CANADIAN
MENTAL HEALTH
ASSOCIATION

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BALANCING INDIVIDUAL RIGHTS & PUBLIC INTEREST:

A Submission to the House of Commons Committee on Justice, Human Rights, Public Safety and Emergency Preparedness

Submitted by:
Canadian Mental Health Association

Date:
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Executive Summary

Founded in 1918, the Canadian Mental Health Association (CMHA) is Canada's only voluntary, charitable organization that deals with both mental health and mental illness. CMHA's vision of *"mentally healthy people in a healthy society"* provides the framework for the work that we do. Our mandate is to promote the mental health of all people and to support the recovery and resilience of people with mental illness. As a leading organization for mental health and mental illness in Canada, CMHA promotes mental health and advocates for policy change related to mental illness through the strong connections we forge with policy-makers, mental health consumers and their families, educators, the media, employers, stakeholders and other service providers.

CMHA plays an important role in providing a voice for a community of people who have not been active in public policy development until recently. CMHA is a strong supporter of increasing the role of all stakeholders in the mental illness and mental health communities in public policy development, most particularly the users of services.

The impact of September 11th, 2001 on individuals and Canadian society as whole is still being measured. Individuals have become far more careful and scrutinize other individuals in a way we have not experienced in the past. Governments have increasingly added additional security requirements in an untold number of ways in an effort to prevent such a tragedy from happening again and, at the same time, to assist its citizens to feel more secure in the wake of what happened.

Based on the draft legislation, Bill C-10, presently being reviewed by the House Standing Committee on Justice, Human Rights, Public Safety and Emergency Preparedness, the Canadian Mental Health Association strongly advises the Committee to ensure that the legislation will provide for appropriate safeguards to ensure the balance between public interest and individual rights is achieved.

The unique problem of NCR* accused and other mentally disordered persons who become involved in the criminal justice system will not go away, or even be substantially improved, with legislation, even excellent legislation, alone. Systemic problems within the mental health delivery system will end any effective progress in treating mentally disordered offenders unless steps are taken to improve these systems. What is not happening, and as far as we are aware has never happened, is the delivery of adequate treatment to the individuals involved.

The Canadian Mental Health Association is generally in agreement with the provisions of Bill C-10, however, we have some specific technical recommendations, which are outlined in more detail in our submission.

* *Not Criminally Responsible*

The Canadian Mental Health Association also recommends the Committee support the development and implementation of a Pan-Canadian Strategy on Mental Illness and Mental Health – one which would include the necessary treatments and services for NCR accused and those convicted; and that the variety of treatment and services needed by those living with mental illness and other serious mental health problems, including mental health care, be fully integrated.

The Canadian Mental Health Association believes that for the legislation to be successfully implemented, the federal government must make a long-term financial commitment to ensure adequate and appropriate treatment and services are available, in a timely manner, to NCR accused as well as those convicted and make a commitment with other levels of government to ensure that NCR accused in the provincial/territorial justice system also have adequate treatment and services available in a timely manner.

What is the Canadian Mental Health Association (CMHA)?
Founded in 1918, the Canadian Mental Health Association (CMHA) is Canada's only voluntary, charitable organization that deals with both mental health and mental illness. CMHA's vision of *"mentally healthy people in a healthy society"* provides the framework for the work that we do. Our mandate is to promote the mental health of all people and to support the recovery and resilience of people with mental illness. As a leading organization for mental health and mental illness in Canada, CMHA promotes mental health and advocates for policy change related to mental illness through the strong connections we forge with policy-makers, mental health consumers and their families, educators, the media, employers, stakeholders and other service providers.

With 12 provincial and territorial offices and over 125 local Branches from coast-to-coast-to-coast, CMHA is well-positioned in communities across the country. On an annual basis, CMHA serves over 100,000 people with the support of 10,000 volunteers. Communities in Canada are served by CMHA with programmes and services in education, advocacy, research, programmes, direct service, promotion, information, and public policy development. Our funding comes from government, corporations, foundations and individuals.

CMHA's Role in Public Policy Development
CMHA has had a proud history of contributing to public policy development at all levels of government. Our recent contributions to public policy at the federal level include submissions to the Senate Committee on Science, Social Affairs & Technology; submissions to the Commission on the Future of Health Care in Canada (Romanow Commission); previous submissions to the House of Commons Standing Committees on Finance, Health and Justice as well as programmes and research which have informed our work, the stakeholder community and government (eg: *Citizens for Mental Health; Routes to Work).*

CMHA plays an important role in providing a voice for a community of people who have not been active in public policy development until recently. CMHA is a strong supporter of increasing the role of all stakeholders in the mental illness and mental health communities in public policy development, most particularly the users of services.

CMHA will continue to be active in public policy development and looks forward to increasing its capacity in this area in the years to come.

Balancing Public Interest/Concerns & Individual Rights
The impact of September 11th, 2001 on individuals and Canadian society as whole is still being measured. Individuals have become far more careful and scrutinize other individuals in a way we have not experienced in the past. Governments have increasingly added additional security requirements in an untold number of ways in an effort to prevent such a tragedy from happening again and, at the same time, to assist its citizens to feel more secure in the wake of what happened.

The Canadian Mental Health Association understands that as a result of such tragedies, additional measures are put in place in the name of security. The challenge, though is to ensure that the balance between individual rights and the public interest is kept as evenly as possible.

Based on the draft legislation, Bill C-10, presently being reviewed by the House Standing Committee on Justice, Human Rights, Public Safety and Emergency Preparedness, the Canadian Mental Health Association strongly advises the Committee to ensure that the legislation will provide for appropriate safeguards to ensure the balance between public interest and individual rights is achieved.

Mental Illness and the Justice System

There are so many mentally disordered persons in Canadian prisons that in fact Canadian prisons are the largest psychiatric institutions. Community treatment and services are stretched beyond capacity in communities throughout the nation. The Canadian Mental Health Association is concerned that the number of prisoners affected by mental illness will continue to increase if the lack of treatment and services in the community is not addressed.

The reality all too often is even when an accused is to receive psychiatric evaluation due to the lack of psychiatric or health facilities, the person in question is sent to prison as there is no other place for them.

In the province of Alberta there is an innovative project which diverts those mentally disordered persons from the justice system to the health system so their illness can be properly treated. In Calgary the criminal justice diversion program is responsible for diverting hundreds of individuals who are ill and who have committed minor crimes, to be moved from police, court and jail processes, saving taxpayers millions while providing better service. Similar programs exist in other provinces including New Brunswick and Ontario.

Issues & Concerns with Bill C-10

In preparing for this submission, the Canadian Mental Health Association has had the good fortune to receive and review the submission of the British Columbia Legal Assistance Society, Mental Health Law Program. This organization has had the practical experience of dealing with NCR accused on a day-to-day basis. We urge the Committee to pay attention to what is being recommended in their Brief. The Canadian Mental Health Association supports their Brief in full.

The unique problem of NCR accused and other mentally disordered persons who become involved in the criminal justice system will not go away, or even be substantially improved, with legislation, even excellent legislation, alone. Systemic problems within the mental health delivery system will end any effective progress in treating mentally disordered offenders unless steps are taken to improve these systems.

It is important to keep in mind the following:

- The original purpose of C-30 was two-fold: "…to improve protection for society against those few mentally disordered accused who are dangerous; and to recognize that mentally disordered offenders need due process…." (Evidence of Daniel Prefontaine before the Standing Committee on Justice, October 9th, 1999)
- By the time of C-30, it was recognized that the belief that the mentally ill were predisposed to violence or lawlessness was not founded on any proper analysis of the evidence. Indeed, it appears that the belief found its origins in stereotypical prejudices held for centuries about persons who lived with such conditions. Further, it has now been established that even NCR accused are no more likely than their convicted counterparts to commit any offence, let alone a violent offence. (McLachin J. in *Winko vs BC* (1999) 2 SCR 625 at page 655).
- "…unlike the sanctions faced by a convicted person, the scheme that addresses NCR accused "exacts no penalty, imposes no punishment and casts no blame…" (Winko, at page 684). Accordingly, the "least restrictive approach" was to be taken with respect to NCR accused. To the extent that dentention of NCR accused was permitted, it would only be in cases where it was justified for the protection of the public **and** for the purpose of treatment;
- A very large proportion of the convicted prisoners serving time in our jails are suffering to some extent from a recognized mental disorder. Indeed the penitentiary system may very well be the largest "psychiatric" institution in the country at this point in time. The NCR population represents only the tip of the iceberg. Many others are incarcerated who do not meet the test for application of the NCR provisions or who chose not to take advantage of them but are nonetheless in very serious condition.

Legislative reform is no doubt essential to lay the framework for dealing with all mentally disordered accused or offenders. The Criminal Code now has that framework in that it makes legally possible the diversion of those who take advantage of the NCR provisions to the possibility of treatment.

What is not happening, and as far as we are aware has never happened, is the delivery of adequate treatment to the individuals involved.

The November 2002 recommendations of this Committee included (#16) a recommendation to "….review the resources available to deal with the needs of mentally disordered accused and offenders so as to determine whether they are being used effectively and to see if the level of budgetary allocations is adequate to meet those needs."

The response by the Department of Justice referred to the fact that "…many witnesses that appeared before them expressed their concern about the inadequacy of current resources and their inability to do their job effectively and in the spirit of the law."

Further, we now observe from the above referred to submission from the BC Community Legal Assistance Society that funding is generally **not** available to do what is necessary to release detainees into the community for treatment. The situation in British Columbia does not appear to be any different in other parts of the country.

We would suggest that the entire legislative scheme is floundering on the fact of inadequate funding. Surely it is apparent that to implement any scheme suggested by legislation, a great deal of financial commitment will be necessary from all levels of government to make it a success. Without the funding, Bills C-30 and C-10 will have little effect.

There is, of course, a legal ramification to all of this. It is simplistic to suggest that the courts have given a constitutional carte blanche to the government as long as a legislative framework has been established for the humane treatment of NCR accused and other mentally disordered offenders. It seems reasonably clear from the *Winko* and other cases that the validity of the legislation is at least partly based upon the assumption that detainees and other prisoners will actually receive adequate treatment. How can we say that detainees are being treated in the least restrictive manner if reasonable funding is not available to do what is necessary to treat detainees or to release them into the community for treatment? How can indeterminate periods of detention be justified if little bona fide treatment is being afforded?

The Department of Justice response to the November 2002 recommendations of this Committee stated that: "As a starting point, the Deputy Minister of Justice and the Deputy Minister of Health will discuss strategies for ongoing review and consultation."

CMHA looks forward to hearing of progress on this front and some very specific and significant programs. We are aware of the jurisdictional difficulties with this but these must be overcome and are willing to work with all levels of government to ensure the successful development and implementation of specific and significant programs.

Lack of Health Care Resources

Supporting Recovery

Recovery can be seen as a point in people's lives where they are free of the need for most formal treatment and services and, while they may continue to experience some symptoms, individuals who are mentally ill can live their lives according to their own dreams and desires, and contribute positively to Canadian society. Achieving recovery suggests reaching a stage where mental illness no longer dominates one's life; it reflects only one part of a person's identity. Medical and psychosocial services as well as other community resources all contribute to recovery.

a) Medical Services

With advances in scientific research and the discovery of more effective and tolerable psychotropic medications, it is clear that recovery from mental illness is possible and it is reasonable to expect that people with mental illness will lead productive lives. Clinical services, both medication and psychotherapy, are critical components of the recovery process.

b) Beyond the Medical Model: A Range of Services

Besides taking control of one's symptoms, recovery also involves meaningful daily activity and a secure place to stay, requiring services beyond the medical approach.

Although it did not happen uniformly across the country, the deinstitutionalization process of the 1970s and 80s has taught us some important lessons that have implications for how treatment, services and supports are delivered to persons living with mental illness and/or coping with other serious mental health problems and why the prisons of this country are home to so many with mental health problems.

Lessons learned:

- Medical services are necessary but by no means sufficient to deal with the crippling social and economic factors that often accompany serious mental illness – social exclusion, poverty, homelessness, unemployment and stigma.
- Services beyond biomedical must be present in the community. Other services that provide assistance with activities such as securing decent housing, income support, psycho-therapy and employment opportunities have a critical role to play in promoting good mental health.
- An accessible, integrated mental health system, equipped to deal with biomedical, psychological and psychosocial issues, must address the full continuum of care, promotion/prevention, diagnosis, treatment, rehabilitation and recovery across institutional and home/community settings. These services are necessary and must be universally available through publicly funded systems.
- Active participation of the individual living with a mental illness and their family is an important ingredient for success. People with mental illness and their families have critical knowledge and understanding. By including their perspective in planning, policy making, service design and delivery and evaluation, many false steps can be avoided.

Barriers to Recovery

Stigma

Although recent scientific breakthroughs have provided new insights into the complex working of the human brain, mental illness still remains a mysterious and frightening phenomenon for the majority of the public, especially when the commitment of a crime is associated with a mentally disordered person. Public ignorance and fear are reinforced by hurtful stereotypes of mental illness in the media. While there is no empirical evidence to support a causal link between mental illness and violence, a recent survey re-confirms that the public continues to believe this myth, which then clouds judgements associated with mentally disordered accused.

While public perception may be more grounded in myth than reality, negative attitudes towards those with mental illness, as shaped by this perception, are all too real. Canadian society is cold and rejecting to people with serious mental illness or other serious mental health problem. Most landlords don't want to rent to someone who is mentally ill; many employers don't want to hire such individuals and for too many people, friends have

become few and far between. Police and the courts typically over-react to mental illness and insurance providers may deny people with mental illness the same sort of coverage they provide to others.

Stigma represents a major obstacle to recovery in another significant way; it creates one of the most critical barriers to seeking treatment within the formal health care system.

Fragmented Care

Canada's health care system does not treat the illnesses of the mind the same way as the illness of the rest of the body. The primary care system is usually the first point of contact by individuals experiencing mental health problems or serious mental illness. Up to a third of persons presenting to primary care services suffer from psychological problems. Yet many medical generalists lack sufficient knowledge, skills and motivations to manage patients with mental illness, to accurately screen for mental health problems, or to navigate the appropriate referral pathways to access the specialized system.

The mental health system is a complex array of services, delivered through federal, provincial and municipal jurisdictions, non-profit and profit providers. It can best be described as a mix of acute care services in general hospitals, specialized services for specific disorders or populations, outpatients community clinics, community-based services, psychosocial supports (housing, employment, education and crisis intervention) and private counselling, all of varying quality and operating in separate silos, and generally disconnected from the broader health care systems.

The result is a system that is non-responsive to the needs of those individuals living with a mental illness and/or other serious mental health problem, where misdiagnoses and delays in obtaining proper support/treatment have become the norm. Finding the appropriate supports and treatment requires a fairly high degree of understanding of the system and the patience to navigate an incredibly challenging one. This is rarely a short journey, and far too many fall through the cracks along the way – ending up in jail or living on the streets.

Shortage of Professionals

The need for adequately trained professionals from a variety of disciplines is becoming increasingly apparent. In particular, certain regions such as rural and remote areas and population groups such as children and youth experience a serious lack of services in this country.

According to the Ontario Federation of Community Mental Health and Addiction Programs, about half of the adult population who need mental health services must wait for eight weeks or more – an eternity in the lifetime of a person, a family or a community, struggling with a serious mental health or addiction problem. For some people, having to wait for services is the difference between life and death, between committing a crime or not.

Poverty

Given that poverty is strongly associated with a number of broad health and social issues and that family poverty is contributing factor to increased incidences of child and parental depression, suicide, violence, mental illness and other emotional problems that tend to be passed on from one generation to the next, those individuals least likely to be able to benefit from services and supports are often those with the greatest mental health needs. This is particularly true for most people with serious mental illness, who live an impoverished and disfranchised existence.

Recommendations

The Canadian Mental Health Association is generally in agreement with the provisions of Bill C-10, however, we have some specific technical recommendations, which we have outlined below:

1. **Clause 16 (1): The CMHA supports a requirement that counsel be appointed to represent an accused at a hearing. However, the provision stipulates that the appointment may be made "at the time of the hearing". These matters are often far too complex for legal counsel who is appointed at the time of the hearing to have much effect. We would recommend that this amendment be altered so as to require appointment within a reasonable period of time prior to the hearing;**

2. **Clause 16 (3): This provision amends section 672.5 (16) so as to permit a victim to read a victim impact statement at a hearing and to require the Court or Review Board to inquire of a prosecutor or a victim whether they have been advised of the opportunity to prepare such a statement. Of course, this must be read in light of the amendment proposed in Clause 21 to section 672.54 (1) of the *Act* which states that the Court or Review Board shall take into consideration only those parts of a statement which are relevant to its consideration of the criteria set out in section 672.54. Given the fact that by definition an NCR individual is, in effect "not guilty", having lacked the requisite intent to commit a criminal act, we are puzzled at why victim impact statements are of any relevance in the first place, let alone why it is proposed that victims be permitted to read such a statement (as opposed to submitting it in written form) and why it becomes mandatory for the Review Board or Court to inquire if a victim has been informed of his or her rights in this regard. While it may very well be appropriate in specific cases for an accused to be made aware of the impact of his or her activity, surely there is a better way of doing so than having the victim perform this task. Further, if a case should arise where a victim impact statement is of relevance, surely the legislation should restrict the statement to matters that are relevant to the criteria set out in section 672.54 of the Code rather than permitting the victim to say anything that he or she wants in the statement.**

3. **Clause 27(2): This provision permits a review of a disposition to be extended from 12 months to 24 months when the accused consents <u>or</u> the accused has been found NCR with respect to a serious personal injury offence, is in a hospital and is not likely to improve. The CMHA does not believe that the nature of the offense should dictate when a disposition is reviewed. This imports an element of punishment into the proceedings. In the *Winko* case, the Supreme Court noted on several occasions that the 12 month automatic review was an important consideration in upholding the constitutional validity of Bill C-30. This should not be departed from lightly. Further, this is not saved by the provisions of 672.82 of the Code which provide only a discretionary obligation on the part of the Review Board to conduct a hearing when requested by any party;**

4. **Clause 29: This repeals section 672.82 (2) of the Code which in turn referred to section 672.52 (3) of the Code which required a Review Board to state its reasons for making a disposition in the record of the proceedings and provide a copy to all parties. It is exceedingly important that a Review Board state its reasons for any disposition. How else can a decision be effectively challenged? CMHA recommends that this amendment be deleted;**

5. **Clause 33: This provision enables the Review Board to hold a hearing to determine whether or not it should recommend a stay of proceedings in the case of accuseds that are found not fit to stand trial. CMHA supports this provision;**

6. **Clause 34(2): This provision seems to permit the Review Board to direct the transfer of an accused who is not in custody to any other place in Canada for the purpose of reintegration into society, recovery or treatment. This should be approached with caution. An accused that is not in custody is by definition thought not to be dangerous. It would therefore seem extraordinary to provide an unqualified authority permitting a Review Board to transfer such a person anywhere they sought fit.**

7. **Clause 39: The effect of this clause is to repeal S. 747 of the Code which provides for detention in a treatment facility as the initial part of a sentence of imprisonment where the court finds that that the offender is suffering from a mental disorder in an acute phase and that immediate treatment "…is urgently required to prevent further significant deterioration of the mental or physical health of the offender…". We can't understand why this provision has never been proclaimed, let alone why repeal is now proposed. Without the authority provided by 747, it seems to us that the court has no alternative but to send the offender to a conventional jail. We don't like the chances of an offender being adequately treated in a conventional jail very much. If the problem with s. 747 is lack of funding the answer is not repeal, but to properly fund a program for this.**

The Canadian Mental Health Association also recommends:

1. **That the House of Commons Standing Committee on Justice, Human Rights, Public Safety and Emergency Preparedness support the development and implementation of a Pan-Canadian Strategy on Mental Illness and Mental Health – one which include the necessary treatments and services for NCR accused and those convicted.**
2. **That the variety of treatment and services needed by those living with mental illness and other serious mental health problems, including mental health care, are fully integrated. This will ensure that disorders of the mind are treated the same as disorders of the rest of the body at the same time other services that are non-medical in nature are integrated and available.**

Conclusion

The Canadian Mental Health Association is pleased to have the opportunity to submit its response to Bill C-10 and to present at the Hearings of the Committee later this month. The Association does believe that the Committee needs to take into serious consideration the technical recommendations in this submission and to ensure that the balance between individual rights and the public interest is considered.

We believe that for the legislation to be successfully implemented, the federal government must make a long-term financial commitment to ensure adequate and appropriate treatment and services are available, in a timely manner, to NCR accused as well as those convicted and make a commitment with other levels of government to ensure that NCR accused in the provincial/territorial justice system also have adequate treatment and services available in a timely manner.