LANDING IN THE CUCKOO'S NEST: THE HOSPITAL DISPOSITION OF GUILTY MENTALLY ILL OFFENDERS — LESSONS FROM THE UNITED KINGDOM

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This article explores the current schemes for sentencing guilty mentally ill offenders in Canada and the United Kingdom. The author highlights the deficiencies of the current Canadian scheme, arguing both that it is limited to the traditional sentencing smorgasbord and that principles of sentencing are difficult to balance with respect to guilty mentally ill offenders.

In his analysis of the mental health sentencing dispositions available in the United Kingdom, the author assesses how such a scheme could be implemented in Canada and what modifications are necessary in order to better conform with Canadian law and policy. In particular, the areas concerning disposition thresholds, consent to treatment and discharge are examined.

The author concludes that implementation of a hospital disposition in the Canadian sentencing regime is necessary to overcome conflicting sentencing principles and correctional aims, to address the lack of correctional programs and infrastructure courts encounter when sentencing guilty mentally ill offenders, and to enhance the protection of society — the primary goal in sentencing.

Cet article explore les arrangements courants d'imposition de sentence à des délinquants atteints de maladie mentale au Canada et au Royaume-Uni. L'auteur souligne les manques dans le projet canadien actuel, faisant autant valoir que les arrangements se limitent à l'assortiment traditionnel de l'imposition de peines et qu'il est difficile d'équilibrer les principes de l'imposition de sentence et le respect des délinquants atteints de maladie mentale.

Dans cette analyse des dispositions sur l'imposition de sanctions aux malades mentaux qui existent au Royaume-Uni, l'auteur évalue la mesure dans laquelle de tels arrangements pourraient être mis en œuvre au Canada et quelles modifications seraient nécessaires pour se conformer à la loi et aux politiques canadiennes. Les secteurs qui concernent les seuils de disposition, le consentement au traitement et la décharge sont particulièrement étudiés.

L'auteur conclut que l'implantation des dispositions hospitalières dans le cadre du régime d'imposition de sanctions canadien est nécessaire pour régler les conflits entre les principes et les objectifs correctionnels, pour régler le manque de programmes correctionnels et de tribunaux d'infrastructure au moment d'imposer une peine à des délinquants atteints de maladie mentale et pour améliorer la protection de la société ce qui est le but premier de l'imposition d'une peine.

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I. INTRODUCTION

Canadian courts cannot satisfactorily address the disposition of a mentally ill offender who is found guilty of or pleads guilty to an offence punishable by imprisonment.[1] The current sentencing options available to a court are limited to the "traditional" sentencing smorgasbord.[2] However, the current sentencing options do not adequately address an offender's mental health circumstances. Indeed, Canadian sentencing law does not even recognize the defence of diminished responsibility.[3] As a result, for sentencing purposes, mental illness can at best be proffered as a mitigating factor.

A disposition which specifically addresses the mental health of the offender is a truant in Canadian sentencing law. One solution to this lacuna is by way of a mental health disposition which interfaces with the criminal justice system. Such mental health-criminal justice interfaces have been available in other Commonwealth jurisdictions for some time. However, the disposition of a mentally ill offender through a mental health-criminal justice interface is not without its own unique lessons.

This article will examine the United Kingdom's mental health-criminal justice interface as it relates to the disposition of mentally ill offenders who plead or are found guilty of an offence punishable by imprisonment. Specifically, attention will be drawn to issues influencing the translation of a similar interface into the Canadian sentencing landscape.

Part II considers the case for a mental health-criminal justice interface in Canada. Along with a discussion on the impact of current sentencing principles on mentally ill offenders, both the recommendations of the Law Reform Commission of Canada and judicial response relevant to the disposition of guilty mentally ill offenders will be explored.

Part III will describe the United Kingdom's statutory interface with an aim of providing a general framework of how the interface operates. In particular, provisions relating to evidentiary requirements, specific hospital dispositions, discharge, and consent to treatment will be outlined. In addition, specific practical constraints to the interface will be discussed.

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1 The issues of fitness to stand trial or the verdict of not criminally responsible on account of mental disorder are outside the ambit of this article. Part XX.1 of the *Criminal Code*, R.S.C. 1985, c. C-46 [hereinafter *Code*] addresses these matters.

2 In particular cases the Crown may bring a Dangerous Offender application under Part XXIV of the *Code*.

3 *R.* v. *Chartrand*, [1977] 1 S.C.R. 314.

Part IV provides a view of the United Kingdom's scheme through a Canadian lens. This Part will explore translating the scheme into the Canadian context, with a focus on threshold issues, consent to treatment, and discharge.

This article will conclude by suggesting that the current Canadian regime for the disposition of a guilty mentally ill offender is deficient. That in light of the disposition options currently available in the United Kingdom and other Commonwealth countries, Parliament ought to implement a similar scheme. It will be suggested that any Canadian scheme, however similar, ought to be modified in order to better understand the lessons learned from the United Kingdom's scheme.

II. THE GUILTY MENTALLY ILL OFFENDER IN CANADA

At present, the *Code* does not contain any specific provisions expressly respecting the disposition of guilty mentally ill offenders. There are dispositions available for persons who are found to be "unfit to stand trial"[4] as well for those who are found "not criminally responsible on account of mental disorder."[5] The problem lies in the middle of these two extremes. It concerns the offender who is trapped between the threshold of being found mentally fit enough to stand trial and the threshold for a finding of NCRMD. In light of the defence of diminished responsibility being unavailable, the offender is either acquitted or convicted and sentenced. In this vein, three scenarios can be envisaged. First, the evidence establishes that the offender, due to mental illness, lacked the necessary *mens rea* for the offence charged. As a result, the focus of the trial shifts to a lesser and included offence.[6] The second scenario envisages a conviction for the offence charged, irrespective of the intent requirement. In such a case, the evidence regarding mental illness is immaterial to the inquiry, or if an insanity defence is attempted, the NCRMD threshold is not crossed. In the last scenario, the accused pleads guilty. In any of these events, the end result is the "traditional" sentencing principles and objectives being brought to bear on the offender. Mental illness will undoubtedly be argued to be a mitigating factor in determining a sentence. Thus, in arriving at a fit sentence, immediate tensions arise between mental illness and the degree of responsibility on the one hand, and mental illness and sentencing principles on the other. Sentences are to be imposed according to the gravity of the offence and the moral blameworthiness or degree of responsibility of the accused.

Mitigation due to mental illness, however, carries limited currency. There are constraints. First, the nature of the offence in and of itself creates a range of responsibility

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4 *Code*, *supra* note 1, ss. 672.22-672.33.

5 *Ibid.*, ss. 672.34-672.63 [hereinafter NCRMD].

6 See R.D. Schneider, "Sentencing Mentally Ill Offenders" in J.V. Roberts & D. P. Cole, eds., *Making Sense of Sentencing* (Toronto: University of Toronto Press, 1999) 160 at 163ff for another discussion on the mitigating effect of mental disorder. With respect to viewing the offender as less culpable (as opposed to diminished responsibility) see, *e.g.*, *R.* v. *Shore* (1999), 122 B.C.A. 140, B.C.J. No. 832, online: QL (BCJ) (C.A.). Shore was charged with arson with disregard for human life contrary to s. 433 of the *Code*. She had a history of mental illness and psychiatric contacts. However, as the trial unfolded the Crown realized that Shore lacked the necessary *mens rea* for the offence. As a result, the indictment was amended, on consent, to arson "*simplicter*," and the accused was convicted. However, the same scenario can take place with lesser and included offences in the indictment.

or moral blameworthiness for an offender. The degree of responsibility is pegged by aggravating and mitigating factors, and a fit sentence within a customary range is determined. At best mental illness will pull the quantum towards the bottom end of that range.[7] However, this process is carried on not with mental illness as an ingredient in determining disposition, but rather as a garnish. Also, it is unclear whether a nexus between the mental illness and the commission of the offence ought to exist. The requirement of such a nexus will narrow the field of mentally ill offenders who can rely on their illness in order to reduce responsibility and mitigate their sentence or justify an exceptional one. The nexus approach also fails to consider mentally ill offenders with cognitive problems. The point here is that cognitive problems by virtue of mental illness ought to play a more central role in reducing the degree of responsibility assigned to an offender.

The second constraint occurs in balancing the sentencing principles of denunciation, deterrence, and rehabilitation. The requirement of a denunciatory sentence can blur the lines between a fit sentence for a mentally ill offender and an offender who is not mentally ill. Specifically, the difficulty lies in the inability to clearly distinguish between offenders who are mentally ill and those who are not. Thus the principle of denunciation can militate against the imposition of a sentence which accounts for a lessened degree of responsibility due to mental illness. Again, quantum within a range is affected, not the range itself.

In addition, obfuscation respecting the value of deterrence occurs. If one can conceptualize general deterrence as the deterrence of individuals minded to committing the same offence, the problem becomes readily identifiable. This principle loses relevance with regard to a mentally ill offender, and the "deterrent effect of sentences *per se*"[8] becomes even more problematic. The same can be said for specific deterrence. It is questionable what value a sentence fashioned with specific deterrence as a primary principle will have. For example, an offender suffering from schizophrenia who hears voices in his/her head commanding the burning of a building is not going to consider the general deterrent effect of a sentence.[9] Nor is specific deterrence going to affect the course of action taken by that offender at some future point in time.

Last, the goal of rehabilitation is also confused. The confusion lies in whether rehabilitation of an offender means the "reinstatement [of an offender] as a functioning

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7 However, it is acknowledged that a court may reduce a customary sentence and impose an exceptional one: see *R.* v. *Fireman* (1971), 4 C.C.C. (2d) 82 (Ont. C.A.). See also Schneider, *ibid.* at 164-65 where the author discusses *R.* v. *Wallace* (1973), 11 C.C.C. (2d) 95 (Ont. C.A.) [hereinafter *Wallace*] and *R.* v. *Lockhart* (1987), 19 O.A.C. 158 (C.A.) in the context of the Court reducing the sentence in order to allow for psychiatric treatment.

8 Law Reform Commission of Canada, *Studies on Sentencing* (Ottawa: Information Canada, 1974) at 8 [hereinafter *Studies*]. See also Law Reform Commission of Canada, *The Principles of Sentencing and Dispositions* (Working Paper No. 3) (Ottawa: Information Canada, 1974) at 4.

9 Fit to stand trial and not ill enough for a finding of NCRMD. I credit lawyer Michael Mandelcorn for this example in relation to deterrence.

and law abiding member of the community"[10] or the restoration of an offender's mental health.[11] For a mentally ill offender, such a binary or compartmentalized approach is dubious. It ignores the reality that mere reinstatement of membership without a rehabilitative measure for the offender's mental illness will not serve to protect society. Indeed, the Law Reform Commission of Canada recognized that "[r]ehabilitation, in the sense of improving the offender's ability to cope with life, may not be an unimportant factor in sentencing"; "to improve an offender's life skills or to reduce his personal suffering are simple, humane gestures that should have a proper place in sentencing policy."[12] In this regard, a hospital disposition provides "remedial action in the form of medical or psychiatric treatment in an attempt to rehabilitate or retard the deterioration of a mentally disordered person," and "[i]t is here that the object of rehabilitation assumes most meaning."[13] However, Verdun-Jones warns that "it would be somewhat shortsighted to view the hospital order purely in terms of its therapeutic goals."[14] It must be remembered that a hospital disposition, like imprisonment, deprives the offender of his/her liberty. It also protects the community by separating the individual from societal interaction.[15] The Department of Justice's Discussion Paper, *Mental Disorder Project: Criminal Law Review*, states the thrust of the argument most succinctly.[16] One of the primary aims of the criminal law is the protection of society. Imprisonment can provide short-term protection. However, if a secondary object of criminal law is rehabilitation, the Department of Justice has concluded that "imprisonment probably does not provide" it.[17] The Discussion Paper concludes "[b]ut where is the protection for the future if there is no rehabilitation? *The use of prison sentences when dealing with mentally disordered offenders is therefore questionable.*"[18] Furthermore, the Law Reform Commission has recognized the reality that "[p]risons are not ... institutions of treatment, custody taking priority over treatment, punishment over rehabilitation,"[19] notwithstanding the

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10 *R.* v. *Shahnawaz* (2000), 149 C.C.C. (3d) 97, 51 O.R. (3d) 29, 1370 A.C. 363 (C.A.) [hereinafter *Shahnawaz*]. Shahnawaz was charged with trafficking in heroin. At the time of the offence, he was suffering from post-traumatic stress disorder resulting from being detained by Russian troops during the Russian occupation in Afghanistan. Everyday, for a period of five months, he was tortured by being electrocuted, strangled, and beaten on the head and body with and without weapons. Physically, the ordeal left him scarred and blind in one eye. His cognitive skills were severely impaired. The trial judge determined an exceptional fit sentence to be two years less a day and imposed a conditional sentence of seventeen months less a day after crediting 3½ months of pretrial custody. The majority increased this to six years incarceration after deciding that the customary range was nine to twelve years. Shahnawaz had already served two-thirds of the conditional sentence. The Crown had conceded that two years less a day was a fit sentence. Laskin J.A., in dissent, would not have disturbed the trial judge's sentence.

11 In the sense of restoration of mental health, it is recognized that complete restoration cannot always take place.

12 *Studies*, *supra* note 8 at 8.

13 I. Potas, *Just Deserts for the Mad* (Canberra: Australian Institute of Criminology, 1982) at 13-14; see also S.N. Verdun-Jones, "Sentencing the Partly Mad and the Partly Bad: The Case of The Hospital Order in England and Wales" (1989) 12 Int'l J. L. & Psy. 1 at 11.

14 Verdun-Jones, *ibid.* at 10.

15 Potas, *supra* note 13.

16 (Ottawa: Department of Justice, 1983).

17 *Ibid.* at 285.

18 *Ibid.* [emphasis added].

19 Law Reform Commission of Canada, *A Report to Parliament on Mental Disorder in the Criminal Process* (Report) (Ottawa: Information Canada, 1976) at 27 [hereinafter *Mental Disorder Report*].

recommendation that the sentenced "offender should be given the benefit of ... health services similar to those available to a free citizen."[20]

Our courts presently rely on correctional authorities to provide post-sentencing services relating to the mental health of an offender.[21] Such a reliance is tenuous. It fails to consider that even in light of a court recommendation, it is ultimately up to correctional authorities to decide if any realistic treatment will be given. Indeed, the reference by a court to treatment in a prison setting "always raises expectations, and those expectations for good reasons are frequently disappointed."[22] The situation is further exacerbated by "[t]he fact that psychiatric facilities at Canadian prisons are seriously inadequate."[23] In addition, offender classification is dictated by institutional security requirements, which focus on the risk posed by an offender. Studies have shown that "there may be a biased presumption of greater risk for offenders with mental disorders, particularly for those who also have a lengthy [criminal] record."[24] Access to programs and mental health services is directly affected by the security level of the institution into which an offender is placed. There is also institutional culture to consider. The prime consideration for this aspect is what effect the institutional culture, as between inmates or correctional officers and inmates, will have on a mentally ill offender. In this regard, it has been observed that correctional officers associate both unpredictability and dangerousness with mental disorder.[25] Correctional officers have also stated that working with mentally ill offenders increases job stress.[26] Thus, as Porporino & Motiuk observe, "if these sorts of perceptions are pervasive within the correctional environment, then one would expect that they would be reflected in more negative outcomes for offenders with mental disorders flowing from the decisions of correctional authorities."[27] Finally, "there is a tendency for offenders with disorders to serve more time prior to release, in absolute terms, and to serve a greater portion of their sentence, in relative terms."[28] As a result, "high levels of psychiatric morbidity ... will probably continue," and prison psychiatry will be caught in the wake of a "repressive bureaucracy" with "alien aims and philosophies."[29] In sum, the watertight approach to rehabilitation espoused by some courts is ill-informed.

A partial solution to such sentencing conundrums was proposed by the Law Reform Commission of Canada. In 1976 the Commission proposed a criminal justice-mental heath disposition, recognizing that judges were powerless to order that "[the] term of

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20 Law Reform Commission of Canada, *A Report on Dispositions and Sentences in the Criminal Process: Guidelines* (Report) (Ottawa: Law Reform Commission of Canada, 1979) at 26 [hereinafter "LRC *Guidelines*"].

21 *Shahnawaz*, *supra* note 10 at para. 34.

22 *R.* v. *Hook* (1980), 2 Cr. App. R. (S) 353 (C.A.) at 355.

23 *Mental Disorder Project: Criminal Law Review*, *supra* note 16 at 285.

24 F.J. Porporino & L.L. Motiuk, *The Prison Careers of Offenders with Mental Disorders* (Ottawa: Correctional Service Canada: 1994), online: Correctional Service Canada <www.csc-scc.gc.ca/text/rsrch/reports/reports_e.shtml> (date accessed: 15 February 2001).

25 *Ibid.*

26 P.R. Kropp *et al.*, "The Perceptions of Correctional Officers Toward Mentally Disordered Offenders" (1989) 12 Int'l J. L. & Psy. 181 at 188.

27 Porporino & Motiuk, *supra* note 24.

28 *Ibid.*

29 G.N. Conacher, *Management of the Mentally Disordered Offender in Prisons* (Montreal: McGill-Queen's University Press, 1996) at 92.

imprisonment be [served] ... in a psychiatric facility," transfers from prison to mental hospitals were rare, recommendations by judges for psychiatric treatment were often not followed, and the "sparse facilities for psychiatric treatment in prisons" meant that prisoners suffering from serious mental illness were "detained without the prospect of treatment."[30] The Commission recommended that "judges be given the power to order that a term of imprisonment be spent in whole or in part in a psychiatric facility" by way of a "hospital order," and further recognized that the United Kingdom has had similar provisions since 1959.[31] Subsequently, in 1976, the Commission repeated its call for the "hospital order" to be included in the range of sentences available to a court and for Parliament to implement legislation.[32]

Unfortunately, Parliament has not followed the Commission's recommendations. The reasons for this may range from lack of interest due to political fallout to early skepticism of the Commission's work. In addition, constitutional considerations come into play.[33] While the scheme in the United Kingdom comes under the rubric of a unified constitutional system, the division of powers in Canada between the federal government and the provinces may seem to create constitutional difficulties. This is due to provinces having responsibility for mental health legislation. In other words, it can be argued that it would be *ultra vires* Parliament to pass laws pertaining to mental health legislation. This is not the case. So long as the pith and substance of any proposed hospital disposition scheme falls under federal criminal law power, it cannot be said that the scheme is not within Parliament's competence. Sentencing is a legitimate part of the federal criminal law power. Moreover, classifying which head of power the pith and substance of the disposition falls under is "not an exact science."[34] This, combined with the fact that "[t]he double aspect doctrine permits both levels of government to legislate in one jurisdictional field for two different purposes" also allays concerns of a constitutional dilemma.[35] Indeed, no such dilemma was even identified by the Law Reform Commission. Further support for the proposition that a hospital disposition is *intra vires* Parliament comes from Chief Justice Lamer's statement for the majority of the Court that "criminal law sentencing may deal with considerations of rehabilitation" and that "[i]f Parliament chooses to respond ... in a manner more sensitive to rehabilitation concerns, *it does not thereby lose its legislative competence.*"[36] The critical distinguishing feature between NCRMD and hospital dispositions is the conviction of the accused. Since the NCRMD scheme has been held to be constitutional,[37] there is authority to support the

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30 Law Reform Commission of Canada, *The Criminal Process and Mental Disorder* (Working Paper No. 14) (Ottawa: Information Canada, 1975) at 46 [hereinafter "Working Paper 14"].

31 *Ibid.*

32 LRC *Guidelines*, *supra* note 20 at 31-32, 66. See also *Mental Disorder Report*, *supra* note 19 at 24ff, 46.

33 While a complete discussion on the constitutionality of sentencing dispositions is beyond the scope of this article, the authorities appear to support the proposition that mental health dispositions are within the competency of Parliament: see generally *R.* v. *Swain*, [1991] 1 S.C.R. 933 [hereinafter *Swain*]; *R.* v. *Winko*, [1999] 2 S.C.R. 625 [hereinafter *Winko*]; and P.W. Hogg, *Constitutional Law of Canada*, looseleaf (Toronto: Carswell, 1997) c. 18-19.

34 *Reference Re Firearms Act (Can.)*, [2000] 1 S.C.R. 783 at para. 26 [hereinafter *Firearms Reference*].

35 *Ibid.* at para. 52.

36 *Swain*, *supra* note 33 at 1007, Lamer C.J.C. [emphasis added].

37 *Winko*, *supra* note 33; see *Swain*, *ibid.*, from which the new NCRMD scheme was based.

conclusion that a hospital disposition for a guilty mentally ill offender will also be constitutional. Thus, so long as there is no improper motive, nor Parliament's taking over of a provincial power under the guise of criminal law,[38] a properly crafted hospital disposition scheme for such offenders within the *Code* will be presumed to be constitutional[39] and indeed *intra vires* Parliament.

It may also be argued that there will not be a uniform set of criteria for a hospital disposition. However, this argument contains a flaw. Its premise is that any *Code* provision dealing with a hospital disposition would have to be harmonized with provincial mental health legislation. This does not have to be the case. Professor Hogg has stated that "the power to punish by imprisonment carries with it the power to define the nature of the imprisonment, even though that involves *federal imposition of national standards* on the provincial prison systems."[40] The principle to draw upon is that in the context of criminal dispositions, Parliament can define the contours of how the disposition is to be effected. Just as the *Code* provides a complete statutory scheme for the disposition of those found to be unfit to stand trial or NCRMD, the *Code* can also provide a complete scheme for hospital dispositions. Indeed, individuals coming within the rubric of unfit to stand trial or NCRMD are typically placed in a provincial mental health facility, notwithstanding the disposition under a federal head of power.[41] Because the destination is most likely to a provincial mental health facility, the issue of cost arises. The answer to this issue was provided by an Information Paper published in 1986 by the Minister of Justice and the Attorney General of Canada. The findings revealed that there would "not likely be a substantial cost increase resulting from [the] proposed ["hospital order"] amendment," and moreover, the findings also revealed that the Law Reform Commission's proposal for a hospital disposition "was very well received on consultation."[42]

So far Parliament's only response has been to provide for a hospital order at the time of sentencing in s. 747 of the *Code*. This disposition is limited in both scope and duration and has not yet been proclaimed. The application of s. 747 is limited to emergency situations in order to prevent a sentenced offender from suffering "further significant deterioration of ... mental or physical health, or to prevent the offender from causing serious bodily harm to any person."[43] In addition, before the expiration of the sixty-day limit, the court may authorize, in writing, the transfer of the offender from the first

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38 These two factors would go to the colourable intrusion into a provincial power: *Firearms Reference*, *supra* note 34 at para. 53.

39 See *Nova Scotia Board of Censors* v. *McNeil*, [1978] 2 S.C.R. 662.

40 Hogg, *supra* note 33 at 19-22 [emphasis added]. The context of this statement comes from the requirement in s. 24 of the *Young Offenders Act*, R.S.C. 1985, c. Y-1 to keep juveniles in separate custody within provincial institutions.

41 For example, in Ontario, the Mental Health Centre Penetanguishene provides "beds in the minimum, medium and maximum security designations" for individuals requiring psychiatric assessments (Assessment Orders) and those found to be unfit to stand trial or NCRMD: see Ontario, Ministry of Health, *Referral and Admission Guidelines: Mental Health Centre Penetanguishine Forensic Division*, online: <www.mhcva.on.ca/mhcporad.htm> (date accessed: 2 January 2002).

42 Minister of Justice and the Attorney General of Canada, *Mental Disorder Amendments to the Criminal Code* (Information Paper) (Ottawa: Minister of Justice and the Attorney General of Canada, 1986).

43 *Code*, *supra* note 1, s. 747.1.

treatment facility to another for treatment of one's mental disorder.[44] The duration of the transfer is not stated, and from a fair reading of s. 747, it would seem that the duration is either for the remaining portion of the sixty days or, at most, sixty days. After the order expires or is brought to an end, the offender is returned to prison custody to serve the remainder of his/her sentence. This provision is an unsatisfactory response for addressing the needs of mentally ill offenders. It is a short-term solution which lacks any rehabilitative objective — it merely placates an offender in crisis.[45]

The lack of any meaningful response by Parliament has forced courts to construct a criminal justice-mental health disposition. The Supreme Court of Canada entered the arena by upholding a provincial court judge's fashioning of a hospital disposition through the use of the conditional sentencing regime.[46] However, the Court's decision arrived with controversy in tow. Professor Kaiser implies that the majority decision, penned by Madame Justice Arbour, engaged in "the radical judicial rewriting of the conditional sentencing provisions as they apply to offenders who are dangerous and who have a mental health problem."[47] In this regard, the Court divided squarely on both the use of the conditional sentence regime as a vehicle for constructing hospital dispositions and on the issue of dangerousness.[48] In both instances, Professor Allan Manson has stated that the majority's decision is an extension of the scope of the conditional sentence.[49] While both professors agree that the combined judgments may help rally proponents for reform and stir political will,[50] both Professor Kaiser's comment and the minority's decision miss the mark. The promotion of long-term public safety is ignored. If one accepts that the primary goal of criminal law is the protection of society,[51] how then is this achieved by the minority which would rather see Knoblauch incarcerated, despite psychiatric opinion regarding the potential fallout?[52] The minority's temporary solution would not have assisted Knoblauch to (re)adjust to society. Rather, it would have wasted both time and an opportunity towards rehabilitation. The disposition that the minority envisaged would have been to a provincial prison. Today the focus of public fiscal policy has

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44 *Ibid.*, s. 747.5(2).

45 See also A. Manson, *The Law of Sentencing* (Toronto: Irwin Law, 2001) at 387; H.A. Kaiser, "*R.* v. *Knoblauch*: A Mishap 'at the often ambiguous crossroads between the criminal justice and the mental health care systems'" (2001) 37 C.R. (5th) 401 at 409.

46 *R.* v. *Knoblauch*, [2000] 2 S.C.R. 780 [hereinafter *Knoblauch*].

47 Kaiser, *supra* note 45 at 401, where he says "the four dissenting justices ... explicitly resisted the tempation to engage in the radical judicial rewriting of the conditional sentencing provisions...."

48 *Supra* note 46: on the issue of using the conditional sentence as a hospital disposition, the Court divided 6:3, while on the issue of dangerousness, the Court divided 5:4. Section 742.1(b) of the *Code* states that "serving the sentence in the community would not endanger the safety of the community and would be consistent with the fundamental purpose and principles of sentencing set out in ss. 718 to 718.2."

The potential fallout of fitting this decision into the conditional sentencing regime is outside the ambit of this article. The question that remains to be answered is whether this decision is a case-specific application or one of general application. The answer to this question will drive the answer to whether the Court intended to or in fact did forge a limited mental health-criminal justice interface. However, at least one court has seen this as an opportunity to make a mental health disposition: see notes 61-63 below and accompanying text.

49 Manson, *supra* note 45 at 385, 386.

50 *Ibid.* at 388, and Kaiser, *supra* note 45 at 411, 413, and see notes 17-20 and accompanying text.

51 See, *e.g.*, *Wallace*, *supra* note 7.

52 *Knoblauch*, *supra* note 46 at para. 31.

become tax and deficit reduction. Thus, with such an agenda, there is a growing trend towards provincial "mega jails" with their cost saving devotion to perimeter security and lessened internal movement. The end result is that treatment and programming, which are typically administered closer to release eligibility and which are essential to stabilizing the mentally ill offender, are rendered nugatory.[53] As stated by the majority in *Winko*, which included Bastarache J., society "cannot content itself with locking the ill offender up for a term of imprisonment and then releasing him or her into society, without having provided any opportunities for psychiatric or other treatment."[54] Thus "[p]ublic safety will only be ensured by stabilizing the mental condition."[55]

While Professor Allan Manson notes that the majority's decision was "pragmatic" and employed "a liberal interpretation to the conditional sentencing regime,"[56] the *Knoblauch* disposition comes with inherent limits. First, without the offender's consent, it is unlikely that such a disposition could be given.[57] Indeed, it is within the offender's prerogative to decline the disposition and serve the sentence in gaol. However, this choice becomes questionable when dealing with an offender whose mental condition is such that capacity to consent is borderline yet treatment is urgently required.

Second, even if consent is obtained, the court must be satisfied that the professionals taking charge of the offender are committed for the duration of the sentence. As Professor Manson points out, "[t]here is no room to re-negotiate the basic bargain," and the offender cannot be incarcerated if the mental health facility has a change of heart.[58]

Third, leaving aside the controversial practice of extending the duration of sentence solely because a conditional sentence is being imposed, there is no mechanism to guard against a court imposing a longer conditional sentence in order to facilitate treatment. The paternalistic approach to imposing a *Knoblauch* disposition must be avoided.[59] In a similar vein, courts must be wary not to fall into the "net widening" trap.[60]

Last, sentencing principles and objectives prevail despite growing frustration with the "lock-up" approach. For example, although Madam Justice Ratushny expressed "frustration with the system that doesn't let her send someone like Ghebreselassi ... to a psychiatric

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53 For more on the issue of resources, see Manson, *supra* note 45 at 366-68.

54 *Winko*, *supra* note 33 at para. 40. While this quote pertains to the NCRMD disposition, it is submitted that its principle is equally applicable to this discussion. See also *R.* v. *Jones*, [1994] 2 S.C.R. 229 at 290-91 wherein Gonthier J., for the majority, stated that the "concern for societal interests ... has always been present in our general sentencing system.... The sentencing stage places a stronger emphasis on societal interests."

55 *Winko*, *ibid.*

56 Manson, *supra* note 45 at 388.

57 *Ibid.* at 386-87.

58 *Ibid.*

59 See Schneider, *supra* note 6 at 168-69.

60 See J. Rudin, "Sentencing Alternatives" in J.V. Roberts & D.P. Cole, eds., *Making Sense of Sentencing* (Toronto: University of Toronto Press, 1999) 295 at 307: net widening takes place when a disposition or diversion is made not on the merits of the case but rather for the "benefit" of the accused or offender. On default, more severe punishment is imposed, typically incarceration, otherwise known as "net widening."

hospital,"[61] the learned judge, in considering the need to protect the public, refused to use a conditional sentence as a vehicle for a hospital disposition. In distinguishing a *Knoblauch* disposition, the learned judge opined that the sentence "would not fit the crime."[62] As a result, Ghebreselassi was sentenced to imprisonment for four years, with Ratushny J. stating that "[i]t's not an answer to the accused's needs and the needs of the public for safety to simply lock him up."[63] Another example is the Ontario Court of Appeal decision in *R.* v. *Yip*.[64] In upholding a twelve-year sentence for aggravated assault, the Court observed that "the protection of the public ... was the *only option realistically open* to the trial judge" despite the fact that Yip had "*a major mental disorder*"[65] which caused him to become violent.

In concluding this part of the article, several observations have been made. The present options available to sentencing judges are unsatisfactory. The interplay between the principles of sentencing and the responsibility of the offender cannot be applied effectively to mentally ill offenders. Indeed, questions of relevancy arise. Moreover, courts placing reliance on correctional authorities to provide treatment for an offender's mental illness is fraught with systemic problems. The Law Reform Commission called long ago for a hospital disposition; however, that call has remained unanswered in any meaningful way. Parliament has merely proposed a stop-gap in the way of a sixty-day treatment order for emergency situations. Courts are now beginning to express frustration at the sentencing options available. While a hospital disposition solution by way of a conditional sentence has been legalized by the Supreme Court of Canada, inherent limitations and traditional considerations with respect to sentence fitness enter and confound the process.

III. THE GENERAL FRAMEWORK OF THE UNITED KINGDOM'S MODEL

In the United Kingdom, Part III of the *Mental Health Act 1983*[66] provides the interface with the criminal justice system by way of hospital dispositions for mentally ill offenders. The *Act* draws a distinction between offenders who are before a court for sentencing and offenders who are already serving a sentence of imprisonment. In sum, the disposition may be effected by the courts or the Secretary of State. In addition, the *Act* also provides the authority to not only detain the offender for treatment in a specified hospital by virtue of a hospital disposition, but also to further limit the liberty of the offender through the imposition of a restriction order.

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61 Ottawa/Canadian Press, "Judge sends mentally ill rapist to jail" *The Kingston Whig Standard* (2 February 2001) 16.

62 *Ibid.*

63 *Ibid.*

64 (14 July 2000), Toronto C30459 (Ont. C.A.).

65 *Ibid.* at para. 1 [emphasis added]. In arriving at the sentence imposed, the trial judge had credited Yip for one year of pretrial custody. Thus the trial judge had determined the fourteen-year maximum as a fit sentence. Query: whether the facts in *Shahnawaz* (*supra* note 10) commended a *Knoblauch* (*supra* note 46) disposition, despite the Court's tripling of the sentence?

66 (U.K.), 1983, c. 20 [hereinafter *Act*].

A. GENERAL EVIDENTIARY REQUIREMENTS

The provisions relating to medical evidence for the purposes of hospital dispositions are located in ss. 12 and 54 of the *Act*. There must be medical evidence before the court stating that the offender is suffering from "mental disorder," a term which is statutorily defined.[67] The evidence must come from "two registered medical practitioners," either orally or in writing.[68] One of the practitioners must be approved by the Secretary of State as possessing "special experience in the diagnosis or treatment of mental disorder."[69] In addition, both practitioners must diagnose a common mental disorder. Although the practitioners can disagree as to the number of forms of mental disorder that the offender may be suffering from, there must be one common form of disorder, meeting the requirements of the *Act*, which the two practitioners agree upon. If the evidence is in the form of a written report, it must be signed by the practitioner,[70] and the offender can require the practitioner to be called to give evidence in court and can call evidence to rebut the contents of the report.[71] Moreover, unless the approved practitioner has had previous acquaintance with the offender, the second assessment and recommendation ought to come from an arm's-length practitioner.[72]

Although mental disorder is statutorily defined, not every form of disorder falling within the definition will open the door to a hospital disposition. The offender can only be "suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment."[73] Mental illness is undefined, and clinical judgment provides its operational definition and usage on a case-by-case basis.[74] The lack of a statutory definition is the result of the inability of psychiatrists to reach a consensus as to what that

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67 *Ibid.*, s. 1(2): "mental disorder means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind." This section also defines "severe mental impairment," "mental impairment," and "psychopathic disorder":

> "severe mental impairment" means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "severely mentally impaired" shall be construed accordingly;
>
> "mental impairment" means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "mentally impaired" shall be construed accordingly;
>
> "psychopathic disorder" means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

68 *Ibid.*, s. 37(2)(a).

69 *Ibid.*, s. 12(2). See also s. 54(1).

70 *Ibid.*, s. 54(2).

71 *Ibid.*, s. 54(3)(c).

72 *Ibid.*, s. 12(2).

73 *Ibid.*, s. 37(2)(a).

74 Department of Health and Welsh Office, *Mental Health Act 1983 Memorandum on Parts I to VI, VIII and X* (London, UK: Her Majesty's Stationery Office, undated) at para. 8, online <www.doh.gov.uk/pub/docs/doh/mhmemorandum.pdf> (date accessed: 15 February 2001) [hereinafter *Memorandum*].

definition, in sufficiently precise terms, should be.[75] Also, the definitions for "severe mental impairment" and "mental impairment" are intended to "distinguish the small minority with learning disabilities who need to be detained in hospital ... from the great majority who do not."[76] These definitions achieve this objective in two ways: the state of arrested or incomplete development of the mind must first be associated with abnormally aggressive or seriously irresponsible conduct; and second, the degree of impairment must either be severe or significant.

Finally, the evidence must show that the mental disorder that the offender suffers from is of a "nature or degree which makes it appropriate ... to be detained in a hospital for medical treatment and, in the case of psychopathic disorder or mental impairment, that such treatment is likely to alleviate or prevent a deterioration of his condition."[77]

B. FOUR FORMS OF HOSPITAL DISPOSITIONS

The effect of a hospital disposition order is twofold. First, the order confers "authority on a constable, an approved social worker or any other person approved by the court" to convey the offender to the hospital specified in the order within twenty-eight days.[78] Second, the order confers "authority on the managers of the hospital" to admit the offender within the twenty-eight day period "and to detain him"[79] "*in accordance with the provisions of* [the *Mental Health*] *Act*."[80] This is an important distinction for the purposes of s. 37. It transforms the offender's status, provided that a restriction order has not been imposed, to that of a patient who has been admitted to hospital under Part II of the *Act*, and the offender is "treated essentially the same."[81] The key difference lies in the period of detention and discharge of the offender from hospital. The authority to detain an offender is conferred by s. 20 and expires after six months. However, the hospital disposition may be renewed by the medical officer in charge of the offender's treatment (or by the hospital managers) for another six-month period and then on an annual basis. The offender may not apply to the Mental Health Review Tribunal ("MHRT") for a form of discharge "until six months after the date of the making of the order, if the order is renewed."[82] As such, the minimum period of detention is for six months.

A hospital disposition may be imposed in four instances.[83] The four instances may be separated into two groups, which account for the *Act*'s distinction between offenders. The

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75 N. Walker & N. Padfield, *Sentencing Theory, Law and Practice*, 2d. ed. (London, UK: Butterworths, 1996) at para. 21.23.

76 *Memorandum*, *supra* note 74 at para. 8.

77 *Act*, *supra* note 66, s. 37(2)(a)(i).

78 *Memorandum*, *supra* note 74 at para. 179. See also *Act*, *ibid.*, ss. 37(4)-(5), 40(1)(a)-(b).

79 *Memorandum*, *ibid.*

80 *Act*, *supra* note 66, s. 40(1)(b) [emphasis added].

81 *Memorandum*, *supra* note 74 at para. 181. Part II is concerned with compulsory admission to hospital.

82 *Ibid.*

83 There are other provisions within the *Act* which also allow for hospital dispositions; however, they have been excluded from the ambit of this article. For example, s. 46 provides for the removal of a person kept in custody during "Her Majesty's pleasure" to a specified hospital.

first group accounts for hospital dispositions for offenders who are before a court for sentencing. The second accounts for hospital dispositions where the offender is serving a sentence of imprisonment.

1. OFFENDERS WHO ARE BEFORE A COURT FOR SENTENCING

Three provisions in the *Act* account for offenders who are before a court for sentencing: ss. 37, 38 and 45A. Section 38(7) empowers the court, if it is undecided about a hospital disposition, to impose a renewable interim hospital order.[84] The underlying purpose of this section is to allow for both closer observation of the offender in a hospital setting and the reporting of the offender's progress and response to treatment to the court.

Section 37 empowers a court to impose a hospital order instead of imposing a sentence of imprisonment.[85] It is submitted that s. 37 is the primary provision from which the remaining three sections are derived. It sets out the qualifying criteria, the evidentiary requirements, and the constraints that have to be considered before an order can be imposed.[86] Typically, the statutory requirements found in ss. 45A, 47(1) and 38 are contextually modified; however, the effect is the same as that of a hospital order.[87] Both the Magistrates' Court and the Crown Court can impose a hospital order. Before a court is able to do so, a conviction must be entered. The conviction must be for an offence punishable "with imprisonment other than an offence the sentence for which is fixed by law or [falls to be imposed under section 109(2) of the *Powers of Criminal Courts (Sentencing) Act 2000].*"[88] In other words, the conviction must be for an offence punishable by imprisonment "other than murder,"[89] a second serious offence as listed in s. 109(5) of the *Powers of Criminal Courts (Sentencing) Act 2000*,[90] or an offence which carries a minimum term of imprisonment.

With respect to hospital orders at the Magistrates' Court level, the Court need not enter a conviction after a finding of guilt. If the offender otherwise qualifies for a hospital order as set out in s. 37(1) of the *Act*, and the Court is satisfied that the offender suffers from mental illness or severe mental impairment, then a hospital order can be imposed without entering a conviction provided that the offender "did the act or made the omission charged."[91] Walker and Padfield describe this procedure as "a crude equivalent" to the unfit for trial and acquittal on the ground of insanity dispositions open to the Crown Court.[92] The authors further suggest that the mentally ill or severely mentally impaired offender is usually convicted at any rate.[93]

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84 This is not the same as a hospital remand made under s. 36 (court) or s. 48 (Secretary of State).

85 Section 37 also provides for guardianship orders. This form of disposition is not within the rubric of this article.

86 See text above and below.

87 See *Act*, *supra* note 66, ss. 45B(2) and 47(3).

88 *Ibid.*, s. 37(1).

89 *Memorandum*, *supra* note 74 at para. 157.

90 (U.K.), 2000, c. 6 [hereinafter *PCCA*].

91 *Act*, *supra* note 66, s. 37(3).

92 Walker & Padfield, *supra* note 75 at para. 21.37d.

93 *Ibid.*

a. Hospital Orders — The Effects of Conviction

A conviction can act as a double-edged sword. It can trigger or preclude a s. 37 hospital disposition. While convictions for petty offences do not cause much concern, a conviction for more serious crimes can have serious repercussions for the mentally ill offender. It is at this stage that several disposition considerations come to light. The first is that for a conviction for murder, which carries a mandatory life term of imprisonment, a hospital order under s. 37 is precluded.[94]

The second consideration is for convictions which trigger s. 109(2) of the *PCCA*.[95] This section comes into play when an offender is convicted of committing "two offences falling within section [109(5)], a disparate collection of serious offences, all punishable by a maximum of life imprisonment."[96] In such a case, a life sentence is automatically imposed. A hospital order is precluded "unless the court is of the opinion that there are *exceptional circumstances* relating to either of the offences or to the offender which justify its not doing so."[97]

The term "exceptional circumstances" imposes a high threshold. The meaning of "exceptional" was clarified by Lord Bingham C.J. in *Kelly*. In that case the learned judge, in delivering the judgment of the Court, stated that the term is to be construed as an ordinary adjective and not as a term of art: the circumstances, relating to either to the offender or to either of the offences had to be such that they "form an exception, which is out of the ordinary course, or unusual, or special, or uncommon."[98] Bingham C.J. also stated that "[t]o be exceptional a circumstance need not be unique, or unprecedented, or very rare; but it cannot be one that is regularly, or routinely, or normally encountered."[99] In addition, the exceptional circumstances had to justify the sentencing court "in not imposing a life sentence, and in forming that opinion the court must have regard to the

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94 The Home Secretary would have to issue a warrant effecting a transfer direction, with a limitation direction, if necessary, by virtue of s. 47. For a discussion on s. 47, see Part III(b)(2) below.

95 Section 109(2), *supra* note 90, states that

> [t]he court shall impose a life sentence, that is to say—
>
> (a) where the offender is 21 or over when convicted of the offence mentioned ... above, a sentence of imprisonment for life,
>
> (b) where he is under 21 at that time, a sentence of custody for life under section 94 above, [a sentence of imprisonment for life]
>
> *unless the court is of the opinion that there are exceptional circumstances relating to either of the offences or to the offender which justify its not doing so* [emphasis added].

96 *R.* v. *Kelly*, [1999] 2 W.L.R. 1100 at 1107 (C.A.) [hereinafter *Kelly*].

97 *PCCA*, *supra* note 90, s. 109(2) [emphasis added]. It must be noted that although a life sentence must be imposed, another part of that *Act* leaves to the judge's discretion the minimum term of imprisonment that the offender must serve. This period is determined by reference to approximately one-half of the term a court would have otherwise imposed but for the mandatory imposition of a life sentence. Any pretrial custody would also have to be taken into account when determining the term which would have otherwise been imposed: *R.* v. *M. (Discretionary Life Sentence)*, [1999] 1 W.L.R. 485 (C.A.).

98 *Kelly*, *supra* note 96 at 1107.

99 *Ibid.*

purpose of Parliament in enacting the section."[100] The learned judge raised the bar further by stating that the youthfulness of the offender, and the fact that the two serious offences were "of different kinds," and were committed at different times were not exceptional factors.[101]

The judgment in *Kelly* has been followed by the Court of Appeal even for cases involving a mentally ill offender. For example, in *R.* v. *Offen*[102] the offender suffered from, *inter alia*, schizophrenia, depression and pseudo-psychotic voices in his head. Offen was convicted of a second serious offence, robbery. However, Offen was not suffering from a mental disorder "of a nature or of severity which would warrant a hospital admission."[103] In dismissing the appeal, Justice Jowitt, in delivering the judgment of the Court, made two refinements to what would be considered exceptional for the purposes of s. 109(2) of the *PCCA*. First, exceptional circumstances "cannot be found simply because a robbery is at the *lower end of the scale of gravity*."[104] Thus offences falling within the serious offence category cannot be distinguished by virtue of gravity. Second, Jowitt J. stated that mental illness of a nature or severity which does not warrant a hospital admission is not a factor which can be found to be exceptional.[105] The Court left open the question of whether a mentally ill offender who met the requirements for a hospital order would present a sufficiently exceptional circumstance.

Lord Bingham C.J. provided the answer to this question in the Court of Appeal's decision in *R.* v. *Newman*.[106] In that case, Newman had been the subject of two previous hospital orders, including one for the commission of a serious offence. He was then convicted for a second serious offence, and s. 109(2) of *PCCA* was triggered. During the sentencing phase, Newman met all the criteria for a hospital order, and the court was invited to impose one. However, the trial judge did not find exceptional circumstances to exist and imposed the mandatory life sentence. On appeal, Bingham C.J. ruled that Newman's acute mental illness could not be considered "as an exceptional circumstance justifying the making of a hospital order instead of a life sentence of imprisonment."[107] The learned judge found that the statute compelled a negative answer and that nothing in

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100 *Ibid.* Bingham C.J. stated that the section was enacted by Parliament in order to have its will followed; the learned judge opined that courts were not doing so due to judicially created constraints or reluctance. Typically, the offender would have to be "judged to present a serious threat to the safety of the public, whether because of their mental instability or for other reasons, for a period which could not be predicted or foreseen at the time of sentence": *ibid.* at 1107-108 [citations omitted].

101 *Ibid.* at 1108. In addition, the degree of risk posed to the public is immaterial: R. Henham, "Sentencing Dangerous Offenders: Policy and Practice in the Crown Court" [2001] Crim. L.R. 693 at 705. Note: Henham's analysis specifically excluded *Mental Health Act* disposals. However, it contains an excellent discussion regarding the interplay between and the judicial uncertainty in utilizing the various protective sentence measures that are available in the United Kingdom: *PCCA* s. 80(2)(b) (extension of a fit sentence); *PCCA* s. 109 (automatic life sentence); *PCCA* s. 85 (extended supervision) and discretionary life sentences.

102 [2000] Crim. L.R. 306 (C.A.), online: LEXIS (UK Cases, Combined Courts).

103 *Ibid.*

104 *Ibid.* [emphasis added].

105 *Ibid.*

106 *The Times*, 3 February 2000 (C.A.) [hereinafter *Newman*], online: LEXIS (UK, Combined Cases).

107 *Ibid.*

the *Act* "contradicts the clear effect of the statutory provisions."[108] Bingham C.J. went on to observe that it was "not suggested that there is here any exceptional circumstance other than mental illness" and that mental illness "alone will not avail the appellant."[109] Thus, in Newman's case, there was no avenue open for the Court to impose a hospital order.[110] However, the Court also expressed concern that Newman, who the Court observed was "so obviously and acutely suffering from mental illness should be ordered to prison and not to hospital."[111] As a result, the Court now requires not only mental illness of a nature or severity which warrants admission to a hospital, but also something more which fits into the meaning of an exceptional circumstance. That "something more" is, by virtue of appellate guidance, illusory. Ironically, the one accepted exceptional circumstance relates not to the merits of the case, but rather to the plea bargaining process. Where defence counsel fails to inform the defendant of the likelihood of receiving an automatic life sentence, rather than pleading guilty to a lesser offence not triggering the operation of s. 109(2), the Court of Appeal finds this failure to be an exceptional circumstance.[112]

Section 109(2) of *PCCA* allows an offender convicted of a "qualifying offence" only one chance at a hospital order. The decision in *Newman* supports such a proposition: in ceding to the will of Parliament, the Court of Appeal has demanded a very high threshold in case of a second serious offence. It requires an exceptional factor over and above that of mental illness warranting a hospital admission.[113] It also addresses the view that if a mentally ill offender is discharged, then the operating presumption is that the offender's behaviour and supervision, if any, will ensure the safety of the public. Thus if the offender commits another serious offence, then a disposition requiring separation and retribution[114] is mandated in order to ensure the public's safety.[115] The argument is

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108 *Ibid.*

109 *Ibid.*

110 For a discussion of the impact of s. 45A of the *Act*, see generally notes 135-37, 195 and accompanying text.

111 *Newman*, *supra* note 106.

112 *R.* v. *Stephens*, *The Times*, 29 March 2001 (C.A.), Rose L.J. Such an approach has been criticized for placing a "further premium on the plea [bargain] as a bureaucratic expedient" which equates justice not to the merits of the case but rather to the deprivation of an opportunity to manipulate the system to one's own advantage: Henham, *supra* note 101 at 705.

113 Other inmates preying upon the vulnerability of the mentally ill offender may qualify as an exceptional circumstance.

114 Home Office, *Managing Dangerous People With Severe Personality Disorder: Proposals for Policy Development* (Consultation Paper) (London: Home Office, 1999) at Part 3, para. 15, online: Home Office <www.homeoffice.gov.uk/cpd.dangcie.htm> (date accessed: 15 February 2001) [hereinafter "DSPD Report"]. See also Home Office, *Managing Dangerous People With Severe Personality Disorder Taking Forward the Government's Proposals* (Leaflet/Booklet) (London: Home Office, 1999), online: Home Office <www.homeoffice.gov.uk/cpg/dspdleaf.pdf> (date accessed: 15 February 2001); Department of Health, *Reforming the Mental Health Act* (White Paper Summary) (London: Department of Health, 2000), online: Department of Health <www.doh.gov.uk/mentalhealth/summary.htm> (last modified: 20 December 2000) [hereinafter "DSPD White Paper Summary"]; and see Home Office, *Next Phase of Dangerous & Severe Personality Disorder Assessment and Treatment Pilot Projects* (Press Release) (London: Home Office, 2001), online: Home Office <www.homeoffice.gov.uk/cpg/dspdpress.pdf> (last modified: 12 February 2001) [hereinafter "DSPD Press Release"].

115 The merits of separation and retribution under such a scheme are outside the rubric of this article.

that a sentence of imprisonment for life provides additional protection for the public. This was the view of the Court of Appeal in *R.* v. *Fleming*.[116] In that case, Fleming had been the subject of a hospital and restriction order. While on conditional discharge[117] he plead guilty to two counts of manslaughter. Another hospital and restriction order was recommended to the sentencing judge. Fleming was suffering from chronic paranoid schizophrenia. Lord Justice Watkins, for the Court, acknowledged previous case law[118] which stated that "a sentencing judge should not pass a sentence of life imprisonment simply because in his opinion it would be wrong that in future the decision of a Mental Health Review Tribunal might determine where the defendant should be."[119] The learned judge referred to those same authorities, and to *Howell* which stated that "where medical opinions are unanimous and a bed is available in a secure hospital, a hospital order should be made together with a restriction order."[120] But the Court distinguished both *Howell* and *Mbatha* on the basis that the case at bar was "unusual and exceptional" because both a hospital and restriction order had previously been attempted and that it proved unsafe to let Fleming go free.[121] The learned judge concluded that "the experiment, so to speak, had been tried previously and failed with disastrous consequences."[122] The Court stated that a sentence of life imprisonment entailed the necessary precautions for the public.[123] However, the decision in *Fleming* was soon put on very distant shores. In *R.* v. *W.M.H.*[124] Lord Justice Rose followed Lord Justice Otton's decision in *R.* v. *Mitchell* wherein Otton L.J. stated that

> [o]n the balance of previous decisions the principle is clearly established that when the pre-conditions for a hospital order are satisfied and a bed is available in a secure hospital, a hospital order, with the appropriate protection of a section 41 [restriction] order, is the appropriate disposal, rather than a life sentence. We attach little weight to Fleming, which is better disregarded.[125]

Thus one may argue that per se, the *Mitchell* rule governs subject to two constraints. First, due to *Newman*, the offender cannot be convicted of a second serious offence triggering s. 109(2) unless exceptional circumstances exist.[126] For a mentally ill offender, there must be exceptional circumstances above a mental disorder warranting a hospital admission.

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116 (1992), 14 Cr. App. R. (S) 151 (C.A.), online: LEXIS (UK Cases, Combined Courts) [hereinafter *Fleming*]. Note: s. 109(2) of *PCCA* nor its predecessor, s. 1(2) of the *Crime (Sentences) Act 1997* (U.K.), 1997, c. 43 were enacted at the time of this judgment.

117 The offender is subject to a restriction order and has been conditionally discharged from hospital, subject to recall.

118 See *R.* v. *Howell* (1985), 7 Cr. App. R. (S) 360 (C.A.) [hereinafter *Howell*] and *R.* v. *Mbatha* (1985), 7 Cr. App. R. (S) 373 (C.A.) [hereinafter *Mbatha*].

119 *Fleming*, *supra* note 116 at 155, interpreting *Howell* and *Mbatha*: *ibid.*

120 *Howell*, *ibid.* at 360. See also *Mbatha*: *ibid.*

121 *Fleming*, *supra* note 116 at 156.

122 *Ibid.*

123 *Ibid.*

124 [1996] E.W.J. No. 2147 (C.A.), online: QL (EWJ) [hereinafter *WMH*].

125 *The Independent*, 1 July 1996 at 16 (C.A.) (date of decision: 9 May 1996), online: QL (EWJ) [hereinafter *Mitchell*], as quoted in *WMH*, *ibid.* at para. 20.

126 *Newman*, *supra* note 106.

The second constraint for *Mitchell* comes by way of an offence carrying a maximum term of imprisonment for life and not triggering s. 109(2) of *PCCA*. In order to impose a discretionary life sentence, the offender would have to be "judged to present a serious threat to the safety of the public, whether because of their mental instability or for other reasons, for a period which could not be predicted or foreseen at the time of sentence."[127] As such, the offence must be so grave as to warrant an extremely long sentence, and good grounds would have to exist to believe that the offender would remain a serious danger to the public for a period not reliably predictable at the date of sentencing.[128] At first blush, the *Mitchell* requirement may appear to be easily distinguishable in such a case. However, as opposed to the situation in *Newman*, in this instance the *Act*'s statutory provisions would serve to contradict the need for imposing imprisonment for life.[129] Indeed, a disposition consisting of a hospital order coupled with a restriction order not limited in time serves the same purpose.

The third consideration before imposing a hospital order is for convictions which trigger mandatory minimum sentences. Sections 110(2) and 111(2) of the *PCCA* impose a minimum sentence of seven and three years respectively for a third conviction for trafficking in a Class A drug or for domestic burglary. However, there are two tandem provisions which allow a court to sidestep the mandatory sentencing provisions. First, both ss. 110(2) and 111(2) have a lower circumstantial threshold which states that "except where the court is of the opinion that there are *particular circumstances* which — (a) relate to any of the offences or to the offender; and (b) would make it unjust to do so in all the circumstances."[130] Second, s. 37(1A) of the *Act* states, in reference to ss. 110(2) and 111(2), that "nothing ... shall prevent a court from making an order ... for the admission of the offender to a hospital" provided the court is of the opinion required in ss. 110(2) or 111(2).[131]

The last consideration is for other offences. Although the court always has discretion when deciding whether to impose a sentence of imprisonment or a hospital order, the Court of Appeal has substituted a hospital order, with and without a restriction order, for sentences of imprisonment in several cases.[132] These cases have included instances where the offender's mental disorder was not diagnosed properly at the time of

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127 *Kelly*, *supra* note 96 at 1107-108 [citations omitted]. See also *R.* v. *Hodgson* (1967), 52 Cr. App. R. (S) 113 (C.A.).

128 *Halsbury's Laws of England, Annual Abridgment 1999*, 4th ed. (London: Butterworths, 2000) at 751, para. 2972.

129 See, *e.g.*, s. 45A discussed both above and below.

130 *PCCA*, *supra* note 90, ss. 110(2) and 111(2) [emphasis added].

131 *Act*, *supra* note 66, s. 37(1A). If this hurdle cannot be surpassed, the court will be unable to make a hospital disposition at the time of sentencing.

132 See, *e.g.*, *R.* v. *M.L.J.*, [2000] E.W.J. No. 904 (C.A.), online: QL (EWJ), where a hospital order was substituted for five years' imprisonment on a count of cruelty to a child [hereinafter *M.L.J.*].

sentencing[133] but have excluded instances where the effect of substituting a hospital order would be the same.[134]

b. Section 45: A Solution for Psychopaths

In instances where the Crown Court imposes a sentence of imprisonment, s. 45A(3) gives the Court the option to impose a hospital direction at the time of sentencing. The hospital direction has the same effect as a transfer direction: the offender will be detained for treatment in a specified hospital instead of serving the sentence in prison.[135] However, a hospital direction cannot be imposed in all cases. A conviction for murder forecloses the possibility of a hospital direction. Moreover, a mentally ill offender can only be "suffering from psychopathic disorder."[136] Thus the otherwise qualifying forms of mental disorder are precluded. As a result, the operation of s. 45A will take an offender suffering psychopathic disorder out of the teeth of s. 109(2) of *PCCA*. Section 109(2) of *PCCA* combined with the legislative shortfall in s. 45A of the *Act* culls a much needed disposition from a set of mentally ill offenders for whom treatment may prove to be most beneficial. This anomaly has been criticized as achieving "greater punitiveness and less welfare for mentally disordered offenders *as a whole* whilst leavening such effects on the group about whom the courts and criminal justice policy makers have expressed greatest concern as regards risk to the public"[137] — an exceptional exception indeed.

2. OFFENDERS WHO ARE SERVING A SENTENCE OF IMPRISONMENT

For offenders serving a sentence of imprisonment or where ss. 37(1) or 45A were not or could not be applied, s. 47(1) empowers the Home Secretary to issue a warrant effecting a transfer direction of a prisoner to a specified hospital. The criteria for effecting a transfer direction are the same as a hospital order with regards to mental disorder; however, additional criteria are superadded. The Secretary of State must also have "regard to the public interest and all the circumstances," and in regards to effecting the transfer direction, it must be "expedient to do so."[138]

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133 See, *e.g.*, *R.* v. *S.A.F.*, [1995] E.W.J. No. 4054 (C.A.), online: QL (EWJ), where a hospital order was substituted for four years' imprisonment for blackmail and various property related offences. The trend is the same for Scotland, whose *Mental Health (Scotland) Act 1984* is very similar to the *Act*: see, *e.g.*, *Jackson* v. *Her Majesty's Advocate*, [1998] S.C.C.R. 539 (H.C.J.) and *Baike* v. *Her Majesty's Advocate*, [2000] S.C.C.R. 119 (H.C.J.), online: LEXIS (UK Cases, Combined Courts).

134 See, *e.g.*, *R.* v. *Williams*, [1993] E.W.J. No. 1043 (C.A.), online: QL (EWJ), where the offender had been sentenced to twelve years' of imprisonment for robbery and firearm offences and was subsequently removed to hospital under s. 47 of the *Act*. Note: at para. 8 of the judgment, the provision referenced is s. 48. It is submitted that this is merely a referencing error.

135 See *infra*, Part III(b)(2) for a discussion on the transfer direction and Parts III(c) and (d)(2) for a discussion on the mandatory coupling of the transfer direction with a limitation direction and its effect on discharge provisions.

136 *Act*, *supra* note 66, s. 45A(2)(a).

137 N. Eastman & J. Peay, "Sentencing Psychopaths: Is the 'Hospital and Limitation Direction' an Ill-Considered Hybrid?" [1998] Crim. L.R. 93 at 107 [emphasis added].

138 *Act*, *supra* note 66, s. 47.

C. RESTRICTION ORDERS

A discussion of hospital dispositions is incomplete without reference to restriction orders.[139] A restriction order overrides the *Act*'s general discharge provisions as they relate to offenders subject to hospital dispositions. The provisions for imposing a restriction order are found in s. 41 of the *Act*. Four conditions must be satisfied. First, a restriction order can only be considered along with a hospital disposition. Second, only the Crown Court may impose a restriction order. As such, if the Magistrates' Court is minded to impose such an order, it must commit the offender, through s. 43, to the Crown Court for disposition. Third, it must appear to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of the offender committing further offences, that a restriction order is necessary for the protection of the public from serious harm. Last, at least one of the medical practitioners, who is of the opinion that a restriction order is necessary, must have given oral evidence in court.[140]

A hospital disposition coupled with a restriction order distinguishes the offender from those who are simply subject to a hospital disposition. The authority to detain an offender "does not expire while the restriction order is in force."[141] Since a restriction order can be limited or unlimited in time,[142] the offender can be subject to an indefinite hospital disposition. In addition, s. 42 empowers the Secretary of State to terminate a restriction order provided that the order is no longer required to protect the public from serious harm. Moreover, the Secretary of State also has the discretion to conditionally or absolutely discharge the offender from hospital. If the offender is absolutely discharged, then both the hospital and restriction orders cease to have effect. If the offender is conditionally discharged and the restriction order is still in force, then the Secretary of State can by warrant recall the offender to a specified hospital. If during conditional discharge the restriction order ceases to have effect, then the offender is deemed to have been absolutely discharged. However, if the offender has been recalled to or is in a hospital at the time that the restriction order ceases to have effect, either by termination or expiry, s. 41(5) deems a hospital order, without a restriction order, to have been "made on the date that the restriction order ceased to have effect."[143] Thus the offender is subject to at least another six months of detention in hospital.

For an offender who has been removed from prison to a hospital by virtue of a s. 47 transfer direction, the Secretary of State is authorized to impose a limitation direction, which has the same effect as a restriction order. A restriction direction ceases to have effect on the earliest date that the offender "would have been released from prison" if the offender had not been removed to a hospital.[144] This includes sentence expiry as well as any period where the offender would have been granted some form of early release. If the Secretary of State terminates the restriction direction or it expires, then s. 41(5)

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139 Also referred to as a limitation direction or restriction direction for the purposes of ss. 45A and 47(1) respectively.

140 *Memorandum*, *supra* note 74 at para. 163.

141 *Ibid.* at para. 184.

142 *Act*, *supra* note 66, s. 41(1).

143 *Ibid.*, s. 41(5); *Memorandum*, *supra* note 74 at para. 187.

144 *Act*, *ibid.*, s. 50(3); *Memorandum*, *ibid.* at para. 197.

operates as described above. In addition, s. 50(1) authorizes the Secretary of State, if notified that the offender no longer requires treatment or no effective treatment can be given in the hospital specified in the transfer direction, to either direct the offender's "return to prison ... or discharge him from hospital on the same terms on which he could be released from prison."[145] The notification may come from the medical officer responsible for the offender's treatment, the hospital managers or the MHRT.

While the effect of a hospital direction is in effect the same as a transfer direction, there is one major difference. On a fair reading of s. 45A, the imposition of a hospital direction *must* be made in conjunction with a limitation direction.[146] The Crown Court cannot avoid doing so. In contrast, the Secretary of State retains discretion in imposing a restriction direction.

D. DISCHARGE

Part V of the *Act* deals with the power of the MHRT to discharge an offender. The MHRT panel must be comprised of at least one legal member, one medical member, and one lay member. The legal member may be a practitioner or a judge. The legal member presides over the hearing and advises on any question of law which may arise. The medical member has a dual role. First, the medical member must examine the applicant offender and form an opinion regarding the offender's mental condition. The medical member's role is also judicial. Thus the member must disclose any disagreement of opinion regarding the offender's condition. The lay person's purpose is to provide a balance of community representation "outside the legal and medical professions" while the role of the member is to "supply a responsible lay person's view."[147] The MHRT also exercises the power to discharge an offender.[148]

1. THE OFFENDER SUBJECT TO HOSPITAL ORDER ONLY

Section 72 sets out the criteria for discharge. The MHRT must discharge the offender if it is satisfied that either the offender is not then suffering from any of the mental disorders specified in the hospital disposition of a nature or degree which makes detention in hospital for treatment appropriate, or that the offender's detention is unnecessary for the health or safety of the offender or for the protection of others. The MHRT may also discharge an offender not satisfying the above criteria. In such a case, s. 72(2) requires that the MHRT consider the likelihood that medical treatment will alleviate or prevent a deterioration of the offender's condition. In the case of a mentally ill or a severely mentally impaired offender, the MHRT must also consider the likelihood the offender will be able to care for him/herself, obtain needed care, or guard against serious exploitation.

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145 *Memorandum, ibid.* at para. 198.

146 See Eastman & Peay, *supra* note 137 at 98, n. 23.

147 Department of Health, *Mental Health Review Tribunals for England and Wales* (Annual Report 97-98) (London: Department of Health, 2000) at 73-80, 83-84, online: Department of Health <www.doh.gov.uk/mhr> (date accessed: 15 February 2001) [hereinafter "MHRT Report"].

148 The discussion below has been modified to account for the manner of and limitations to discharge described in the text above.

2. RESTRICTED OFFENDERS

Section 73 mandates the MHRT to absolutely discharge an offender. There are three conditions to be satisfied. First, the offender must not be suffering from any of the four specified forms of mental disorder of a nature or degree which makes it appropriate for him/her to be liable to be detained in hospital for medical treatment; second, the offender's detention must be unnecessary for the health or safety of the offender or for the protection of others; and, third, it would not be appropriate that the offender remain liable for recall to hospital. For a conditional discharge to be granted, this third criterion need not be met. Where the MHRT is minded to order a conditional discharge, the panel may defer its final decision until such time as the arrangements to satisfy the discharge are made. However, the panel cannot defer its final decision in order to reconsider its decision or to secure the offender's admission to another hospital.[149]

If a hospital disposition was made under s. 45A (hospital direction) or s. 47 (transfer direction) and was combined with a restriction order respectively in the form of a limitation or restriction direction, then the offender is liable to be returned to prison in order to serve the remainder of his/her sentence. Notwithstanding an absolute or conditional discharge being ordered, the MHRT can, in its decision, recommend that the offender continue to be detained in hospital. In such an instance, the Home Secretary may agree to the discharge. If not, the offender must be returned to prison to serve the remaining sentence. Such a mechanism is deficient. It allows for the return of a relatively stabilized offender to an environment without comprehensive mental health facilities instead of to the community which has such facilities.[150] However, there is an exception. The MHRT, in its decision, can *specifically* recommend that the offender continue to be detained in a hospital in the event that the Home Secretary does not agree to the discharge.[151]

E. CONSENT TO TREATMENT

Part IV of the *Act* governs consent to treatment. Section 56 casts a broad net with respect to the class of "patient" to which the part applies. In addition, the consent to treatment provisions apply to "any medical treatment ... for the mental disorder from which [the offender] is suffering."[152] The procedural safeguards in this part operate at two levels. First, s. 57 requires both the consent of the offender[153] and a second opinion for surgical operations performed to destroy either brain tissue or the functioning of brain

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149 See *Home Department* v. *Oxford Regional MHRT*, [1987] 3 All E.R. 8 (H.L.) and *Secretary of State for the Home Department* v. *MHRT for the Mersey Regional Health Authority*, [1986] 3 All E.R. 233 (Q.B.D.) respectively.

150 Eastman & Peay, *supra* note 137 at 102.

151 *Memorandum*, *supra* note 74 at para 253; *Act*, *supra* note 66, s. 74. See also *R.* v. *Cannon's Park MHRT, ex parte A*, [1994] 3 W.L.R. 630 (C.A.) wherein the continued detention of an "untreatable" psychopath was held to be lawful.

152 *Act*, *ibid.*, s. 63. Indeed, the words have been interpreted liberally to include treatment for both the underlying cause and symptoms of mental disorder: *Memorandum*, *ibid.* at para. 215, referencing the decision in *B.* v. *Croyden Health Authority*, [1995] 1 All E.R. 683 (C.A.).

153 If the offender is incapable of giving consent, that is the end of the matter: *Memorandum*, *ibid.* at para. 217.

tissue. The section also applies to any other form of treatment specified by regulation for the purpose of that section.[154] In order to establish consent, a registered medical practitioner as well as two other persons not being registered medical practitioners, all appointed by the Secretary of State for the purposes of Part IV, must certify in writing that the offender is capable of understanding the nature, purpose, and likely effects of and has consented to the proposed treatment. The second opinion requirement is satisfied by the approved practitioner consulting both with a nurse and a non-nursing/medical practitioner all of whom are professionally involved with the offender. After doing so, the approved practitioner must certify that, having regard to the treatment's likelihood of alleviating or preventing a deterioration of the offender's condition, treatment should be given. Thus two certificates must be issued: one for consent and another for the second (concurring) opinion; together they constitute the authority to give treatment.[155]

The second layer of protection, found in s. 58, applies to "other serious treatments" and requires the offender's consent or a second opinion.[156] Specifically, the section applies to forms of treatment specified for the purposes of this section by regulation. In addition, the section extends to the administration of medicine if three months or more have elapsed since the medicine was first given to the offender, "by any means," for mental disorder during that period of detention.[157] Thus, for an offender subject to a hospital disposition without restriction, the timeline for the purposes of calculating the period of detention is six months for the initial authority to detain, then at the second six-month period if the disposition is renewed, and then every twelve months, upon renewal, after the expiration of the second six-month period of detention. However, an offender who is subject to a restriction order is not contemplated. Thus it is submitted that for an offender subject to a restriction order, the relevant requirement is that three months must elapse since the last administration of medicine.

If consent is obtained from the offender, the medical practitioner responsible ("responsible medical officer") for the treatment of the offender[158] must certify in writing that the offender is capable of understanding the nature, purpose, and likely effects of and has consented to the proposed treatment. A registered medical practitioner appointed by the Secretary of State for the purposes of Part IV may also do so. Alternatively, if the offender either does not consent or is not capable of understanding the nature, purpose, and likely effects of the proposed treatment, then a second opinion must be obtained from a registered medical practitioner appointed by the Secretary of State for the purposes of Part IV. The approved practitioner must consult with a nurse and a non-nursing/medical practitioner all of whom are professionally involved with the offender. After doing so, the approved practitioner must certify in writing that the offender either did not consent or was not capable of understanding the nature, purpose, and likely effects of the proposed treatment. In addition, the approved practitioner must

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154 At present, only the surgical implanting of hormones to reduce male sexual drive is listed: *ibid.* at para. 216.

155 *Ibid.* at paras. 218-19.

156 *Ibid.* at para. 212.

157 *Act*, *supra* note 66, s. 58(1)(b).

158 The responsible medical officer is defined as the registered medical practitioner in charge of the offender's treatment: *ibid.*, ss. 55(1), 64(1).

also certify, having regard to the treatment's likelihood of alleviating or preventing a deterioration of the offender's condition, that treatment should be given.

Under both ss. 57 and 58, the responsible medical officer cannot act as the approved practitioner. In addition, any consent or certificate obtained under ss. 57 or 58 can relate to a single treatment or a plan of treatment.[159] However, the offender can withdraw consent at any time. In such a case, the remaining part of the treatment or the plan of treatment is severed, and ss. 57 or 58 will apply as if the severed part of the treatment or the plan of treatment is a separate form of treatment.

The exceptions to the consent to treatment provisions are limited. Section 62 exempts the requirements of ss. 57 and 58 in four situations requiring urgent treatment: 1) if the urgent treatment is immediately necessary to save the offender's life; 2) if the urgent treatment, while not being irreversible, is immediately necessary to prevent a serious deterioration of the offender's condition; 3) if the urgent treatment, while not being irreversible[160] or hazardous,[161] is immediately necessary to alleviate serious suffering by the offender; and 4) if the urgent treatment, while not being irreversible or hazardous, is immediately necessary as the minimum interference required to prevent the offender from both being a danger to himself or others or from behaving violently. In addition, the withdrawal of consent will not preclude the continuation of treatment or a plan of treatment pending compliance under ss. 57 or 58 if the responsible medical officer is of the opinion that discontinuance would cause serious suffering to the offender.[162] Finally, the offender's consent is not required for any treatment which does not fall within ss. 57 or 58 provided it is given by or under the direction of the responsible medical officer.[163]

It must also be noted that Part IV does not apply to offenders conditionally discharged by virtue of ss. 42 (the Secretary of State), 73 (the MHRT) or 74 (the MHRT on consent from the Secretary of State).[164] As a result, the common law requirements for consent apply.[165]

IV. LESSONS FOR TRANSLATION

In reviewing the United Kingdom's interface with a view to assessing translation to a Canadian context, three themes cut across hospital dispositions. The themes relate to the threshold for a hospital disposition, consent to treatment, and discharge.

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159 *Ibid.*, s. 59.

160 *Ibid.*, s. 62(3). Irreversible is defined as having "unfavourable irreversible physical or psychological consequences."

161 *Ibid.* Hazardous is defined as entailing "significant physical hazard."

162 *Ibid.*, s. 62(2).

163 *Ibid.*, s. 63.

164 In addition, offenders who are taken to a "place of safety" by virtue of s. 37(4) pending admission to a hospital are not subject to the provisions of Part IV: *ibid.*

165 *Memorandum*, *supra* note 74 at para. 214.

A. THE THRESHOLD FOR A DISPOSITION

Under the rubric of threshold, the first consideration which arises is the station of a hospital disposition. It should not be characterized as a one-off judicial experiment for sentencing. Any policy that mandates imprisonment over hospitalization because "the experiment ... [had] been tried previously and failed" ought to be avoided.[166] In this regard, the English Court of Appeal has developed a per se rule which has laid the one-off approach to rest.[167] Thus a hospital disposition should not be foreclosed due to the offender previously being subject to one. In addition, any policy development, whether legislative or judicial, should follow the English Court of Appeal's admonishment that a judge "not pass a sentence of life imprisonment simply because in his opinion it would be wrong that in future the decision of a [mental health tribunal] might determine where the defendant should be."[168] Such an approach is sensible. Looking behind a hospital disposition would have a chilling effect on such dispositions and would confuse form over content.

The second consideration involves a close examination of the requirement that a hospital be available to admit the offender as a patient — in other words, the need for a bed. Although this is a legislative requirement, on closer inspection, it is imbued with bureaucratic flavour. Since a hospital must agree to admit an offender, a court's discretion can be stymied by hospital staff who are of the opinion that the offender is "difficult, disruptive," and tends to monopolize bed space due to the potential of a long stay.[169] As such, a mentally ill offender who ought to be sent to a hospital is sent to prison. Although the avenue for a transfer exists, it is paved with systemic delays and further bureaucratic wrangling. Indeed, correctional authorities may well be more deferential to the hospital authorities than a court may be. However, this problem needs to be addressed. A court ramrodding a hospital disposition is not the answer. An approach where the offender is placed under a hospital disposition and then temporarily held at a facility until a bed comes available may be the solution. After all, an offender subject to a hospital order cannot be detained in prison. Thus an application for *habeas corpus* may be made if the delay is too long. However, as Alan Gold points out, this approach may result in authorities playing "a regrettable form of musical beds" in relation to offenders subject to a hospital order and other confines.[170]

Closely related to the difficult or disruptive offender is the mentally ill offender who also has a behavioural disorder, with or without psychopathy. Since there is a requirement

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166 *Fleming*, *supra* note 116 at 156.

167 See *WMH*, *supra* note 124 at para. 20 and accompanying text. It is submitted that this approach, although dealing with "serious offences" for which a life sentence can be imposed, also provides authority for hospital orders to be given for other repeat offences. On the other side of the line, an appeal lies to the Court of Appeal for Crown Court dispositions and to the Crown Court for Magistrates' Court dispositions as if the appeal was for both conviction and sentence: See *Memorandum*, *supra* note 74 at para. 178; *Act*, *supra* note 66, s. 45.

168 *Fleming*, *supra* note 116 at 155, interpreting *Howell* and *Mbatha*, *supra* note 118. Note: *WMH* did not disapprove of the interpretation of these two cases.

169 J. Mulvany, "Professional Conflict and the Sentencing Process: The Case of Hospital Orders" (1995) 18 Int'l J. L. & Psy. 101 at 110.

170 A.D. Gold, "President's Report" *Criminal Lawyers Association Newsletter* (May 1998).

that it must be appropriate for an offender to be detained in hospital for treatment, hospital staff may thwart a hospital disposition by painting the offender's illness as untreatable. Although the use of an interim hospital order may provide a stop for such practices, the badge of "untreatable" may still appear. In this regard, Verdun-Jones has observed that "there is a marked degree of disagreement among psychiatrists as to the diagnosis and treatability of psychopaths."[171] Even if admitted for treatment, Verdun-Jones further observes that the psychopathic offender's treatment is limited to "just being in [hospital]."[172] Indeed, if treatability is the focus, it can be argued that a hospital order is merely a guise for a preventive detention.[173]

In changing the focus from treatment appropriateness to the offender, the British government is introducing new measures to effectively deal with psychopathic offenders and dangerous severe personality disorder ("DSPD") offenders.[174] In the Home Office's recent Consultation Paper,[175] the British Government's Home Office has recognized that "[m]ost are not admitted to hospital because they are assessed as being unlikely to benefit from the sorts of treatment that are available in hospital."[176] In this vein, Eastman and Peay have observed that such conclusions are based on the thought that these offenders are "'unattractive' patients" by virtue of their remaining "peculiarly and inherently untouched by therapeutic or rehabilitative interventions."[177] Moreover, the learned authors note that offenders suffering from psychopathy are also characteristically resistant to punitive interventions, thus challenging the fundamental principles of imprisonment.[178] Even still, these offenders are sentenced to fixed terms of imprisonment and return to the community more dangerous than at the time of sentencing.[179] If this resistance to therapeutic, rehabilitative or punitive interventions

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171 Verdun-Jones, *supra* note 13 at 18. In fact, there is a fierce debate amongst psychiatrists that ranges from what psychiatrically defined personality disorders can amount to a psychopathic disorder to whether or not psychopathic disorder should remain in the *Act*: Eastman & Peay, *supra* note 137 at 102-103.

172 Verdun-Jones, *ibid.* at 19.

173 *Ibid.*

174 Although the British government is concerned with adult DSPD individuals in general, including those who also suffer from psychopathy or another mental disorder as defined by the *Act*, the discussion in this article is intended to give a sense of the general affect that the proposed changes will have on adult DSPD offenders *with* mental disorder(s). Moreover, the proposed reforms have many similarities to the *Code's* Dangerous Offender provisions under Part XXIV. See also note 196 below.

175 DSPD Report, *supra* note 114.

176 *Ibid.* at Part 1, para. 3.

177 Eastman & Peay, *supra* note 137 at 94.

178 *Ibid.*

179 *Mental Disorder Project: Criminal Law Review*, *supra* note 16 at 285. The English Court of Appeal has ruled that even if the offender does not satisfy the definition in the *Act*, a life sentence can be imposed for those who suffered from a serious personality disorder: *R.* v. *Hatch*, [1997] 1 Cr. App. R. (S) 22 (C.A.). A hospital direction can then be given under s. 45A of the *Act*, most likely accompanied by a restriction direction. Section 34 of the *Criminal Justice Act (1991)* (U.K.), 1991, c. 53 empowers courts to specify the part of a discretionary life sentence to be served before release procedures can be relied upon. However, discretionary life sentences are only imposed in 2 percent of cases: DSPD Report, *supra* note 114 at Part 3, para. 18. For a discussion on this area, see Home Office, *Crime, Justice and Protecting the Public: The Government's Proposal for Legislation* (White Paper) (London: Her Majesty's Stationery Office, 1990).

signals a lack of susceptibility to change, Eastman and Peay note that "release at the end of a 'proportionate' sentence can only be approached with some trepidation."[180]

Even if admitted to hospital, the initial six-month period of detention has been criticized as inadequate in assessing psychopathy, although a s. 38 interim order has been "considered beneficial in assessing the treatability of psychopathic disorder."[181] In recognizing the difficulty surrounding the issue of treatment, the Home Office has stated that DSPD offenders "have very different needs from most mentally ill [offenders] and often undermine hospital regimes" and that there is a reluctance to recommend a hospital disposition.[182] In order to meet the challenge that treatability poses, a recent British Department of Health White Paper[183] has acknowledged that the "narrow interpretation ... of the 'treatability' provision ... together with a lack of dedicated provision within existing services, means that current arrangements for this group are inadequate both to protect the public and to provide the individuals themselves with the high quality services they need."[184] Thus treatability will now focus on either the mental disorder itself or the "manage[ment of] behaviours arising from the disorder."[185] Finally, the British government has committed itself, in addition to modifying existing legislation,[186] to spending several hundred million pounds in order to provide specialist facilities and pilot treatment programs.[187]

The final reform comes to the definition of mental illness. The proposed reform, contained in the DSPD White Paper Summary, is to include "a broad definition of mental disorder covering any disability or disorder of mind or brain, whether permanent or

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180 Eastman & Peay, *supra* note 137 at 94.

181 R. Churchill *et al.*, *A systematic review of research relating to the Mental Health Act (1983)* (London: Department of Health, 1998) at 91-92, online: Department of Health <www.doh.gov.uk/mhar/mhalitrev.htm> (last modified: 25 November 1998). Note: the s. 38 interim order can last up to twelve months. However, Eastman & Peay note that with respect to offenders suffering from psychopathy, the recidivism rate for this group is "substantially greater than for mentally ill offenders even after a discharge from hospital": *ibid.* [footnotes omitted].

182 DSPD Report, *supra* note 114 at Part II, paras. 12-13. See also B. James, "Mental disorder and the Crimes Bill" in N. Cameron & S. France, eds., *Essays on Criminal Law in New Zealand Towards Reform?* (Wellington: Victoria University Press, 1990) at 85, wherein the author observes that a psychopathic offender with antisocial personality "can very seriously disrupt a treatment programme and the hospital's therapeutic climate ... may be seriously divisive to group dynamics ... [and] may be explosive and destructive ... to the detriment of other patients." Eastman & Peay note that, given the definition of both "treatment" under s. 145(1) of the *Act* and definition of "psychopathic disorder," the clinician is given a broad discretion in deciding which offender to admit as a patient: *ibid.* at 102-103.

183 It must be remembered that since the United Kingdom's scheme is a criminal justice-mental health interface, several governmental bodies are involved.

184 DSPD White Paper Summary, *supra* note 114 at Part 2, para. 3.

185 *Ibid.*

186 In the Department of Justice's Discussion Paper, one of the proposals under the adopted option for reform was to remove from courts the power to give a hospital disposition in the case of a psychopathic offender: *Mental Disorder Project: Criminal Law Review*, *supra* note 16 at Part 3, para. 24. However, such a proposal has not made its way into the DSPD White Paper Summary. It is recommended that attention be paid to such a major shift in policy since only the Home Secretary will be able to make a mental health disposition for such an offender.

187 DSPD White Paper Summary, *supra* note 114 at Part 1, para. 2, Part 2, paras. 12-14. See also DSPD Press Release, *supra* note 114.

temporary, which results in an impairment or disturbance of mental functioning."[188] While such a change mimics the Canadian approach to mental disorder in the criminal sphere,[189] the DSPD White Paper Summary is unclear in regard to how this will impact what precise mental conditions are preconditions for a hospital order: all that it suggests is that the new definition "will be matched by criteria that set clear limits to the circumstances in which compulsory powers may be used."[190] Whether there will be statutory inclusions, exclusions or indeed silence remains to be seen. Thus, in developing the definitional criteria of mental disorder for the purposes of a hospital disposition in the Canadian context, particular attention will have to be paid to application. The difficulty rests in how courts are to apply the definition of mental disorder for disposition purposes, particularly where a NCRMD defence was raised and failed. Another application problem that arises in the context of offenders who are already serving a sentence of imprisonment. Here, the difficulty rests in interpreting any wide definition of mental disorder by civil servants, rather than courts. Bureaucratic and political policy considerations can contaminate what ought to be an independent inquiry. Thus certain safeguards will have to be developed in order to avoid this potential quagmire.

The final consideration involves the nature of the offence. It is suggested that the virtually unlimited scheme of the United Kingdom be adopted. The United Kingdom is presently undertaking diversionary pilot programs in order to identify and hospitalize DSPD offenders, including those with mental illness. It is suggested that close attention be paid to the results of the new reforms. The results will carry considerable currency in evaluating the ultimate disposition approach to be taken with Dangerous Offenders.[191] However, although there is a movement towards disposition reform for DSPD offenders and those suffering from psychopathy, there are no current proposals to reform statutory schemes which impact upon hospital dispositions. Section 109(2) of the *PCCA* is still operational amidst the reforms. As a result, any empirical results from the reforms will have to be adjusted for the following reasons. Firstly, there are no research studies examining the operation of s. 109.[192] So far, all that can be said is that with the operation of s. 109, the number of indeterminate life sentences will rise and there will be a reduction in the number of DSPD offenders.[193] Secondly, Henham points out that s. 109 has "serious deficiencies," particularly with the lack of "qualifying" child-related offences.[194] In addition, the learned author notes that although s. 109 will "continue to attract judicial opprobrium and general condemnation from commentators," it is "certain to remain central to the Government's essentially 'bifurcated' penal policy," despite "fundamental objections to such forms of collective incapacitation."[195] In this regard, Professor Henham notes that s. 109 interferes with other protective provisions in the *PCCA* which can also address the need for protecting the public from serious harm from

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188 DSPD White Paper Summary, *ibid.* at Part 1, para. 7.

189 Section 2 of the *Code*, *supra* note 1, states that "'mental disorder' means a disease of the mind." It follows that "disease of the mind" is a legal concept, and it is thus a question of law for the court what mental conditions are included: *R.* v. *Rabey*, [1980] 2 S.C.R. 513.

190 DSPD White Paper Summary, *supra* note 114 at Part 1, para. 7.

191 See *Code*, *supra* note 1, Part XXIV.

192 Henham, *supra* note 101 at 696.

193 *Ibid.*

194 *Ibid.*

195 *Ibid.* at 708.

the offender.[196] Lastly, the tandem of s. 109 and s. 45 of the *Act* makes a hospital disposition available only to those offenders suffering from psychopathy. While a mechanism exists to expand the disposition to other mental disorders,[197] the British government has not done so,[198] even amidst the proposed reforms.

In conclusion, the threshold for a hospital disposition reveals that the station of the hospital disposition, statutory requirements regarding the availability of a bed, and treatability must be addressed in translating a similar scheme into the Canadian context. Moreover, particular attention must be paid to current reforms — to how and the manner in which DSPD mentally ill offenders will be disposed of and to the new wide definition of mental disorder.

B. CONSENT TO TREATMENT

Verdun-Jones has hypothesized that, along with the deprivation of liberty, treatment without consent may be viewed by some offenders as a punishment.[199] However, if one can conceptualize the loss of liberty as the nexus between punishment and imprisonment, then compulsory detention in a hospital facility assumes the same punitive role. Imprisonment, besides the non-consensual loss of liberty, does not contemplate any further bodily interference with the offender.[200] More importantly, treatment must remain

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196 *Ibid.* For the other provisions, see note 101. From the types of protective sentences that are available, it seems that there is a direction towards the Canadian Dangerous Offender scheme.

197 Eastman & Peay point out that s. 45A(10) empowers the Secretary of State to "extend the order to other mentally disordered [ill] offenders. Indeed, this section's wording uses the term "mental disorder," which can have broad application: *supra* note 137 at 97-98.

198 Even with the scheme in Scotland covering all categories of mental disorder, the initial reason given for not extending the s. 45A order was the Department of Health's financial concern of the rise in cost to the National Health Service for the provision of additional secure beds: *ibid.* at 98, n. 22.

199 Verdun-Jones, *supra* note 13 at 11.

200 There may also be additional protection implications arising from s. 7 of the *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*].

While an examination of the issues surrounding consent to treatment is not within the rubric of this article, some brief observations regarding this important issue must be made. First, the Ontario Court of Appeal decision in *Fleming* v. *Reid* (1991), 4 O.R. (3d) 74 established that both the common law and the *Charter* co-extensively recognize the inviolability of the human body as a principle of fundamental justice: *ibid.* at 88. In addition, the state's *parens patriae* jurisdiction cannot be used to abrogate *Charter* or statutorily conferred rights; it operates in order to justify state intervention when a person cannot take care of him/herself: *ibid.* at 91. As a result, the notion of self-determination viewed against consent to treatment takes on a different light, particularly when the issue of competency has been decided with respect to trial and disposition. The best interests of a patient cannot necessarily override prior competent wishes. In that vein, the Court ruled that the treatment wishes of a competent patient could not be vitiated if the patient becomes incompetent, particularly where a substitute consent-giver has affirmed that wish: *ibid.* at 91ff. However, the right to be free from non-consensual psychiatric treatment is not an absolute right. The Court alluded to hearing requirements which may justify circumvention of the patient's wishes: *ibid.*

See also *Swain*, *supra* note 33, wherein Lamer C.J.C., for the majority, stated that the issue of treatment was within Parliament's criminal law power. The length of detention and any review was within Parliament's competence, including the right to balance individual interests with the interests of protecting society.

conceptualized as just that and not as a form of punishment. Otherwise its therapeutic character will be lost.

There is a divergence in policy with the issue of consent to treatment. While the United Kingdom's interface provides for compulsory treatment, save for a few exceptions discussed above, Canadian policy developed for a similar interface has required consent.[201] In formulating such policy, the Law Reform Commission departed from prior Canadian studies and the practice in the United Kingdom.[202] The Commission's view was that an offender, who has been found both "capable of being tried" and responsible for the act(s) complained of, "should also be capable of consenting or refusing treatment" and that status as a prisoner should not affect one's right to consent.[203] Even with the opportunity to revisit this issue, the DSPD White Paper Summary has premised compulsory treatment on the alternate theories that compulsory treatment is in the best interests of the offender or that compulsory treatment is needed because of the risk of serious harm that the offender poses to others.[204]

Recent studies have shown that there is a great psychological value to be placed on choice; that choice is correlated to treatment success, particularly in the case of offenders.[205] Winick argues that treatment cannot succeed until there is an acceptance by the individual affected. Indeed, the author argues that "conscious involvement and active cooperation" are essential for treatment ranging from psychotherapy and behavioural therapy to "even organic forms of treatment."[206] Winick further posits that consenting to treatment — in other words exercising treatment choice — may trigger "'cognitive dissonance'"[207] which affects both perception and behaviour and produces additional motivation for the offender to meet or exceed treatment goals.[208] However, the author concedes that studies supporting such conclusions have been based on "less impaired populations" but maintains that allowing "as great a choice as the circumstances permit may still be therapeutic."[209] Finally, Winick states that coercive treatment "does not work as well" and that the option of a unilateral treatment decision breaks down the

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For an excellent discussion with respect to the consent to treatment issue in the American setting, see T.L. Hafemeister & J. Petrila, "Treating the Mentally Disordered Offender: Society's Uncertain, Conflicted, and Changing Views" (1993/94) 21 Fla. St. U.L. Rev. 729 at 761ff. The authors point to cases where courts are beginning to balance offender rights regarding consent to treatment against the interests of institutional and other offenders' safety.

See also M. Bay & H. Bloom, *A Practical Guide to Mental Health Capacity and Consent Law in Ontario* (Scarborough: Carswell, 1996).

201 See Working Paper 14, *supra* note 30 at 48-49 and *Mental Disorder Report*, *supra* note 19 at 30-32.

202 Working Paper 14, *ibid.* at 48.

203 *Ibid.* The threshold for fitness to stand trial is beyond the ambit of this article.

204 DSPD White Paper Summary, *supra* note 114 at Part 2, para. 4.

205 B.J. Winick, "The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis" (1994) 17 Int'l J. L. & Psy. 99 at 100-101.

206 *Ibid.* at 101-102.

207 "[T]he tendency of of individuals to reinterpret information or experience that conflicts with their internally accepted or publicly stated beliefs in order to avoid the unpleasant personal state that such inconsistencies produce": *ibid.* at 105 [citations omitted].

208 *Ibid.* at 108.

209 *Ibid.*

dialogic process between therapist and patient, leading to frequent dispensing of dialogue.[210] However, the consensus with regard to treatment effectiveness and consent is still unclear. For example, a study examining "the relationship between coerced hospitalization and treatment outcome" could find "no evidence that outcomes for 'coerced' patients were worse than outcomes for patients whose hospital admissions were characterized by minimal or no coercion."[211]

In both Working Paper 14 and the *Mental Disorder Report*, the Commission took the view that compulsory treatment did not reduce further criminality.[212] This is a broad sweep. If one can limit the scope of this statement to recidivism rates, this conclusion is now questionable. The statistics from the United Kingdom contradict the Commission's conclusion. Between 1984 and 1997, the average reconviction rate for mentally ill offenders subject to a restriction order involved in violent and sexual offences was three percent, eight percent lower than the expected percentage.[213] Specifically, the MDO Stats show that reconviction rates within two and five years for both grave and standard list offences are respectively one and three percent and nine and seventeen percent.[214]

For a practitioner ethical considerations also arise. In this regard, the first issue that requires addressing is identifying the client. There can be two outcomes. It is either the offender, corrections/hospital authorities or both. As a result, if the possibility of multiple clients exists, then the practitioner must clarify his/her role and responsibilities for each, particularly with respect to consent.[215] This view was earlier adopted by the Ontario Health Disciplines Board, which stated that "[i]nmates in correctional institutions are not free agents, who can pick and choose ... physicians.... [T]he Board believes that there is a greater onus placed on the professional to clearly obtain consent."[216]

As described above, the *Act* provides for treatment without consent except for the two statutory exceptions. While the second opinion acting as a surrogate to the offender's consent scenario seems to provide additional procedural protections, criticism has been levelled at its operation. The surrogate second opinion "routinely overrules a refusing

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210 *Ibid.* at 116.

211 R.A. Nicholson, C. Ekenstam & S. Norwood, "Coercion and the Outcome of Psychiatric Hospitalization" (1996) 19 Int'l J. L. & Psy. 201 at 213-14. The authors acknowledge that empirical study in this area is wanting: *ibid.* at 202.

212 See Working Paper 14, *supra* note 30 at 49 and *Mental Disorder Report*, *supra* note 19 at 31.

213 S. Johnson & R. Taylor, *Statistics of mentally disordered offenders 1999 England and Wales* (Bulletin) (London, UK: Home Office Research and Statistics Directorate, November 2000) at 23 (see also para. 18), online: <www.homeoffice.gov.uk/rds/pdfs/ hosb2100.pdf> (date accessed: 15 February 2001) [hereinafter MDO Stats].

214 *Ibid.* at 22 (see also paras. 18-19). Note: the standard list offences percentages include offenders convicted of grave offences.

215 Concerns regarding confidentiality are also at issue. See J.R.P. Ogloff, "Information Sharing and Related Ethical and Legal Issues for Psychologists Working in Corrections" (1994) [unpublished, archived with Aman S. Patel].

216 *In the matter of a complaint under section 8 of the Health Disciplines Act R.S.O. 1990, c. H.4 between Ralph MacInnis and Robert Dickie M.D.* (19 November 1993), File# 3278 (O.H.D.B.). While this case was concerned with consent for assessment and subsequent release of the assessment report, it is submitted that the principle is the same.

patient."[217] The types of treatment that can thus be given without consent include both experimental and electroshock therapy. Professor Alan Stone has observed that "the single issue of involuntary mind alteration has leapt to the forefront of public concern," and that "[m]uch of the furor concerning involuntary treatment has centered [*sic*] on the use of electroshock therapy."[218] What can be taken from Professor Stone's argument is that in balancing "the great need for flexibility in good clinical practice," greater regulation and control will be required for certain therapies like electroshock, even in light of gaining consent.[219] With respect to the issue of consent, Professor Stone advocates shunning the extremes of paternalism and the absolute right to refuse thus forcing the development of "some concept such as 'competent informed consent.'"[220] In doing so, three interconnected elements are identified: competency, informed nature of consent, and consent itself. In addressing these three elements, Professor Stone suggests imbedding procedural safeguards such as the right to appeal, hearings, etc. within each element.[221] As an end result, if consent is refused and the physician believes that the consent is not *bona fide* or fully informed, some resort must be made to a substitute decision-maker.[222] However, in order to avoid the surrogate second opinion debacle experienced by the United Kingdom, it is suggested that the disposition hearing itself be used to decide issues relating to competency, consent, the reasons behind a refusal, and any viable alternatives or less "intrusive" measures that may be available. Thus the offender has the protection of being represented by counsel, a judicial determination, and a fully disclosed treatment plan. In addition, the offender can appoint a substitute decision-maker who could participate in the process. The purpose of such procedural safeguards for the Canadian context is to insulate against a hospital disposition being thwarted or abused by virtue, respectively, of offender paranoia or masochism.[223] In this vein, it is submitted that the Law Reform Commission's view regarding consent as a precursor to a hospital disposition is simplistic. It ignores the reality that the diagnoses and treatment of mental illness is a complex process. The precursor approach to a hospital disposition is as coddling as the paternalistic approach. The Commission ignores the precursor approach's coercive character, which bares its fangs in two instances. First, coercion surfaces at the prison-or-hospital juncture of the sentencing hearing. If a hospital disposition is effected, coercion hangs over the offender's head like the sword of Damocles. Its effect is even more powerful since a refusal of treatment will lead to a return to prison. Thus, at a level, the precursor approach espoused by the Law Reform Commission and the *Act's* compulsory treatment regime converge. In addition, the Commission cannot account for the consenting offender who does so only to satisfy masochistic proclivities. In order to placate fears of treatment abuse, electroshock, experimental, and controversial treatments ought to require

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217 Verdun-Jones, *supra* note 13 at 17.

218 A.A. Stone, *Mental Health and Law: A System in Transition* (Rockville, Md.: National Institute of Mental Health, 1975) at 98-99. See also B.F. Hoffman, *The Law of Consent to Treatment in Ontario*, 2d ed., (Toronto: Butterworths, 1997) at 161 wherein the author states that "[t]he social distrust of the theory and practice of psychiatry has been intensified by abuses, both political and social."

219 Stone, *ibid.* at 100.

220 *Ibid.* at 102.

221 *Ibid.* at 103.

222 *Ibid.* at 104.

223 For the purposes of this discussion, the term "masochism" is limited to the offender's desire to subject oneself to treatment not for rehabilitation, but rather for gratification and potential harm at the hands of a third party, namely the treatment facility.

both consent and strict regulation, including third party monitoring. While it is conceded that consent to a mental health disposition and treatment will usually be a matter of routine, the disposition must be robust enough so as avoid both dispositive sensitivity by virtue of the non-consenting offender[224] as well as offender exploitation because of masochistic tendencies. In this vein, the *Act's* requirement of two psychiatric assessments, as opposed to one overarching opinion, does appear to offer some protections with regard to the concerns raised above. In developing a policy which better addresses the philosophy, ethics, and medicine involved in a Canadian criminal justice-mental health interface, Hoffman's conclusion that the public and politicians must be "educated about the tragic realities of mental illnesses so that more compassionate laws can be considered" bears consideration.[225]

Charter implications must also be borne in mind. Forced or coerced psychiatric treatment without the offender's consent will give rise to security of the person implications under s. 7. Given the context of the disposition together with judicial guidance regarding hearing requirements as well as balancing the interests of the offender against institutional other offender safety, and indeed the protection of society in general, a scheme can be developed which will not offend the *Charter*. In addition, the considerations discussed above will also aid in finding constitutional solutions.

In conclusion, treatment must not be conceptualized as a form of punishment. The divergent approaches to consent to treatment must be resolved. The United Kingdom's paternalistic approach is subject to administrative and treatment abuse, while the precursor approach espoused by the Law Reform Commission ignores the realities of procedural coercion. Thus in developing policy surrounding consent to treatment, a compromise imbued with sufficient procedural safeguards must be developed, with regard paid to any *Charter* concerns that may arise.[226] However, the bare paternalistic approach in the United Kingdom, while providing guidance, is not a solution.

C. DISCHARGE

"In no case should the term of treatment exceed the length of the sentence imposed."[227] There are two reasons underpinning this proposal. First, the state avoids having to assume any greater paternalistic role *than necessary*.[228] More importantly, "capping" the term of detention for treatment is consistent with the fundamental objective

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224 The non-consenting offender can be one who either expressly does not consent or fails to dissent to a hospital disposition.

225 Hoffman, *supra* note 218 at 175.

226 See *Fleming* v. *Reid*, *supra* note 200 and text in note.

227 LRC *Guidelines*, *supra* note 20 at 32.

228 While this suggestion could be considered at odds with the analysis regarding consent to treatment above, it is submitted that paternalism operates at different levels in relation to treatment and location. In order to reconcile the apparent inconsistency, a sliding scale approach to the deprivation of liberty can be taken. The concept of punishment through the deprivation of liberty can then range from imprisonment *in stricto sensu* to detention in other milieus. Thus the choice of location results from balancing offender needs with sentencing principles. It is in this context that the term paternalistic is used.

of restraint. Indeed, capping properly belongs to the sentencing system.[229] According to the Law Reform Commission, the duration of hospitalization should be capped by a court imposing a finite sentence and ordering "that a portion of the entire term of imprisonment imposed on an offender be spent in a mental hospital."[230] This is sensible. The credo that like sentences be imposed for like offences committed in like circumstances by like offenders must remain paramount. For a mentally ill offender, only the "like offenders" element is given specialized consideration; however, consistency is still maintained as offender needs and placement do not affect the credo. In addition, sentence maximums should not be considered for capping purposes as it also offends parsimony. By virtue of this proposal, an offender will not spend more time in detention than that contemplated by a sentence. It is also proposed that, notwithstanding a hospital disposition, the mentally ill offender still have resort to a contextually modified release scheme similar to those release procedures that an imprisoned offender would have available.[231]

Another area of concern relates to the restriction order. It has no place in the Canadian context for two reasons. First, there exists a per se rule with regard to the imposition of restriction orders. The rule states that a restriction order should be unlimited in time,[232] and to place a time limit would be unusual and unwise, requiring a medical foundation stating that the offender can be cured within a specified period.[233] A court must assess "not the seriousness of the risk that the offender would re-offend, but the risk that, if he did so, the public might suffer serious harm."[234] However, the order should not be given in order to "mark the gravity of the offence ... nor as a means of punishment."[235] The end result of the imposition of a restriction order by virtue of the per se rule is indefinite detention. This is also contrary to parsimony. As such, the restriction order option should be abandoned in the Canadian context. A second reason for abandoning the restriction order option is to safeguard against a correctional or political official wielding the powers of such an order. Provision for longer detention within a sentence could be structured, with contextual modifications, to mirror the options available through the *Code* and *Corrections and Conditional Release Act*.[236] Any further detention beyond that contemplated by a sentence should be achieved through involuntary commitment through the civil process.[237] This avoids conflation of criminal and civil dispositions. The distinction is important. The end of a sentence typically marks the end of the state's coercive power by virtue of the criminal law. Thus the punitive aspect of the disposition must terminate. By continuing detention, punishment is prolonged without justification.

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229 *Winko*, *supra* note 33 at para. 172, Gonthier J. (dissenting). The learned judge made this statement in relation to the NCRMD disposition.

230 *Mental Disorder Report*, *supra* note 19 at 46-47.

231 See LRC *Guidelines*, *supra* note 20 at 32.

232 See *R.* v. *Gardiner*, [1967] 1 All E.R. 895 (C.A.); *R.* v. *Birch* (1989), 11 Cr. App. R. (S) 202 (C.A.) [hereinafter *Birch*].

233 *R.* v. *Nwolhia*, [1996] 1 Cr. App. R. (S) 170 (C.A.), online: LEXIS (UK Cases, Combined Courts).

234 *R.* v. *A.M.*, [1995] E.W.J. No. 5514 at para. 19 (C.A.), online: QL (EWJ). The assessment of risk is for the court: *ibid.*

235 *M.L.J.*, *supra* note 132 at para. 46 quoting *Birch*, *supra* note 232 at 212.

236 S.C. 1992, c. 20, Part II and *Code*, *supra* note 1, s. 753.1. Indeed, long-term offender designation would have partly the same result as a restriction order, but the advantage is that it is time limited.

237 See also A. Grounds, "Transfers of Sentenced Prisoners to Hospital" [1990] Crim. L.R. 544 at 550-51 where the author advocates for detention to "cease at the expiry of sentence" and any continued detention be justified on civil commitment and detention criteria.

In order to justify detention, a civil commitment is the proper focus.[238] Moreover, the criteria and policy for civil and criminal commitment and retention can be divergent.[239] With regard to mentally ill Dangerous Offenders, the solutions are not clear cut, particularly when it can be argued that "dangerousness" will decrease as a function of time. However, the new identification and treatment programs being undertaken in the United Kingdom lead to the inference that imprisonment is not the only option. Indeed, the results of the efforts undertaken in the United Kingdom with respect to this group of offenders will provide further education in this regard. As a result, Dangerous Offender status should not be determinative with respect to the imposition of a hospital disposition.

Tribunal procedures are also a concern. The role of the medical member is peculiar and may lead to a breach of the rules of procedural fairness. Recall that the medical member must examine the offender and provide a psychiatric opinion to the tribunal. Thus the role of the medical member as both an expert witness and judge will likely breach the doctrine of *nemo judex*. However, the *Act* provides two saving provisions. First, there is the requirement that the medical member declare a differing opinion. Second, the defence of statutory authorization may lend a saving hand to a similar scheme in the Canadian context.[240] Even still, there has been criticism of the medical member's role. Although one of the primary roles of the legal member is to ensure procedural fairness, there is still the lurking danger of the legal and lay members deferring to the opinion of the medical member.[241] This danger is attenuated by the medical member giving direct opinions during deliberations, particularly since the medical member has examined the offender. The integrated role of the medical member as "member, expert and witness is anomalous," and the requirement of disclosing a differing opinion has been called ineffective.[242] The end result of these risks playing out is the tribunal effectively being turned into a clinic.[243] A simple solution to these concerns is for the tribunal to obtain an independent

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238 However, as Professor Manson points out, there must be "indicia of imminent risk": Manson, *supra* note 45 at 344. The learned author posits that a civil commitment immediately at the gates of the jail is not without controversy, as he identifies the Ontario Court of Appeal decision in *Starnaman* v. *Panetanguishene Mental Health Centre* (1995), 100 C.C.C. (3d) 190 as a "controversial decision upholding the power to commit a convicted paedophile immediately upon release from penitentiary [*sic*] on the grounds of paedophilia and risk": *ibid.* at 344, n. 126.

239 The House of Lords has ruled that the test for discharge is the same as that for admission and that the focus is on treatability. However, one cannot take a modernized "clinical" look behind the justification of the initial detention: *Reid* v. *Secretary of State for Scotland*, [1999] 1 All E.R. 481 (H.L.). Moreover, the disorders listed in the hospital order is a starting point and can be amended so as not to frustrate conditional discharge powers in the future. Thus "[r]eclassification relates to whether the patient suffers from a particular mental disorder; not to whether he is detainable for that mental disorder if it stood alone": *R.* v. *Anglia & Oxfordshire Mental Health Review Tribunal ex parte Hagan*, [2000] Lloyd's Rep. Med. 119 (C.A.), online: LEXIS (UK, Combined Courts). Also note that in contrast to the Canadian context, the offender bears the persuasive burden for discharge.

240 Whether the liberty interests of the offender, protected by s. 7 of the *Charter*, will trump the sliding scale approach to procedural fairness and statutory authorization is a separate and complex consideration and is not within the ambit of this article.

241 See J. Peay, "Mental Health Review Tribunals and the *Mental Health (Amendment) Act*" [1982] Crim. L.R. 794 at 802.

242 G. Richardson & D. Machin, "Judicial Review and Tribunal Decision Making: A Study of the Mental Health Review Tribunal" [2000] Pub. L. 494 at 506-508.

243 *Ibid.* The authors point out that fundamental changes regarding the role of the medical member have been recommended and endorsed in a government Green Paper: *ibid.* at n. 57.

third party psychiatric assessment of the offender. This will obviate any *nemo judex* concerns as the assessor could be subject to questioning from the tribunal, cross-examination, or both, and this would preserve procedural fairness.[244]

The prospect of a transfer or return to prison must also be addressed. First, the issue of treatability resurfaces. It is suggested that a more expansive approach to treatability be adopted that considers both cause and effect. Thus the problem of hospital staff affecting discharge and fettering the discretion of a reviewing tribunal can be avoided. As Mulvany states, a de facto discharge can be effected by hospital staff providing little or no information to a reviewing tribunal in order to justify ongoing detention.[245] In addition, if a hospital disposition is tied too closely to the prospect of a return to prison, then consent to treatment becomes even more coerced.[246] While accounting for instances where a transfer or return to prison can be justified, this should be the exception and not the rule.[247] A return to prison would require the offender "to adapt to life as an inmate."[248] Rudin further notes that "[s]uch adaptation ... does nothing to help the offender readjust to society upon release ... and the skills acquired [in prison] will not prove to be of any positive assistance outside the jail environment."[249] With respect to release, a return to prison for that purpose would be counterproductive. The potential risk of destabilization and wasted resources militate against any such policy. As such, procedures for the eventual discharge of an offender should be based on cascading discharge into the community from hospital, not prison.

In concluding this section, it has been suggested that restraint must be paramount. An offender should not be held by virtue of the criminal law beyond a contemplated sentence. In addition, cascading release provisions should be made available to the offender subject to a hospital disposition. The restriction order ought to be abandoned in the Canadian context due to it both offending parsimony and the danger of it being wielded by bureaucrats. Also, discharge ought to be in the direction of the community, not prison. This will avoid hospital staff fettering release decisions and minimize coercion with respect to consent to treatment. Finally, any tribunal in the Canadian context ought to obtain independent psychiatric assessments of the offender. Although the presence of a medical member is meritorious, the role of that member should be an informational and not a dispositive one.

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244 This will all depend on the amount of procedural fairness that will be accorded to the offender.

245 Mulvany, *supra* note 169 at 110-11. This goes hand-in-hand with the manner in which difficult or disruptive offenders are denied a hospital disposition.

246 Hafemeister & Petrila give the example of an offender being isolated from other offenders for refusing to take medication. However, the offender was not transferred back to prison. Thus, although isolation provided coercion for taking one's medication, its degree was far lower than the threat of being returned to prison: *supra* note 200.

247 The justifications for this suggestion abound. For example, it could lead to a deterioration of a mental condition or a relapse.

248 Rudin, *supra* note 60 at 297.

249 *Ibid.*

V. CONCLUSION

The current Canadian regime for the disposition of a guilty mentally ill offender is deficient. The interplay between the principles of sentencing and the responsibility of the offender cannot be applied as effectively to mentally ill offenders. Reliance on correctional authorities to provide for the needs of this group is tenuous. Both institution culture, and conflicting correctional aims and philosophies combine to create a significant systemic barrier to mental health treatment. The Law Reform Commission recommended the implementation of a hospital disposition over twenty-five years ago. Despite support from the Department of Justice, Parliament is not taking calls. Courts are now beginning to express frustration at the sentencing options available. While in limited circumstances a *Knoblauch* disposition can be given, inherent limitations, traditional sentencing considerations, and lacking infrastructure can nevertheless frustrate a crucially needed disposition.

In assessing the criminal justice-mental health interface as applied in the United Kingdom, several considerations relating to translatability have been raised. First, offender treatability cuts through the entire fabric of the interface. Particular attention must be paid to current reforms of how treatability will be assessed. In considering the hospital disposition of Dangerous Offenders, reforms to the manner of disposition of (mentally ill) DSPD offenders will provide critical empirical data for a similar Canadian scheme. Second, the divergent approaches to consent to treatment must be resolved. The shortcomings of the United Kingdom's paternalistic approach are matched by the Law Reform Commission's precursor approach. Policy regarding consent to treatment must be mindful of any *Charter* concerns, and sufficient procedural safeguards must be developed in order to shield against undue coercion. Third, restraint must be paramount. Mental health detention in the criminal context cannot go beyond a sentence. An offender should, as a rule, cascade into the community, not to prison. Last, any tribunal, while having expert composition, should obtain independent psychiatric assessments of the offender in order to preserve procedural fairness.

In conclusion, this article has examined the United Kingdom's criminal justice-mental health interface through a Canadian lens. While some of the problems associated with the United Kingdom's scheme have been identified, it is submitted that no disposition scheme will be devoid of problems. However, the concerns identified in this article can be addressed both in policy and substantively. In light of similar hospital disposition schemes operating in Australia and New Zealand, and in order to better meet the needs of mentally ill offenders and to ensure a just criminal justice system, the time has come for Parliament to implement a similar, albeit modified, disposition. Mentally ill offenders ought not "pay the price for our failure to provide sufficient resources to the sentencing system."[250]

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[250] Manson, *supra* note 45 at 389.