference with individual liberty than is necessary to protect the interests of society as a whole is justifiable".

This formulation could also be applied to the process of determination of dispositions, to require the availability of a range of sanctions in law, an onus to apply the least restrictive form of sanction adequate to the

---

<sup>39</sup> *Mental Disorder Project, id.*, at 33.

<sup>40</sup> *Mental Disorder Project, id.*, at 40, 41, 44, 49, 50, 52-55; Tollefson & Starkman, *supra*, note 36, at 3-4.

<sup>41</sup> *The Criminal Law in Canadian Society* (Ottawa: Government of Canada, 1982), at 42.

circumstances, and a requirement to restrict the amount of that sanction to that which is justifiably necessary and adequate.<sup>42</sup>

The principle of least restrictive intervention is a principle found throughout mental health law. As noted by Jocelyn Downie:

... this criterion, even if not required by legislatures, but rather superimposed by courts, health care professionals, and other legal decision-makers, protects the individual's dignity and autonomy far better than untrammelled use of the concepts of "dangerousness" and "incompetence". The least restrictive (and least onerous or intrusive) alternative guarantees that at a minimum some residuum of liberty and autonomy will be preserved for the person with a mental disability where legitimate and compelling state interests do justify some action ... Indeed, any decision made concerning the status of a person with a mental disability that does not incorporate the least restrictive principle risks being seen as illegitimate and may also be subject to legal and constitutional challenge.<sup>43</sup>

The mental disorder provisions of the *Criminal Code* were comprehensively amended in 1992 as Part XX.1 of the *Criminal Code* and therein section 672.58 was enacted.

The amendments substantially altered the forensic mental health landscape by ending the unfettered discretion of the Provincial Lieutenant Governors and the hospitals to which that discretion was delegated and placing the management of mentally disordered persons in the criminal justice system with Courts and review Boards. The Supreme Court of Canada in *Winko v. British Columbia (Forensic Psychiatric Institute)* (although considering the situation of a person found not criminally responsible on account of mental disorder) found that the new Part XX.1 replacing the common law was "a new approach emphasizing individualized assessment and the provision of opportunities for treatment" where the accused was to be treated in the least onerous, least restrictive fashion consistent with public safety.<sup>44</sup> While *Winko* was focused on section 672.54 as it applied to the NCR accused, the Court's comments apply to the scheme of Part XX.1 as a

---

<sup>42</sup> *Id.*, at 48.

<sup>43</sup> J. Downie *et al.*, *Canadian Health Law and Policy* (Markham, ON: Butterworths, 2002), at 278-80.

<sup>44</sup> *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] S.C.J. No. 31, at paras. 42-43, [1999] 2 S.C.R. 625 (S.C.C.) [hereinafter "*Winko*"].

whole. In addition, section 672.54 relates to unfit accused as well as NCR accused as it is the disposition-making provision for unfit accused persons.

Finally, the Supreme Court of Canada in *Pinet v. St. Thomas Psychiatric Hospital* and *Penetanguishene Mental Health Centre v. Ontario (Attorney General)* [Tulikorpi], the Supreme Court of Canada held that the least onerous, least restrictive test applied to the package of conditions attached to a disposition. At the time of the hearing of *R. v. Conception*, therefore, there existed a long line of Supreme Court of Canada cases that directed an interpretation of Part XX.1 of the *Criminal Code* that complied with the Charter.<sup>45</sup> While those cases dealt primarily with NCR accused, it was the Court's interpretation about the scheme of Part XX.1 and the principles underlying it which make the arguments in those cases applicable to the unfit accused. Even recent amendments, which alter the language of section 672.54 to "necessary and appropriate", leave the principle of least restrictive, least onerous intact.<sup>46</sup>

The decision of the majority produced a result that practically undermines the twin branches of Part XX.1 of the *Criminal Code*, namely, the assessment and treatment of the accused.<sup>47</sup> By exposing the unfit accused in need of a treatment order to detention in jail where he is vulnerable, the decision appears to violate a primary purpose of Part XX.1 of the *Criminal Code*: the fair treatment of the accused.<sup>48</sup> It is also for those reasons that the experiences of the NCR accused when their liberty is managed by hospital administrators, as discussed further below, are relevant to the question of whether the Court ought to have retained more robust supervision over treatment orders.

## 2. Court's Departure from Principle of Restraint and Oversight

The Supreme Court of Canada had ample evidence of the onerous nature of detention in jail in the circumstances in which an unfit accused meets the criteria for a treatment order. In particular, there was no dispute

---

<sup>45</sup> *Winko, id.*; *Pinet v. St. Thomas Psychiatric Hospital*, [2003] S.C.J. No. 66, 2004 SCC 21 (S.C.C.) [hereinafter "*Pinet*"]; *Penetanguishene Mental Health Centre v. Ontario (Attorney General)*, [2003] S.C.J. No. 67, [2004] 1 S.C.R. 498 (S.C.C.) (Tulikorpi, appellant); *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services)*, [2006] S.C.J. No. 7, 2006 SCC 7 (S.C.C.) [hereinafter "*Mazzei*"].

<sup>46</sup> *Re Osawe*, [2015] O.J. No. 2050, at para. 45, 2015 ONCA 280 (Ont. C.A.).

<sup>47</sup> *Winko, supra*, note 44, at paras. 39-43.

<sup>48</sup> *Winko, id.*, at paras. 20, 21, 33, 35-39, 41-43. *Mazzei, supra*, note 45, at paras. 27, 28, 32: "fair treatment" refers to procedural fairness, as well as the promotion of dignity and the minimization of infringements on liberty.

that the detention was perilous and anti-therapeutic. The legislative fact evidence, filed by the *Amicus Curiae* at the Court of Appeal (forming part of the Appellant's record at the Supreme Court of Canada and relied on by the Court), revealed that since the mid-1990s, the number of mentally disordered persons (unfit and NCR) under the jurisdiction of the Ontario Review Board grew by a rate of approximately 5 per cent annually while the supply of forensic beds had not kept pace. In addition, a related shortage of community mental health resources for forensic mental health patients meant that those detained in hospital could not cascade out into the community with support. In short, the system was plugged.

While Mr. Conception would have been required to wait six days for a bed, many unfit and NCR accused awaiting transfer to a psychiatric facility, or between facilities or security levels, often must wait months or years. Delayed transfers prolong detentions that are not least onerous and least restrictive. They slow or prohibit opportunities for rehabilitation and community reintegration and can trigger deterioration in the accused's mental state.<sup>49</sup> These problems were the subject of concern by

---

<sup>49</sup> *Re Boucher*, [2012] O.R.B.D. No. 1120, at para. 15: "It is unconscionable that there has been a delay of over a year in effecting the transfer of Mr. Boucher in accordance with the Board's prior Disposition Order. Delays such as this threaten to undermine the spirit and purpose of the legislative scheme designed to protect the public while at the same time furthering the important legislative objective of ensuring that NCR accused are not treated as convicted criminals."; *Re Krivicic*, [2012] O.R.B.D. No. 2247, at para. 139: delayed transfer of 12 to 36 months; *Re Elampooranam*, [2012] O.R.B.D. No. 760, at para. 17 "... the Board notes its great concern that Mr. Elampooranam has been on the waiting list for more than a year. In particular, he has apparently been told since December that he is at the 'top of the list' for transfer to CAMH, but at the time of the hearing in late March, that still had not occurred. The characterization of his position as 'top of the list' appears in that light to be at best misleading and at worst nonsensical."; *Re Kline*, [2013] O.R.B.D. No. 98, at para. 17: "The evidence is that there are only three intrahospital transfers a year into CAMH. As a result of this unfortunate circumstance, he may have to spend years waiting for an opportunity to be where the supports for him are most ideal. This is lamentable."; *Re Leclair*, [2009] O.R.B.D. No. 162, at para. 17: delayed transfer of at least nine months — "The evidence before the Board is that Mr. Leclair's stress has been exacerbated by the failure of the Royal Ottawa Hospital to effect Mr. Leclair's transfer. The ongoing uncertainty as to whether he will be going, and when, has been the foundation of Mr. Leclair's destabilization."; *Re Savory*, [2012] O.R.B.D. No. 1987, at paras. 11, 18, 20: delayed transfer of at least one year; *Re George*, [2012] O.R.B.D. No. 2033, at paras. 15, 17: "The evidence is clear that Mr. George arrived at Waypoint, not because his risk required him to be placed in a maximum security facility, but rather because there were no beds available anywhere else in a less secure facility. ... Having remained on the waiting list for transfer for some seven months, he may yet have a lengthy wait until his transfer."; *Re Dass*, [2011] O.R.B.D. No. 439, at paras. 34, 39-43: wait time for transfer indeterminate; *Re Aganeh*, [2008] O.R.B.D. No. 2, at para. 23: four-month delay, accused's mental state deteriorated as a result; *Re Lucas*, [2011] O.R.B.D. No. 68, at paras. 31-36: at least six-month delay; *Re McClinton*, [2010]

many.<sup>50</sup> While some of these cases related to inter-hospital transfers of NCR accused, they bear consideration on the onerous nature of detention in a higher level of security than required and the impact of that detention on rehabilitation.

Unfit accused are also vulnerable when imprisoned awaiting a hospital bed. Mental health resources vary in availability and quality across Ontario's remand and correctional facilities. The care offered to unfit accused in prison is of poorer quality than that offered in psychiatric facilities. Segregation and restraint are commonly used to manage and/or punish unfit accused and are often carried out by unqualified staff.<sup>51</sup> Mentally ill individuals have died while detained in prisons.<sup>52</sup> In at least one facility, nurses often assess mental health through the food slot in the cell door.<sup>53</sup>

There was no dispute in the appeal that unfit accused subject to treatment orders are better off in a psychiatric facility than in jail. This is not to say that mental health facilities are always kinder and gentler facilities. One need only look at the verdict from the coroner's jury at the inquest into the death of Kulmiye Aganeh and the seclusion cell where he

---

O.R.B.D. No. 1385, at para. 35: anticipated eight-month delay.; *Re Morgado*, [2012] O.R.B.D. No. 623, at paras. 31-32: anticipated 10- or 11-month delay; *Re Blake*, [2011] O.R.B.D. No. 610: delay of indeterminate length.

<sup>50</sup> Ontario, Legislative Assembly, Select Committee on Mental Health and Addictions, "Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians" (Toronto: Legislative Assembly of Ontario, August 2010), at 7, 8, 11 and 20-21); Janet Leiper, "Cracks in the Façade of Liberty: The Resort to *Habeas Corpus* to Enforce Part XX.1 of the *Criminal Code*" (2009-2010) 55 Crim. L.Q. 134; Contained in the legislative fact record were many similar fact cases involving unfit accused ordered treated pursuant to s. 672.58(2). See *R. v. Rose*, [2006] O.J. No. 1608, 2006 ONCJ 141 (Ont. C.J.); *R. v. Consuelo*, unreported (September 14, 2010), Toronto, Court File Nos. 10-10001715, 10-10004017, 10-70009469 (Ont. C.J.); *R. v. Hneihen*, [2010] O.J. No. 4115, 261 C.C.C. (3d) 375 (Ont. S.C.J.); *R. v. Procope*, unreported (October 6, 2010), Toronto, Court File Nos. 10009107, 1200160 (Ont. C.J.). Most of these unfit accused were represented by duty counsel.

<sup>51</sup> From the legislative fact evidence filed: Affidavit of Graham Glancy, Vol. V, Appellant's Record, p. 2, paras. 4-6; Affidavit of Eduardo Almeida, Vol. II, Appellant's Record, p. 2, para. 2; Cross-Examination of E. Almeida, Vol. III, Appellant's Record, p. 10, line 14 to p. 11, line 15; "Report of Standing Committee on Public Safety and National Security on Mental Health and Addictions in Federal Corrections", Ex. B, Affidavit of E. Almeida, Vol. II, Appellant's Record, p. 22.

<sup>52</sup> Verdict of Coroner's Jury into the death of Joshua Douglas Durnford, unreported (August 31, 2001); Verdict of Coroner's Jury into the death of Glenn Keigo White, 2009 CanLII 92011 (ON OCCO) (Office of the Chief Coroner of Ontario); Coroner's Jury Verdict James O'Brian, Ex. A: Affidavit of E. Almeida, Vol. II, Appellant's Record, p. 6; Coroner's Jury Verdict D.M., Ex. C: Affidavit of E. Almeida, Vol. II, Appellant's Record, p. 114.

<sup>53</sup> Cross-Examination of Graham Glancy, Vol. V, Appellant's Record, p. 48, l. 1-3.

spent the last months of his life, coming out only in restraints, to know that our psychiatric facilities can be punitive and isolating warehouses.<sup>54</sup>

However, but for the issue of bed availability, there is and was also no dispute that once a treatment order is made, unfit accused should be admitted to a psychiatric facility immediately. Indeed, pursuant to the Memorandum of Understanding (“MOU”) between Toronto’s Mental Health Court and the respondent CAMH, consent to treatment was presumed subject to a three-day notice period.<sup>55</sup> In his evidence, Dr. Simpson, as the person in charge, candidly agreed that CAMH will consent to every treatment order and that hospital consent relates entirely to the timing of the order due to bed shortages, not to willingness to implement the treatment order or lack of professional expertise.<sup>56</sup>

The majority made no reference to the vulnerability of the unfit accused awaiting placement in a hospital or the implementation of a treatment order despite the evidence filed. Nor did it balance that vulnerability and the position of the accused is concluding that section 7 breaches would be “rare”. The only mention in the majority of the least restrictive aspect was with respect to the statutory criteria that require that the treatment be least restrictive. There is no nod to the greater liberty interests of the accused. If the Court had had the accused liberty interests at the forefront, it would have considered how to reconcile its statutory interpretation with the overly restrictive and counter-therapeutic situation of the unfit accused awaiting treatment in jail. In ignoring these questions, the Court departed from three decades of reform that advanced the least onerous, least restrictive approach.

---

<sup>54</sup> Jury Verdict, *Inquest into the Death of Kulmiye Aganeh*, unreported (December 19, 2014), Recommendation #22 states: “Waypoint ensure that patients in seclusion should not be punished. They should not be denied canteen, access to water, showers and/or religious practices.”

<sup>55</sup> Affidavit of Dr. Simpson, Vol. VI, Appellant’s Record, p. 136, para. 33; Ex. A, Affidavit of Dr. Simpson, Memorandum of Understanding (May 4, 2005), Vol. VI, Appellant’s Record, pp. 159, 160. The MOU “will constitute consent by the person-in-charge to treatment orders, on the condition that they are organized as specified here, and no further consent need be sought”. CAMH’s “Statement of Principles and Practice for Admissions Prioritization” also provides consent to treat: “It will be presumed by the court that the LAMHP will consent to treat (s. 672.62) all accused who have been found ‘unfit to stand trial’ and in respect of whom the criteria set out in s. 672.59 of the *Criminal Code* have been met at the conclusion of a Crown application for a Treatment Order.” Ex. Q, Affidavit of Dr. Simpson, Vol. VII, Appellant’s Record, p. 186.

<sup>56</sup> Affidavit of Dr. Simpson, Vol. VI, Appellant’s Record, p. 132, para. 20; Cross-examination of Dr. Simpson, Appellant’s Record, Vol. VII, pp. 41, 42, 61, 62, 121.

## V. MANAGEMENT OF LIBERTY INTERESTS BY HOSPITAL ADMINISTRATORS

The experience of the management of liberty interests by hospital administrators informs the analysis of the prioritization of those unfit accused persons ordered treated by the Court. Once a Court or review board makes a disposition, section 672.57 allows a delegation of the powers within the limits of the disposition to the person in charge of the hospital where a person is detained. This delegation makes the person in charge responsible for the management of the liberty of NCR and unfit accused persons on a day-to-day basis. As well, review boards regularly make orders for assessment and orders transferring unfit and NCR accused from one forensic psychiatric facility to another or from one security level to another. Transfer orders are also made to ensure that unfit and NCR accused are subject to the least onerous and least restrictive disposition.<sup>57</sup>

Each of these types of orders directly impact the Charter rights of psychiatric patients. These orders are often made to facilitate the accused's cascade through the forensic system towards an absolute discharge. Hospital administrators manage orders for assessment and transfer. The review boards possess no enforcement powers.<sup>58</sup> Where the review board delegates powers to the person in charge of a hospital by a disposition order, the hospital is expected to exercise its delegated powers in the least restrictive manner possible.<sup>59</sup> All of which is to say that pre-*Conception*, hospital administrators already possessed significant powers to affect the liberty of mentally disordered persons in the criminal justice system but subject to the oversight of the Courts and the review boards.

As noted above, the issue of delay by hospital administrators in the transferring and/or admitting of forensic mental health patients has been the subject of extensive litigation in Ontario. In some cases, Courts have recognized that transfer orders must be expeditious to avoid unjustified interference with Charter rights, whereas in other cases Courts have deferred to hospital concerns respecting bed shortages.<sup>60</sup>

---

<sup>57</sup> *Criminal Code*, ss. 672.11, 672.54.

<sup>58</sup> *Conway v. Barbaree*, [2010] O.J. No. 2466, at paras. 33-34, 215 C.R.R. (2d) 230 (Ont. S.C.J.).

<sup>59</sup> *R. v. C. (M.L.)*, [2010] O.J. No. 5310, at paras. 43-45, 2010 ONCA 843 (Ont. C.A.).

<sup>60</sup> *Orru v. Penetanguishene Mental Health Centre*, [2004] O.J. No. 5203, 126 C.R.R. (2d) 182 (Ont. S.C.J.); *Pinet, supra*, note 45; *Centre for Addiction and Mental Health v. Al-Sherawadi*, [2011]

Given the divergent streams of judicial reasoning in this area, even *habeas corpus* and *mandamus* have, in some cases, been withheld from accused awaiting transfers.<sup>61</sup> Those cases reveal that it takes a Court to enforce orders and, where the Court does not, an (NCR or unfit) accused can wait for an indeterminate period of time for the implementation of an order by hospital administrators.

In deciding that Courts must defer to hospital administrators, the Court of Appeal in *Conception* relied on *The Person in Charge of Mental Health Centre Penetanguishene v. HMQ, Thomas Rea, The Person in Charge of Centre for Addiction and Mental Health*.<sup>62</sup> In *Rea*, the respondents CAMH and the Mental Health Centre Penetanguishene<sup>63</sup> argued that the Review Board failed to include “a residual discretion clause” which would permit a hospital to detain a person pending transfer to another secure facility and that without such residual discretion, the hospital remained vulnerable to a *habeas corpus* application. The Court of Appeal allowed the appeal acknowledging resource concerns. In so doing, the Court undermined the ability of NCR accused to seek extraordinary remedies if a transfer order is not executed.

As noted above, lengthy waiting lists in the Review Board system persist. Practically speaking, those subject to Part XX.1 remain warehoused awaiting transfer. Residual clauses are routinely incorporated into disposition orders in Ontario where a delay in transfer is anticipated.<sup>64</sup> These clauses purport to provide lawful authority for detentions that would otherwise be unlawful because they are not the least onerous and least restrictive.<sup>65</sup> When *habeas corpus* is denied over resource considerations, the result is that NCR accused are being maintained in more restrictive settings pending transfer with no legal

---

O.J. No. 1755, 2011 ONSC 2272 (Ont. S.C.J.); *Fortune v. Centre for Addiction and Mental Health* (2009), Ontario Superior Court of Justice (unreported decision of the Honourable Justice J. MacDonald, Docket 09-7000-0306).

<sup>61</sup> *R. v. Chen*, [2012] O.J. No. 4038, 2012 ONSC 4889 (Ont. S.C.J.).

<sup>62</sup> Reported as *Mental Health Centre Penetanguishene v. Ontario*, [2010] O.J. No. 1044, 260 O.A.C. 125 (Ont. C.A.) [hereinafter “*Rea*”].

<sup>63</sup> Appellants in *Rea*.

<sup>64</sup> *Re Boucher*, *supra*, note 49, at para. 25; *Re Elampooranam*, *supra*, note 49, at paras. 26-27; *Re Kline*, *supra*, note 49, at para. 23; *Re Savory*, *supra*, note 49, at para. 19; *Re George*, *supra*, note 49, at paras. 15-19; *Re Dass*, *supra*, note 49, at paras. 41-49; *Re Morgado*, *supra*, note 49, at paras. 29-32; *Re Blake*, *supra*, note 49, at paras. 9, 16-19; *Re Williams*, [2010] O.R.B.D. No. 1257, at para. 29; *Re Just*, [2013] O.R.B.D. No. 1308, at paras. 37, 45.

<sup>65</sup> *Penetanguishene Mental Health Centre v. Ontario (Attorney General)*, [2003] S.C.J. No. 67, [2004] 1 S.C.R. 498, paras. 51-56 (S.C.C.) (Tulikorpi, appellant).

recourse. It should be noted that many of these cases involved people who had counsel through the review board system and had been progressing. In contrast with unfit accused, they were capable of instructing counsel to argue for an unwarranted restriction of their liberties.

The peril of a pragmatic approach that gives deference to resource concerns is that such deference comes at the expense of fundamental human rights. The Court of Appeal's focus on resources in *Rea* appeared to impair access to the writ of *habeas corpus* as a means to enforce orders of the Board. Significantly, there were no reported extraordinary remedy applications after the release of *Rea* and the hearing of *Conception*. In the absence of judicial pressure to ensure adequate suitable resources for mentally disordered accused, the hospital wait list becomes all powerful.

In the civil mental health context, the CCB has recently been authorized under the *Mental Health Act* to order transfers of patients from one hospital to another. One criterion the CCB must consider is whether the potential receiving hospital "is able to provide for the patient's care and treatment".<sup>66</sup> A narrow interpretation of this criterion would require only that the hospital be able to accommodate the security and treatment needs of the patient, whereas a broader interpretation will permit the potential receiving hospital to refuse to consent based on bed availability. However, in December, 2014, a five-member panel of the Court of Appeal for Ontario struck down provisions of Ontario's *Mental Health Act* as they pertain to long-term detainees.<sup>67</sup> It remains to be seen how the Government of Ontario remedy the issues arising from *S. (P.) v. Ontario*.

Similarly, section 22 of the *Mental Health Act* provides that a judge may remand a person charged with an offence and suffering from mental disorder for admission to a psychiatric facility for a maximum period of two months. However, the judge cannot make such an order without first determining whether the services of the psychiatric facility "are available".<sup>68</sup> Notably, the CAMH's MOU provides that section 22 *Mental Health Act* orders will be effected within a maximum wait time of four weeks.<sup>69</sup> This prioritization highlights the arbitrariness of the *status quo*.

---

<sup>66</sup> *Mental Health Act*, R.S.O. 1990, c. M.7, s. 39.2(10)(a).

<sup>67</sup> *S. (P.) v. Ontario*, [2014] O.J. No. 6151, 123 O.R. (3d) 651 (Ont. C.A.).

<sup>68</sup> *Mental Health Act*, ss. 22-23.

<sup>69</sup> Ex. A, Affidavit of Dr. Simpson, Memorandum of Understanding, Vol. VI, Appellant's Record, at 159, 160.

As we can see above, without meaningful supervision and enforcement powers, the delays persist. The impact on the unfit accused is more pronounced. The unfit accused detained in jail may be in solitary confinement or otherwise segregated without counsel. By definition they are unable to instruct counsel. In *Conception*, the appellant had the benefit of *amicus* at the Court of Appeal appointed from the Court of Appeal's panel but the appeal was initiated by the hospital. Practically speaking, it is hard to imagine that unfit accused persons would be able to bring an application to the Court to challenge the nature of their detention or the failure of hospital administrators to implement a treatment order.

#### VI. REGULATORY FRAMEWORK DOES NOT REGULATE HOSPITAL CONSENT

While the intervener MHLC argued that the provincial hospital statutory and regulatory framework relied upon by the Court of Appeal as a check on the hospital power to give or withhold consent, the majority did not address that framework in its reasons. It did, however, state that subsection 672.62(1) "is not concerned simply with admission but with treatment upon admission".<sup>70</sup>

On examination, that statutory framework does not appear to actually check hospital power in the way envisaged by the Court of Appeal. Despite the majority question not specifically addressing that framework, understanding it remains important for understanding what power hospital administrators have under those statutes.

In Ontario, treatment is a concept distinct from admission, the latter being governed by the *Public Hospitals Act*<sup>71</sup> and the *Mental Health Act*.<sup>72</sup> The *Health Care Consent Act, 1996* specifically excludes "the admission of a person to a hospital or other facility" from the definition of "treatment".<sup>73</sup> The act of admission is about whether the person requires the care (*i.e.*, that they are sick) and the treatment is an issue to be determined following admission.

---

<sup>70</sup> *Conception*, *supra*, note 1, at para. 27.

<sup>71</sup> R.S.O. 1990, c. P.40.

<sup>72</sup> R.S.O. 1990, c. M.7.

<sup>73</sup> S.O. 1996, c. 2, Sch. A, s. 2(1) "treatment".

The criteria for involuntary admission to hospital under the *Mental Health Act* are not relevant to the admission of unfit accused subject to a treatment order and therefore do not assist as a check on hospital power. Voluntary admissions are discretionary and guided only by considerations of urgency or necessity.<sup>74</sup> The *Public Hospitals Act* provides that a hospital must accept a person as an inpatient if (a) the person has been admitted to the hospital pursuant to the regulations and (b) the person requires the level or type of hospital care for which the hospital is approved by the regulations.<sup>75</sup> Regulations provide that no person shall be admitted to a public hospital except on the order or under the authority of a physician and only where clinically necessary.<sup>76</sup> Regulations further define “admitted” as “received and lodged”.<sup>77</sup> Under the *Public Hospitals Act*, hospital administrators do not have a role in admissions save the requirement that physicians notify them if a patient is dangerous or infectious.<sup>78</sup> Even that requirement is about notification rather than a need to seek permission to the admission. Admission is based on need, not capacity or the nature of the patient. There is no reason why a patient with a mental illness should be treated any differently and, indeed, the statute provides no justification for so doing. Therefore, if the *Public Hospitals Act* is to guide the provision of consent to the disposition under section 672.62(1), it must be with respect to the clinical criteria outlined in section 672.59 and not to the allocation of hospital resources.

As noted by Karakatsanis J., under Part XX.1 the Court undeniably has the ability to make other dispositions that send an unfit accused to be admitted to hospital without the consent of a hospital. Hospital consent is not required when Review Boards or the Court make dispositions outside of section 672.58 that do not impose treatment, including assessment orders, annual disposition orders, and placement orders respecting dual status offenders.<sup>79</sup> That treatment is to be imposed should not be a distinguishing factor, since the evidence before the Court was that the issue was with the timing, not the provision of treatment. In each of these orders that the Courts and review boards can make, there is no consent

---

<sup>74</sup> *Mental Health Act*, ss. 11, 12, 15, 19, 20, 22, 23, 29, 33; General Regulation (*Mental Health Act*), R.R.O. 1990, Reg. 741, s. 7.2(1).

<sup>75</sup> *Public Hospitals Act*, s. 20.

<sup>76</sup> Hospital Management (*Public Hospitals Act*), R.R.O. 1990, Reg. 965, s. 11(1)(a), (2).

<sup>77</sup> *Id.*, s. 1(1) “admitted”.

<sup>78</sup> *Id.*, s. 14.

<sup>79</sup> *Criminal Code*, ss. 672.11-672.16, 672.29, 672.46(1), (2), 672.49, 672.54(c), 672.57, 672.58, 672.68, 672.93.

provision. Hospitals do not in other circumstances have the ability to prevent an accused from being ordered to its facility. It was argued that, because treatment and admission are traditionally distinct in law, the consent required by section 672.62(1) relates to an agreement to administer the treatment, rather than to a decision to “receive and lodge” the patient.<sup>80</sup> The Court implicitly rejected this argument favouring an interpretation that tied treatment with admission to hospital.

## VII. CANADA’S INTERNATIONAL OBLIGATIONS

It is a well-established principle of statutory interpretation that legislation is presumed to conform to international law. Specifically, section 672.62(1) must be construed in a manner consistent with Canada’s obligations under customary and conventional international law and as a signatory of international treaties.<sup>81</sup> Yet the Court, despite these issues being raised by the intervener MHLC, failed to consider them. Of concern is that the decision has the effect of permitting and sanctioning a practice of imprisoning unfit accused subject to treatment orders pending bed availability without access to needed mental health resources. In practical terms, as the evidence demonstrated, this leaves the vulnerable, mentally disordered accused in a dangerous and onerous position: he or she likely to be isolated or face violence affecting the individual’s safety, dignity and/or autonomy. As noted above, health care resources in detention facilities is variable. The relevant international conventions and norms, many of which Canada has ratified, endorsed or adopted as a member of the General Assembly, include the following:

- All prisoners with mental disability shall be treated with humanity and respect for their inherent dignity and autonomy.<sup>82</sup>

---

<sup>80</sup> The *Medicine Act, 1991*, S.O. 1991, c. 30 and the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, also do not govern the conduct of hospitals or medical practitioners in the acceptance or treatment of unfit accused subject to treatment orders.

<sup>81</sup> *R. v. Hape*, [2007] S.C.J. No. 26, at paras. 53-56, [2007] 2 S.C.R. 292 (S.C.C.).

<sup>82</sup> *Basic Principles for the Treatment of Prisoners*, G.A. Res. 45/111 (1990), Principle 1; *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, G.A. Res. 46/119 (1991), Principles 1(2), 9(4); *Convention on the Rights of Persons with Disabilities*, U.N. Doc. A/61/611 (ratified by Canada March 11, 2010), arts. 1, 3(a), 4(1)(c), 17; *International Covenant on Civil and Political Rights 1966*, C.T.S. 1976/47, U.N.T.S. 171, 6 I.L.M. 368 (ratified by Canada May 19, 1976), art. 10; *Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment*, G.A. Res. 43/173, annex, (1988), Principle 1.

- The abolition of solitary confinement or restriction of its use should be undertaken.<sup>83</sup>
- Prisoners shall have access to health services without discrimination on the grounds of their legal situation.<sup>84</sup>
- All persons with mental illness have the right to protection from physical or other abuse and degrading treatment.<sup>85</sup>
- Disability cannot justify unlawful or arbitrary deprivations of liberty.<sup>86</sup>
- Any form of detention or imprisonment and all measures affecting the human rights of a person under any form of detention or imprisonment shall be ordered by, or be subject to, the effective control of a judicial or other authority.<sup>87</sup>
- Effective access to justice shall be ensured for persons with mental disability.<sup>88</sup>
- Persons with mental disability shall not be detained in prisons and arrangements shall be made to remove them to mental health facilities as soon as possible; while in prison, persons with mental disability shall be placed under the special supervision of a medical officer.<sup>89</sup>

---

<sup>83</sup> *Basic Principles for the Treatment of Prisoners, id.*, Principle 7.

<sup>84</sup> *Id.*, Principle 9.

<sup>85</sup> *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, supra*, note 82, Principles 1(3), 8(2); *Convention on the Rights of Persons with Disabilities, supra*, note 82, art. 15; *International Covenant on Civil and Political Rights, supra*, note 82, art. 7; *Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment, supra*, note 82, Principle 6; *United Nations Standard Minimum Rules for the Treatment of Prisoners*, U.N. Doc. E/5988, Rule 31.

<sup>86</sup> *Convention on the Rights of Persons with Disabilities, supra*, note 82, art. 14; *International Covenant on Civil and Political Rights, supra*, note 82, art. 9.

<sup>87</sup> *Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment, supra*, note 82, Principle 4.

<sup>88</sup> *Convention on the Rights of Persons with Disabilities, supra*, note 82, art. 13(1).

<sup>89</sup> *United Nations Standard Minimum Rules for the Treatment of Prisoners, supra*, note 85, Rule 82.

- Every patient with mental disability has the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment.<sup>90</sup>
- All persons with mental disability, including prisoners, have the right to the best available mental health care, which shall be part of the health and social care system.<sup>91</sup>
- A mental health facility shall have access to the same level of resources as any other health establishment and in particular qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a program of appropriate and active therapy.<sup>92</sup>

Further, interpretation pursuant to the Charter must ensure consistency between the meaning of “the full benefit of the *Charter*” and Canada’s international obligations.<sup>93</sup> These obligations inform the section 1 Charter analysis as well as the consideration of the principles of fundamental justice under section 7 of the Charter.<sup>94</sup>

### VIII. CONCLUSION

The Supreme Court of Canada decision in *Conception* represents a departure from over three decades of legal developments in the sphere of civil and forensic mental health law, which were unified by the principles of restraint and oversight. The majority decision effectively sanctions the off-loading of that protection of the most vulnerable people in the criminal justice system to hospital bureaucrats returning unfit accused to a time when they were detained “at pleasure”. While the circumstances in which unfit accused will languish are more limited, they will continue

---

<sup>90</sup> *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, *supra*, note 82, Principle 9(1).

<sup>91</sup> *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, *supra*, note 82, Principles 1(1), 20; *Convention on the Rights of Persons with Disabilities*, *supra*, note 82, art. 25; *United Nations Standard Minimum Rules for the Treatment of Prisoners*, *supra*, note 85, Rule 22(1).

<sup>92</sup> *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, *id.*, Principle 14(1).

<sup>93</sup> *Hape*, *supra*, note 81, at paras. 55, 56.

<sup>94</sup> *Hape*, *id.*, para. 55; *Suresh v. Canada (Minister of Citizenship and Immigration)*, [2002] S.C.J. No. 3, paras. 46, 59-75, [2002] 1 S.C.R. 3 (S.C.C.).

to suffer in onerous and untherapeutic situations unable to instruct counsel to remedy them.

It is hard to conceive of a more vulnerable group of people in our criminal justice system. It is surprising that the Court relinquished that control over them, given that, for over 30 years, the law regarding the treatment of mentally disordered offenders developed in a way that mandated that the mentally disordered person be dealt with in the least onerous, least restrictive way. While the majority's reliance on the Charter permits the Court to have final say, practically speaking, it is difficult to conceive of an unfit accused detained in jail being able to retain and instruct counsel to advance his or her rights. Having reviewed the experience of accused found not criminally responsible on account of mental disorder awaiting transfer, we know that even where a tribunal orders admission, mentally disordered accused face long and debilitating waits.

The decision essentially acknowledges that unfit accused persons may suffer or languish in jail, albeit in "rare" circumstances. Rather than maintaining oversight over those accused (as recommended 30 years ago) and interpreting the statute in a fashion that prevents a Charter breach, the decision leaves it to the most vulnerable accused to complain about a violation of their Charter rights. It remains to be seen whether Courts will be effective means of remedying a Charter breach where hospital resources are limited.

